UAW Retirees of ACC Benefit Trust

Summary Plan Description
As in effect January 1, 2014

Table of Contents

Introduction

The UAW Retirees of ACC Benefit Trust provides medical, including prescription drug benefits for eligible participants. This Summary Plan Description (SPD) describes the benefits of the UAW Retirees of ACC Benefit Trust available as of January 1, 2014.

This SPD covers benefits for participants who are not eligible for Medicare (pre-Medicare participants) and benefits for participants covered by Medicare (Medicare-eligible participants).

- **Pre-Medicare Participants:** Pre-Medicare participants are participants who are not eligible for Medicare. For pre-Medicare participants, the Plan provides medical and prescription drug coverage through the Blue Cross Blue Shield of Michigan (BCBSM) Preferred Provider Organization (PPO) Plan.
- **Medicare-Eligible Participants:** Medicare-eligible participants are participants who are covered by Medicare. For Medicare-eligible participants, the Plan provides medical and prescription drug benefits through BCBSM's Medicare Plus Blue Group PPO Plan (a Medicare Advantage Plan).

Important: This Plan provides benefits for Medicare-eligible retirees, spouses, dependents and surviving spouses through a Medicare program. Therefore, when you become Medicare-eligible as a retiree, spouse, dependent or surviving spouse, you must enroll in both Medicare Part A and Part B to have full coverage under this Plan. If you are eligible for Medicare but you delay your enrollment in Parts A and B, your benefits under the Plan will be paid as if you had Medicare coverage, whether or not you are enrolled in Medicare. To avoid paying additional out-of-pocket medical expenses, be sure to enroll in Medicare Parts A and B. Your out-of-pocket medical costs under the Plan, as well as your Medicare Part B premium, will be significantly higher if you do not enroll in Medicare Parts A and B as soon as you are eligible.

When you become eligible for Medicare:

- Notify BeneSys and send a copy of your Medicare enrollment verification to BeneSys as soon as it is received.
- Do not sign up for an individual Medicare Part D prescription drug plan unless you do not want to receive either medical or prescription drug coverage from this Plan.

This Plan is intended for individuals who are eligible for post-retirement health care coverage due to:

- Retirement from UAW-represented service with Automotive Component Carrier (ACC) LLC on or before August 1, 2009; or
- Termination of employment with ACC on or before August 1, 2009 under Option 4 of the Special Attrition Plan ACC, GM and UAW dated May 28, 2009, as amended by Addenda dated May 29, 2009 and June 2, 2009.

In general terms, a court-approved settlement agreement required ACC to contribute to a Voluntary Employee Beneficiary Association (VEBA) to fund continued retiree health benefits for certain retirees who satisfy the retirement eligibility requirements specified in this SPD. The VEBA is a trust fund independent from ACC and the UAW. A VEBA Committee manages the assets of the VEBA and administers the VEBA's benefits. ACC has no authority or obligation with respect to the VEBA other than to satisfy its funding obligation.

The Committee has the right to change terms of this Plan, such as benefit levels, coverage, carriers, providers and out-of-pocket costs. The VEBA Committee cannot change eligibility requirements for retirees, spouses or surviving spouses; however, the Committee may change eligibility requirements for dependents.

The Plan is designed to help you meet your medical needs. However, it is your responsibility to know what your benefits are and how to use them. Be sure to:

- **Carry Your ID Cards.** Be sure to carry your medical ID cards with you and show them whenever you receive medical care or need to fill a prescription.
- **Follow Plan Procedures.** Review the information in this SPD so that you are familiar with how the Plan works to ensure you make the most of your benefits.
- **Keep the Trust Administrator Informed of Changes.** You should notify BeneSys of any change in your address, family status (such as marriage, birth, adoption, death, divorce, legal separation or a child losing dependent status) or medical insurance coverage of a family member covered by the Plan.
- **Identify Yourself.** If you need to contact BeneSys, be sure to include your name and the last four digits of your Social Security number in your letter. To protect against identity theft, do not include your complete Social Security number in your letter, just the last four digits. If you call, be sure to have your complete Social Security number handy.
- **Keep Copies of Bills, Receipts and Explanations of Benefits (EOBs).** These copies can help you when filing a claim or appeal.
- **Keep Notices You Receive from the Plan.** Keep any notices of Plan changes or information you receive with this booklet. As a participant in the Plan, you have certain responsibilities to protect your eligibility for coverage and to receive your benefits.
- **Read this Booklet.** Take the time to read this SPD and share it with your family. The information contained in this SPD supersedes any earlier SPD you may have received.

If you have specific questions or need any assistance, contact BeneSys:

- **Street Address:** 700 Tower Drive, Suite 300, Troy, Michigan
- **Mailing Address:** P.O. Box 1708 Troy, Michigan 48099-1708
- **Phone:** (855) 641-4911 (toll-free) or (248) 641-4911
- **Fax:** (248) 813-9898
- **Office Hours:** Monday through Friday, 7:30 a.m. to 4:30 p.m.

This SPD describes how the Plan works, what benefits it provides and how to obtain those benefits. This SPD is only a summary of your benefits; full details of the Plan are included in the plans, policies and schedules of the carriers, the policies of the Committee and other documents that govern the Plan. The UAW Retirees of ACC Benefit Trust and the Plan are governed by the Committee. The Committee is the legal Plan Administrator. No one has the authority to speak for the Committee in explaining the eligibility rules or benefits of the Plan, except the full Committee or the Plan Administrator to whom such authority has been delegated. In case of conflict, insurance carriers' plans, policies and schedules, not this summary booklet, will govern, unless this summary specifically states to the contrary. The Committee has the right to interpret the Plan, change or eliminate benefits or amend or terminate the Plan at any time.

Eligibility and Participation

This section describes the eligibility requirements for individuals eligible for coverage under the UAW Retirees of ACC Benefit Trust. You will not be able to enroll in this Plan until you are eligible for this Plan under Plan rules (as described in this section).

Enrollment in Medicare

As soon as you become eligible for Medicare, you must:

- **Sign up for Medicare Parts A and B.**
- **Notify BeneSys.** You must send a copy of your Medicare enrollment verification to BeneSys as soon as it is received if you are transitioning from coverage for pre-Medicare eligible participants.
- **Not sign up for an individual Medicare Part D prescription drug plan.** If you sign up for an individual Medicare Part D plan, you will not receive medical or prescription drug coverage from this Plan.

The Plan provides benefits to eligible participants. You and/or your dependents are only eligible if you meet the eligibility requirements described in this section and enroll in the Plan. The eligibility and enrollment rules in this section control over those attached to any benefit summaries.

As a retiree (or surviving spouse), you may cover eligible dependents, which are generally your spouse (for a retiree only) and children, including children who are the subject of a Qualified Medical Child Support Order (QMCSO).

Eligibility

Retiree Eligibility

Generally, to be eligible for post-retirement health coverage under the Plan, you must be eligible for this coverage based on the terms of retirement or termination of employment from ACC, and you must make any required payments for coverage.

You are not eligible for coverage if you:

- Are eligible only for a deferred vested pension benefit under the Automotive Component Carrier Hourly-Rate Employees Pension Plan, except if you terminated employment from ACC on or before August 1, 2009 under Option 4 of the Special Attrition Plan ACC, GM and the UAW dated May 28, 2009, as amended by Addenda dated May 29, 2009 and June 2, 2009 (2009 SAP Member);
- Are not a retiree or a 2009 SAP Member who becomes eligible for coverage upon attaining retirement age under an ACC pension plan; or
- Were discharged for cause, even if you are receiving a pension from an ACC pension plan.

As a retiree, if you die, coverage for your eligible spouse and dependents will continue until the end of the month in which you die. For example, if a retiree dies on March 15, coverage for his or her spouse continues to the end of March. If your surviving spouse and eligible dependents are eligible for surviving spouse and dependent coverage, this coverage will begin as of the first of month after your date of death (April 1 in the example above).

Spouse Eligibility

Your spouse is eligible if you are an eligible retiree, as described above, enrolled in coverage. Your common-law spouse is eligible for coverage if the relationship is recognized by the laws of the state in which you are enrolled and you meet requirements for documentation as required by the Plan.

A "spouse" is as an individual married to a retiree with a valid marriage certificate from a state, the District of Columbia, a U.S. territory or a foreign country (jurisdiction) where the marriage is recognized as legal according to the laws of that jurisdiction, regardless of whether the individual or the retiree is a current resident of that jurisdiction.

Dependent Children Eligibility

Only retirees may add children as dependents; surviving spouses may not.

Your children are eligible for coverage under the Plan when you enroll if they meet all five of the following eligibility tests:

- **Eligibility Test 1—Relationship:** The child must be:
  - Your natural child;
  - Your stepchild (child of your current spouse);
  - A child legally adopted by you or your spouse;
  - A child placed with you for legal adoption who is under age 18; or
  - A child by legal guardianship.
- **Eligibility Test 2—Age:** The child must be:
  - Under age 26. A child is eligible until the end of the calendar year in which he or she reaches age 25 as long as he or she continues to meet the eligibility criteria (documentation will be required during periodic audit processes); or
  - A child is not subject to the age restriction if he or she is determined to be permanently and totally disabled before the end of the calendar year in which he or she reaches age 25; the child would need to be enrolled as a permanently and totally disabled dependent child before the end of that calendar year.

- A dependent is considered permanently and totally disabled if he or she has a medically determinable physical or mental condition that prevents him or her from engaging in substantial gainful activity and is expected to result in death or be of long-continued or indefinite duration.
- To be eligible, a permanently and totally disabled dependent must not earn more than $10,000 per year from employment.

- **Eligibility Test 3—Marital Status:** The child must not be married.
- **Eligibility Test 4—Residency:**
  - The child must live with you as a member of your household; or
  - You (as the retiree or surviving spouse) must have legal responsibility for providing health care expenses for the child.
- **Eligibility Test 5—Dependency:** The child must be:
  - Dependent on you (as the retiree or surviving spouse); that is, generally someone for whom you claim an exemption on your federal income tax (the IRS has special rules for children who have reached the end of the calendar year in which they turn age 26; see IRS Publication 501 for more information); or
  - Your (as the retiree or surviving spouse) legal responsibility for providing health coverage through a divorce decree, court order related to divorce or a Qualified Medical Child Support Order (QMCSO).

A QMCSO or National Medical Support Order may require you to enroll a child in the Plan when you enroll. The child's eligibility under this order will not extend beyond the Plan's age limits for dependent children. Procedures for handling QMCSOs are available from BeneSys, upon request, at no cost.

Surviving Spouse and Dependent Eligibility

As a retiree, your surviving spouse and dependents continue to receive health care coverage after you death, as long as Plan rules are met.

Your surviving spouse and dependent children, as defined by the Plan, are eligible for coverage under the Plan if you die while an eligible retiree under the Plan. Only your spouse and dependent children who were eligible at the time of your death are eligible to continue coverage. Surviving spouses may not add a new spouse to their coverage.

A surviving spouse may continue coverage for a dependent child who was enrolled by a retiree before his or her death, as long as the child continues to meet the dependent eligibility tests. The surviving spouse may only enroll a new child if the child was eligible to be enrolled by the retiree on the date of the retiree's death.

Like any other eligible participant, a surviving spouse must enroll in Medicare Parts A and B at age 65 to be eligible for continued coverage under the Plan.

You are not eligible for surviving spouse or surviving dependent coverage under the Plan if you

are a surviving spouse or child:

- Of a former employee eligible only for a deferred vested pension benefit other than if you terminated employment from ACC on or before August 1, 2009 under Option 4 of the Special Attrition Plan ACC, GM and the UAW dated May 28, 2009, as amended by Addenda dated May 29, 2009 and June 2, 2009 and died after attaining your retirement age under the Company's pension plan;
- Eligible only for a pre-retirement survivor benefit under the Company's pension plan; or
- Eligible only for receipt of benefits as alternate payees under the Retirement Equity Act of 1984.

When Coverage Begins and Ends

If You Are a	Your Coverage Begins	Your Coverage Continues	Your Coverage Ends on the Earliest of:
Retiree	On your retirement date	As long as you continue to meet the eligibility requirements and make any required payments	• The date of your death • When you do not make any required payments • The date the Plan is terminated
Spouse	On the date your retiree spouse's coverage begins	As long as you and your retiree spouse continue to meet the eligibility requirements and make any required payments	• The date of a final decree of divorce from your retiree spouse • When your retiree spouse's coverage ends for not making any required payments • The last day of the month in which your retiree spouse dies (however, you may be eligible for coverage as a surviving spouse) • The date the Plan is terminated

If You Are a	Your Coverage Begins	Your Coverage Continues	Your Coverage Ends on the Earliest of:
Dependent Child	On the date retiree coverage begins	As long as the retiree and you continue to meet the eligibility requirements and the retiree makes any required payments	• When you no longer meet the Plan's eligibility rules • When the retiree or surviving spouse remove you from coverage • When any required payments are not made on your behalf • The last day of the month in which the retiree dies (if there is no surviving spouse; coverage may continue after a retiree's death if there is a surviving spouse who continues coverage) • The last day of the month in which the surviving spouse dies • The date the Plan is terminated
Surviving Spouse	On the first day of the month after the month in which the retiree dies	As long as you continue to meet the eligibility requirements and make any required payments	• The date of your death • When you do not make any required payments • The date the Plan is terminated

When coverage ends, you may be eligible to continue coverage under COBRA; see the COBRA Continuation Coverage section, beginning on page 10.

Monthly Payments

You are required to make monthly payments to maintain eligibility for Plan benefits; the amount may vary depending on whether you are eligible for Medicare and the level of coverage you elect (such as single or family coverage). If any required monthly payments are not made on time, your coverage will be terminated.

Monthly payment amounts are subject to change from time to time, You will be notified of the amount of any required monthly payments.

Proof of Prior Medical Coverage

In compliance with the Health Insurance Portability and Accountability Act of 1996, the Plan will provide you and/or your dependent with a certificate of creditable coverage when coverage ends. This certificate proves that you were covered.

Enrollment

Your enrollment in the Plan is based on meeting the Plan's eligibility requirements and on all required documentation being completed and received by the Plan. If you do not provide all required documentation, including proof of dependent status and Social Security Number, your and/or your dependents' coverage may be denied or cancelled.

As a retiree, or surviving spouse, you may choose coverage for yourself only or for yourself and your eligible family members. Your plan will apply to all dependents covered by the Plan.

You can only enroll your spouse or dependent child if they meet the Plan's requirements for eligibility as explained earlier.

Deferring Enrollment

As a retiree or surviving spouse, you may defer enrollment under the Plan. For example, this may occur if you have coverage under another plan. If you decide to enroll in the Plan, your coverage will begin on the first day of the month following notification to BeneSys. Proof of other coverage will be required.

Removing a Dependent from Coverage

You must notify BeneSys to remove a spouse or dependent child from coverage as soon as the individual no longer meets the Plan's eligibility requirements. You are liable for any claims paid on behalf of any individual who is not eligible for benefits. The Plan is not responsible for these claims.

Reinstating a Dependent

If a dependent child loses eligibility and later becomes eligible again, his or her coverage may be reinstated if he or she meets all of the eligibility tests. Reinstated coverage begins on the first day of the month after you notify BeneSys.

Reinstatement after Termination for Non-Payment

If you do not make the required contributions for coverage, your coverage under the Plan will end. In this case, you may re-enroll in the Plan on a prospective basis, but only if you provide evidence of other coverage for the interim period. If you do not provide evidence of other coverage, but request reinstatement within 60 days of termination, you will be reinstated retroactive to the date of termination when you pay all contributions in full, on a one-time basis. If you do not provide evidence of other coverage and request reinstatement after 60 days from termination, you may be reinstated at the beginning of the next plan year, on a one-time basis.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, this Plan is considered a group health plan that is subject to COBRA. COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a qualifying event. Specific qualifying events are listed below. COBRA continuation coverage is offered to each person who is a qualified beneficiary. Qualified beneficiaries who elect COBRA continuation coverage must pay for this coverage.

Qualified Beneficiaries

A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Qualified beneficiaries include a:

- Covered spouse of a retired employee; and
- Dependent child of a retired employee or surviving spouse.

In general, for a qualified beneficiary to be eligible to elect COBRA continuation coverage, he or she must have been covered under the Plan on the day before the event that would otherwise cause coverage to terminate. However, any dependent children born to or placed for adoption with a qualified beneficiary while covered under COBRA will be covered under the Plan if the birth or adoption is reported within 31 days of the event.

Qualifying Events

COBRA continuation coverage may be purchased as follows:

- **Retired Employee's Spouse (other than a Surviving Spouse):** A covered spouse of a retired employee may elect COBRA continuation coverage for up to 36 months if the:
  - Covered retired employee dies; or
  - Spouse and the covered retired employee divorce or legally separate.
- **Dependent Children:** A covered dependent child of a retired employee or surviving spouse may elect COBRA continuation coverage for up to 36 months if the:
  - Retired employee or surviving spouse dies; or
  - Covered dependent no longer meets the Plan's definition of an eligible dependent.

Notify the Fund Administrator of Qualifying Events

You must notify BeneSys within 60 days of when a qualifying event occurs, including the death of a retired employee or surviving spouse, or divorce or legal separation. Notification should be sent to:

BeneSys
P.O. Box 1708
Troy, Michigan 48099-1708

A qualified beneficiary must notify BeneSys, in writing, of his or her election for COBRA continuation coverage **during the 60-day election period.** *Once the 60-day election period has passed, the election to decline COBRA continuation coverage cannot be changed.*

Electing COBRA Continuation Coverage

Once BeneSys receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualifying beneficiary. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Parents may elect COBRA continuation coverage on behalf of their dependent children.

If you inform BeneSys that you want COBRA continuation coverage but you do not specify whether you want single or other coverage, BeneSys will assume that you want to cover all eligible qualified beneficiaries. If a qualified beneficiary is totally incapacitated and is not legally competent to make an election for COBRA continuation coverage, the 60-day election period is suspended until the qualified beneficiary is able to make an election or until a guardian or legal representative is appointed who can make the election on behalf of the qualified beneficiary.

Failure to notify the Fund Administrator of a qualifying event within the time limit will result in the permanent loss of COBRA rights.

If you initially elect not to continue coverage under COBRA, you may revoke that choice and decide to receive COBRA continuation coverage at any time during the 60-day election period. However, in that case the Plan will only provide COBRA continuation coverage beginning with the date you inform BeneSys that you want continuation coverage, and back to the date of the qualifying event. This will result in a lapse of continuous coverage under the Plan.

COBRA continuation coverage must be elected no later than 60 days after receipt of the COBRA Election Form. ***If the COBRA Election Form is not submitted by the due date, you will lose your right to elect COBRA continuation coverage.***

Coverage Under COBRA

COBRA continuation coverage is the same coverage that is available to other similarly situated non-COBRA beneficiaries covered under the Plan. However, the Fund Administrator reserves the right to terminate a qualified beneficiary's COBRA continuation coverage retroactively if the qualified beneficiary is determined to be ineligible.

If coverage under the Plan is modified for non-COBRA beneficiaries, the coverage under the Plan will be modified in the same manner for all COBRA qualified beneficiaries.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage lasts until the earliest of:

- 36 months after the date of the qualifying event;
- The date on which coverage ends due to failure to make timely COBRA premium payments;
- The date the qualified beneficiary first becomes entitled to Medicare, under Title XVIII of the Social Security Act;
- The date the qualified beneficiary first becomes covered under any other group health plan that does not contain any pre-existing condition limitation;
- The date the Plan terminates; or
- The date a qualified beneficiary provides written notice that he or she wants to end COBRA continuation coverage.

COBRA Continuation Coverage Cost

A monthly premium must be paid for COBRA continuation coverage. The premium is equal to the Trust's full cost of coverage, plus a 2% administrative surcharge.

You have a grace period of 30 days to pay the monthly COBRA payment, except for the first monthly payment, for which there is a one-time-only 45-day grace period. The first monthly premium payment must include all past amounts to the date of election and will apply to the COBRA continuation coverage period beginning immediately after the coverage under the Plan terminates (except for cases where the qualified beneficiary does not elect to continue coverage and then revokes that decision within the election period).

The Plan is not required to pay for any claims incurred before a timely election of COBRA continuation coverage and proper premium payment for such COBRA continuation coverage; however, such claims will be eligible for payment after you elect and pay the premium for COBRA continuation coverage by the required due date.

Keep the Fund Administrator Informed

To protect your family's rights, you should keep BeneSys informed of any changes in your address and the addresses of family members. In addition, notify BeneSys of any changes in your family status, such as births, deaths, legal separation, divorce, entitlement to Medicare, etc. You should keep a copy, for your records, of any notices you send to BeneSys.

Questions About COBRA Continuation Coverage

If you have any questions or need additional information about COBRA, contact the Fund Administrator at:

BeneSys
P.O. Box 1708
Troy, Michigan 48099-1708
(855) 641-4911 (toll-free) or (248) 641-4911
Fax: (248) 813-9898

Pre-Medicare Medical Benefits

The Trust provides medical benefits for pre-Medicare eligible participants through the Blue Cross Blue Shield of Michigan (BCBSM) Preferred Provider Organization (PPO) Plan.

For more information about this Plan, contact BeneSys or BCBSM:

- Online at www.bcbsm.com; or
- By phone at the telephone numbers on your ID card.

How the Plan Works for Pre-Medicare Participants

- **Contributions:** To be covered under the Plan, you must make your contributions to the Trust.
- **Providers:** The Plan includes a Preferred Provider Organization (PPO) network, the Blue/Blue Preferred Network, administered by Blue Cross Blue Shield of Michigan (BCBSM). BCBSM's network contracts with physicians, hospitals and other medical facilities. Providers in the network, which can change at any time, have agreed to accept this Plan's terms. Every time you need care, you have the option of using a provider in the Plan's network (network provider) or one that does not participate in the network (out-of-network provider). What the Plan pays for most covered services depends on if you use a network or out-of-network provider. Generally, the Plan pays a higher percentage when you use network providers. See the Preferred Provider Organization (PPO) section (page 16) for more information.
- **Annual Deductible:** Each year, between January 1 and December 31, you are responsible for paying a certain amount of covered expenses before the Plan begins to pay most benefits.
  - The deductible applies separately to each person.
  - Once you or a family member meets your individual deductible, you or your family member are not required to meet any further deductibles for the remainder of the calendar year. Once your family members reach the family maximum, no further individual deductibles are required for the remainder of the calendar year.
  - The annual deductibles for network and out-of-network care are separate and do not count toward each other.
  - All covered expenses are subject to the deductible unless specifically noted otherwise, such as network preventive services, which are not subject to the deductible.
- **Copayment:** A copayment is a flat dollar amount that you pay for certain covered services, such as emergency room care and prescription drugs. Copayments do not apply toward meeting the annual deductible or out-of-pocket maximum.

- **Coinsurance:** Once you meet your individual deductible (or family members meet the family maximum), you and the Plan share the cost of covered services.
  - The amount the Plan pays varies depending on the service and whether you use network or out-of-network providers.
  - The percent the Plan pays for network providers is generally higher than what is paid for out-of-network providers.
  - For out-of-network providers, the Plan pays a percent of the allowed amount. The allowed amount is the maximum amount the Plan will pay for a covered service, according to certain standards and considerations established and periodically revised by BCBSM. Network providers have agreed to accept the allowed amount as payment in full, even if their billed charge is more. You are responsible for any charges that exceed the allowed amount.
- **Annual Out-of-Pocket Maximum:** Once amounts you pay for covered expenses reach the out-of-pocket maximum, the Plan pays 100% of most covered expenses for the remainder of the calendar year.
  - The out-of-pocket maximum applies separately to each person.
  - Once you or a family member meets your individual maximum, the Plan begins paying 100% for you or your family member;
  - Once your family members reach the family maximum, the Plan begins paying 100% for all covered family members.
  - Amounts you pay toward meeting the annual deductible count toward meeting the annual out-of-pocket maximum.
  - Copayments, charges for non-covered services, amounts over the allowed amount and any pre-certification penalties do not count toward the out-of-pocket maximum.
  - The network and out-of-network maximums are separate and do not count toward each other.
  - Some expenses may not be paid at 100% even after you meet your out-of-pocket maximum.
- **Maximum Benefits:** Certain covered expenses may be limited to an annual or lifetime maximum, as described in the Summary of Pre-Medicare Medical Benefits, beginning on page 19.
  - Lifetime maximums refer to the maximum the Plan will pay for a covered service for a covered person during his or her lifetime.
  - Plan payments for network and out-of-network expenses apply to any maximum.

Preferred Provider Organization (PPO)

With a Preferred Provider Organization (PPO) network, you have access to a network of hospitals, physicians, specialists and other health care providers (network providers) who have agreed to charge negotiated rates. When you use a network provider, you save money for yourself and the Trust because the negotiated rates are generally less than what the provider usually charges. In addition, when you use a network provider, you save money because the Plan generally pays a higher percentage of covered expenses.

It is your decision whether to use a network or out-of-network provider. You always have the final say about the providers you and your family use. However, if you use an out-of-network provider and their fee is higher than the allowed amount, you must pay the difference between what the Plan will pay and what the provider charges.

Finding a Network Provider

To find a network provider, contact BCBSM by:

• Going online to www.bcbsm.com; or

• Calling the phone number on the back of your ID card.

Remember that if you receive covered services from an out-of-network provider, your out-of-pocket expenses may be higher. So, be sure to contact BCBSM to find out who participates in the network.

Unless specifically noted otherwise, covered services received from an out-of-network provider are always paid at the out-of-network level. If a network provider refers you to an out-of-network provider, this does not mean that benefits will be paid at the network level.

BCBSM contracts with physicians and facilities separately. For example, you could receive covered services at a network hospital by an out-of-network provider. The Plan considers each provider's claim individually. As a result, portions of a claim for a particular covered service may be paid at the network level and others portions at the out-of-network level.

BlueCard Program

The BlueCard Program is a national program comprised of Blue Cross and Blue Shield plans, which allows you to receive covered services from providers who have a contract or agreement with another Blue Cross and/or Blue Shield plan located outside the geographical area served by BCBSM. The local Blue Cross and/or Blue Shield plan that services the geographic area where the covered service is provided is referred to as the host Blue Cross and/or Blue Shield plan. To find a BlueCard Program provider visit www.bcbs.com or call (800) 810-2583.

Utilization Review

BCBSM provides utilization review services to help you make the most of your health care benefits while receiving quality, cost-effective medical care.

Utilization review includes:

- **Pre-Certification:** A required review of certain services, treatments or admissions before they occur to evaluate medical necessity and coverage by the Plan.
- **Case Management:** A voluntary program that helps coordinate and maximize treatment of serious, complex and/or chronic medical conditions.

Pre-Certification

Pre-certification is required before any non-emergency, non-maternity inpatient admission. If you are a Michigan resident, pre-certification may also be required for specific diagnostic/radiology services.

For emergency admissions, pre-certification is not required, but you must report the admission within 24 hours after the admission. Generally, a network provider will coordinate this process for you. However, for out-of-network services, it is your responsibility. If pre-certification is required, but not requested (either by your provider or you), a retrospective review will be completed to determine if care was medically necessary. **You are responsible for any charges that BCBSM determines are not medically necessary.**

If your hospitalization or continued stay is not pre-certified and the stay is not determined to be medically necessary, but you elect to be hospitalized or remain hospitalized, reimbursement will be reduced. This benefit reduction is limited to $750 per person per calendar year, up to $1,500 per family per calendar year. However, if your hospital or provider does not follow the pre-certification process, the reduction applies to their payment, not to you.

The pre-certification process determines when and for how long benefits will be paid. The decision about whether to be hospitalized, and for how long, is still up to you and your health care provider.

Pre-certification is also required before any mental health and/or substance abuse non-emergency treatment. Magellan is responsible for pre-certifying mental health and/or substance abuse treatment.

Pre-certification is not a guarantee of coverage or payment. Benefits are only paid if on the date you receive service:

- You are eligible for benefits;
- The treatment or supplies are covered by the Plan;
- The treatment or supply is not excluded by the Plan; and
- You have not exceeded any applicable maximum benefit.

Pre-certification is recommended for durable medical equipment and therapy services, as well as any other service that may not qualify as described above.

Once pre-certification is requested, BCBSM or Magellan, as applicable, will work directly with you or your requesting provider. You may designate an authorized representative to act on your behalf for a specific request. Your authorized representative can be anyone who is 18 years of age or older.

As noted earlier, generally, a network provider will coordinate the pre-certification process for you. You are responsible for requesting pre-certification in all other circumstances, including, but not limited to, services provided by BlueCard Program providers outside the service area and any out-of-network provider.

Pre-certification is not required to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology in the BCBSM network. However, the health care professional may be required to comply with certain procedures, including requesting pre-certification for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating obstetrical or gynecological health care professionals, contact BCBSM.

Case Management

BCBSM's Case Management Program is designed to help promote the timely coordination of health services for serious, complex and/or chronic medical conditions.

Participation in this Program is confidential and voluntary; it is provided at no additional cost and does not affect covered services in any way. If you meet Program requirements, BCBSM may contact you to participate. If you agree to participate, a licensed health care professional will work with you to complete an assessment and develop an individualized health plan to meet your identified needs. The licensed health care professional coordinates your care with you and/or your designated representative, treating physician(s) or other providers. The licensed health care professional may also assist with coordinating your care with existing community-based programs and services.

Participating in the Case Management Program is not a guarantee of benefits; care and treatment are subject to all Plan provisions.

Summary of Pre-Medicare Medical Benefits

The Plan bases payment on the allowed amount for out-of-network providers. The following services and supplies are covered under this Plan.

	Network	Out-of-Network
Plan Feature		
Annual Deductible	$500 per person $1,000 per family	$1,000 per person $2,000 per family
Coinsurance (unless noted otherwise)	Plan pays 80%, you pay 20% after deductible	Plan pays 60%, you pay 40% after deductible
Annual Out-of-Pocket Maximum (includes deductible and coinsurance)	$1,000 per person $2,000 per family	$2,000 per person $4,000 per family
Lifetime Maximum	None	
Preventive Services		
Pap Smear Screening ***Limit:*** *1 per year*	Plan pays 100%	Plan pays 60% after your deductible
Mammography Screening ***Limit:*** *1 per year*	Plan pays 100%	Plan pays 60% after your deductible
Prostate Specific Antigen (PSA) Screening ***Limit:*** *1 per year*	Plan pays 100%	Plan pays 60% after your deductible
Colorectal Cancer Screening ***Limits:*** *1 per year*	Plan pays 100%	Not covered
Well Baby Care ***Limit:*** *According to the recommended schedule of the American Academy of Pediatrics*	Plan pays 100%	Not covered
Immunizations ***Limit:*** *According to the recommended schedule of the American Academy of Pediatrics*	Plan pays 100%	Not covered

	Network	Out-of-Network
Emergency Care		
Hospital Emergency Room and Qualified Medical Emergency and First Aid Services	You pay $100 copay per visit; copay is waived if admitted	You pay $100 copay per visit; copay is waived if admitted Subject to network provisions if it qualifies as an emergency and meets program standards
Ambulance (medically necessary surface, air and water transportation)	Plan pays 100%	Plan pays 100% Subject to network provisions if it qualifies as an emergency and meets program standards
Physician Services		
Office Visit	Not covered; however, if you use a BCBSM network provider, you pay 100% of the BCBSM allowed amount	Not covered
Pre-Natal and Post-Natal Care	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Delivery and Nursery Care	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Abortion (medically necessary)	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Diagnostic Services		
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Other Diagnostic Tests, X-Rays, Laboratory and Pathology	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Radiation Therapy (for diagnosis of condition, disease or injury)	Plan pays 80% after your deductible	Plan pays 60% after your deductible

	Network	Out-of-Network
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care and Hospital Services and Supplies ***Limit:*** *365 days per continuous period of confinement or for successive confinements separated by less than 60 days*	Plan pays 80% after your deductible	Plan pays 60% after your deductible; subject to certain limitations
Inpatient Medical Care	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Inpatient Respite Care ***Limit:*** *Subject to Hospice Care limit of 210 days per lifetime*	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Chemotherapy	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Alternative Care		
Skilled Nursing Facility ***Limit:*** *2 days for each unused inpatient day available, up to 730 days per continuous period of confinement or successive confinements separated by less than 60 days*	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Hospice Care ***Limit:*** *210 days per lifetime*	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Home Health Care ***Limit:*** *3 visits for each unused inpatient day available if medically eligible. Each visit by a home health care team member or aid is considered 1 visit*	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Outpatient Surgical Services		
Surgery and Related Surgical Services	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Voluntary Sterilization (excludes reversal)	Plan pays 80% after your deductible	Plan pays 60% after your deductible

	Network	Out-of-Network
Human Organ Transplants (specified transplants only) ***Limit:*** *$25,000 per transplant on professional benefits (surgery, technical surgical assistant, anesthesia)*	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Mental Health and Substance Abuse Treatment Pre-certification is required; contact Magellan at 1-800-762-2382		
Inpatient Mental Health and Substance Abuse ***Limit:*** *45 days, with a 60-day renewal*	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Outpatient Mental Health ***Limit:*** *35 visits per year*	Visits 1 – 20: Plan pays 100% Visits 21 – 35: Plan pays 75%	Plan pays 50%
Outpatient Substance Abuse ***Limit:*** *35 visits per year*	Plan pays 100%	Plan pays 50% (pre-certification required or not covered)
Other Covered Services		
Chiropractic Care Note: Emergency first aid and spinal X-ray only; excludes adjustment manipulation and initial office visits	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Outpatient Physical, Speech and Occupational Therapy ***Limit:*** *60 visits per year* ***Note:*** *Covered when performed in the outpatient hospital department or approved freestanding facility. Physical therapy also covered in an independent therapist's office*	Plan pays 80% after your deductible	Plan pays 60% after your deductible
Durable Medical Equipment and Supplies (certain limits may apply)	Plan pays 100%	Plan pays 60% after your deductible
Prosthetic and Orthotic Appliances	Plan pays 100%	Plan pays 60% after your deductible

	Network	Out-of-Network
Hearing Aids ***Limit:*** *Once every three years, up to $1,007 for one hearing aid or $1,707 for two hearing aids* Includes: • Audiometric exam hearing aid evaluation • Hearing aid conformity test • Binaural hearing aids (age 18 and younger) • Ear mold replacement	Plan pays 100%	Not covered
Prescription Drugs	*See the* Prescription Drug Benefits *section for details*	
Maximum Supply		
Retail and Specialty	30-day	30-day
Mail Order	30 – 90-day	30 – 90-day
Diabetic Supply Copayment		
Retail, Specialty and Mail Order	You pay $15 copay	Plan reimburses 75% of approved amount after your $15 copay
Generic Copayment		
Retail and Specialty Pharmacy	You pay $15 copay	Plan reimburses 75% of approved amount after your $15 copay
Mail Order	You pay $30 copay	Plan reimburses 75% of approved amount after your $30 copay
Brand Name Copayment		
Retail and Specialty Pharmacy	You pay $50 copay	Plan reimburses 75% of approved amount after your $50 copay
Mail Order	You pay $100 copay	Plan reimburses 75% of approved amount after your $100 copay

	Network	Out-of-Network
Non-Formulary Copayment		
Retail and Specialty Pharmacy	You pay $100 copay	Plan reimburses 75% of approved amount after your $100 copay
Mail Order	You pay $200 copay	Plan reimburses 75% of approved amount after your $200 copay

Pre-Medicare Medical Covered Expenses

Many preventive and routine medical expenses as well as expenses incurred for a serious illness or injury are covered. This section describes which expenses are covered expenses. Only expenses incurred for the services and supplies shown in this section are covered expenses. Limitations and exclusions apply.

See the Summary of Pre-Medicare Medical Benefits section, beginning on page 19, for details about any applicable deductibles, coinsurance, benefit maximums and limitations.

Preventative Services

Preventive services are encouraged because you can prevent health problems in the future by getting certain screenings. The Plan pays for certain preventive services that are identified and periodically changed by BCBSM, which are covered even though they are not provided for treatment of illness or injury.

Preventive services may have gender, age or frequency limitations, which are established and periodically revised by BCBSM. If the number of preventive services covered in a period is limited, the first service is considered preventive, and any additional services within the period are additional diagnostic services.

Emergency Care

Benefits are provided in the case of accidental injuries (physical injury – such as a fracture, sprain, etc.) and qualifying medical emergencies.

A medical emergency is a health-threatening or disabling condition that requires immediate medical attention and treatment. The condition must be such that if medical treatment is not secured within 72 hours of onset, the patient's permanent health could be in jeopardy or there could be significant impairment of bodily functions. The coverage is administered on the basis of the patient's signs and symptoms, as verified by the physician at the time of treatment, and not on the basis of the final diagnosis.

There may be two components of emergency care:

- Professional Charges: The Plan covers physician services for the initial examination and treatment of conditions due to accidental injuries and qualifying medical emergencies, wherever the services are administered.
- Facility Charges: The Plan covers hospital emergency room services at network and out-of-network hospitals for treatment of accidental injuries and medical emergencies.

Follow-up care (by a physician or emergency room) is not covered under the emergency care benefit. Follow-up care normally can be performed in a physician office or another setting without a separate facility charge.

A copayment applies for emergency room treatment. However, if you are admitted, the copayment is waived. You must report any emergency admission to BCBSM within 24 hours of the admission.

Urgent Care Centers

Urgent care centers can provide care for certain medical emergencies. Urgent care centers are freestanding centers. Charges for physician services at a freestanding urgent care center are covered by the Plan. However, if the center charges for use of the facility, that charge is not covered.

Ambulance Services

The Plan provides coverage, up to the allowed amount, for medically necessary ground ambulance transportation to the closest available facility qualified to treat the patient, as follows:

- Transfers between hospitals because the originating hospital lacks necessary treatment facilities, equipment or staff.
- One way or round-trip transfer if you are a hospital inpatient and need to be taken to a non-hospital facility for a covered CAT scan, MRI or PET examination (provided the facility meets BCBSM's standards for providing the services) when the services are not available in the hospital in which you are admitted or in a closer local hospital.
- Emergency transportation for:
  - One-way transportation from home or the scene of an incident in a medical emergency or accidental injury to the nearest available facility qualified to treat you.
  - Round-trip transfer of a homebound patient from home to the nearest available facility qualified to treat you when other means of transportation cannot be used without endangering your life.

Air or boat ambulance may be covered if required. Coverage may be subject to restrictions, including mileage limitations and coinsurance. If it is determined that transport by ground ambulance would have sufficed, payment will be limited to the amount that would have been paid for ground ambulance.

Physician Office Visits

Except as specifically listed as covered, physician office visits are not covered, including office visits for preventive services. However, if you use a network provider, you can take advantage of the discounted rate for services negotiated by the Plan.

Hospital Coverage

Inpatient admissions must be pre-certified; see the Pre-Certification section (beginning on page 17).

The Plan covers medically necessary inpatient services and supplies for proper care and treatment, subject to any Plan maximum.

A coverage period begins when you have not been an inpatient for 60 consecutive days.

Covered inpatient hospital services include, but are not limited to:

- Semiprivate room, general nursing services, meals and special diets. Charges for a private room are covered at the hospital's standard rate for a semiprivate room, unless a private room is medically necessary.
- Medical and/or surgical supplies, drugs and medicines.
- Use of operating rooms, other surgical treatment rooms, delivery rooms and recovery rooms.
- Anesthesia services.
- Blood products and their administration (blood or component preservation and storage for future use are not covered).
- X-rays, EKGs, CT scans, ultrasounds, Magnetic Resonance Imaging (limited to two per condition per calendar year) and Magnetic Resonance Angiography (MRA).
- Laboratory and pathology services.

Outpatient Freestanding Facility Coverage

Coverage is provided for most outpatient services, such as treatment of accidental injuries and certain medical emergencies, surgery, IV infusion therapy, use of assisted breathing devices or similar equipment and physical therapy.

Out-of-Network Hospitals

Be sure to check which local hospitals participate in the Plan's network. If you receive non-emergency hospital care at an out-of-network hospital, your costs will be higher. The Plan pays a maximum of:

- $250 per day total for room, board and all covered services at an out-of-network, non-psychiatric hospital;
- $15 per day for room, board and all covered services at an out-of-network, non-acute care hospital (e.g., a psychiatric hospital); or
- $35 per condition for covered outpatient services received at an out-of-network hospital.

In an emergency, the first five days of an admission may be covered at the participating hospital rate.

Hospital Exclusions

In addition to any exclusion listed in the Pre-Medicare Medical Exclusions section (beginning on page 36), benefits are not provided for:

- Care received in a hospital that is principally for observation or diagnostic evaluation, physical therapy, X-ray examination, laboratory examination, electrocardiograph, basal metabolism test or reduction of weight by diet control.
- Care received when a diagnosis has already been established and you are admitted to verify the diagnosis. In this case, evidence on the hospital bill and/or physician service report must clearly establish that specific therapy requiring hospitalization was administered. However, diagnostic admissions may be covered in the case of an infant, child or elderly person in a weak or infirm condition as determined by the BCBSM. Factors that may be considered include:
  - Apparent condition and general state of health upon admission (e.g., acutely ill, in severe pain, extreme debilitation);
  - Onset and duration of illness and severity of symptoms (e.g., sudden, acute onset as opposed to vague complaints);
  - Findings upon physical examination (e.g., pain, bleeding, increased temperature); or
  - Specific or definitive treatment rendered that cannot be administered on an ambulant basis.
- Admissions to prepare for X-rays of the gastrointestinal tract.
- Admissions for oral surgery where a concurrent hazardous medical condition, such as a serious blood dyscrasia, unstable diabetes or a severe cardiovascular condition, does not exist.
- Services and supplies for routine dental care.
- Abortion admissions if the service is not legal in the state where it is provided or not performed according to the hospital's rules and regulations.

- Hospital services for inpatient admissions that occur before your coverage is effective.
- Inpatient admissions for treatment, by any method, of joint or jaw hinge problems, including temporomandibular joint syndrome and craniomandibular disorders or other conditions of the joint, including the jawbone and skull and complex of the muscles, nerves and their tissues related to the temporomandibular joint.
- Hospital services that are not medically necessary for the proper care and treatment of a patient.
- Facility charges for care received in an urgent care facility or in a freestanding ambulatory surgical facility or center, unless it is an approved freestanding ambulatory surgical facility or center.
- Charges related to treatment and services that are not covered services.

Alternate Care

Skilled Nursing Facility Coverage

Skilled nursing facility admissions must be pre-certified; see the Pre-Certification section (beginning on page 17).

Skilled nursing facility care services are services that can only be safely and effectively performed by or under the supervision of a licensed nurse in a skilled nursing facility. Skilled nursing facility care is different from residential care, which is not covered. Skilled nursing facility benefits do not include nursing home care, adult foster care, assisted living or other custodial care (such as helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk or take drugs or medicines that can be self-administered).

Medically necessary care provided in a skilled nursing facility is paid based on the allowed amount and is limited to the lesser of 730 days or two days for every one day of unused inpatient hospital care. A new limit begins when you have not been in the hospital, skilled nursing facility or any other facility where a limit applies for 60 consecutive days.

To be covered:

- Any skilled nursing facility admission must be pre-certified;
- The skilled nursing facility must be a Medicare-approved, network facility;
- You must be convalescing from an injury or illness that has a favorable prognosis and predictable level of recovery; and
- The intensity of care needed must require a combination of skilled nursing services that are less than those of a general acute care hospital but greater than those available in your place of residence.

Skilled Nursing Facility Exclusions

In addition to any exclusion listed in the Pre-Medicare Medical Exclusions section (beginning on page 36), benefits are not provided for:

- Conditions that are not medically necessary and do not require skilled nursing services.
- Admissions that are principally custodial or domiciliary in nature or for treatment of tuberculosis.
- Patients who have reached their maximum level of recovery possible for their particular condition and no longer require treatment other than routine supportive care.
- Services provided by non-approved skilled nursing facilities or out-of-network skilled nursing facilities.
- Skilled nursing facility visits in excess of two per week.

Home Health Care

Home health care coverage includes medically necessary services provided by an approved home health care program for skilled, part-time and intermittent care, including payment for necessary skilled nursing and home health care aides. Part-time generally means less than eight hours per day while intermittent generally means less than seven days per week.

Each visit by a member of the home health care team, each approved outpatient visit to a hospital or skilled nursing facility and each home health aide visit is considered one home health care visit. Home health care benefits are limited to three visits for each remaining unused day of an inpatient hospital benefit period. The maximum number of home health care visits is 1,095 (which is 365 hospital care days times three).

Home Health Care Exclusions

In addition to any exclusion listed in the Pre-Medicare Medical Exclusions section (beginning on page 36), benefits are not provided for:

- Expenses for any home health care agency services other than part-time, intermittent skilled nursing services and supplies, except when the services of home health aides are covered under this benefit.
- Expenses services provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle or child of the patient or retired employee or when the patient is not under the continuing care of a physician.
- Expenses for a homemaker, custodial care, childcare, adult care or personal care attendant, except as provided under the Plan's hospice care benefits and when custodial care is provided by home health aides that are covered under this home health care benefit.
- Expenses for transportation to or from a place outside the patient's home to receive a home health care service.

- Supplies, such as elastic stockings and personal comfort items or equipment and appliances, such as hospital beds, oxygen tents, walkers, wheelchairs or orthotics.
- Physician, private duty nursing or housekeeping services.

Hospice Coverage

Hospice care for terminally ill individuals is covered when provided through an approved hospice program. Benefits for hospice care are limited to 210 days per person, per lifetime.

The terminally ill individual must have written certification from a physician that he or she is terminally ill and meets the Plan's criteria for life expectancy. The individual must file an election statement with the hospice program agreeing to the terms of hospice care.

Surgical Services

Covered surgical and medical services include:

- Surgery and anesthesia, including pre- and post-operative care (plastic, reconstructive and dental surgery are subject to limitations and/or exclusions).
- In-hospital consultations.
- In-hospital medical care.
- Doctor's medical visits, limited to two per week for up to 730 days in an approved skilled nursing facility for general conditions.
- Human organ and tissue transplants, subject to a $25,000 per transplant maximum for professional services related to a heart, lung, heart-lung, pancreas, liver-kidney or liver transplants.
- Necessary and appropriate diagnostic imaging, laboratory and pathology services.
- MRI, MRA, CT, PET and similar services as part of diagnostic imaging, which is limited to certain diagnoses, use of BCBSM-approved facilities and/or frequency limits, as established and periodically revised by BCBSM.
- Digital mammograms (payment is limited to the allowed amount for standard mammograms).
- Mastectomy.
- Obstetrical delivery, including pre- and post-natal care provided by a physician or nurse mid-wife when received in a hospital or birthing center affiliated with a hospital.
- Radiation therapy and chemotherapy for certain types of malignant conditions as established and periodically revised by BCBSM and up to three follow-up visits within the 30 days following the therapy.
- Sterilization, but not sterilization reversals.

Second Surgical Opinion Benefits

The Plan covers a second and third surgical opinion before surgery. Contact BCBSM to determine how second and third opinions are provided. If you receive a second opinion, arranged through BCBSM, all services are covered in full, including the physician's consultation and any necessary X-ray and laboratory tests. If the second opinion disagrees with the first, you may obtain a third opinion.

Mental Health and Substance Abuse

Mental health and substance abuse treatment must be pre-certified; see the Pre-Certification section (beginning on page 17).

The Plan's mental health and substance abuse benefits provide coverage for the following medically necessary services (see the Summary of Pre-Medicare Medical Benefits, beginning on page 19, for limitations and cost sharing information):

- Mental health and/or substance abuse inpatient care at a hospital or residential substance abuse treatment facility;
- Outpatient mental health/substance abuse services;
- Mental health inpatient skilled nursing facility care (each day of inpatient hospital care within a benefit period reduces the available days of skilled nursing inpatient care by two days);
- Mental health and/or substance abuse care at a partial hospitalization treatment facility (each day of inpatient hospital care within a benefit period reduces the available days of partial hospitalization treatment facility care by two days; each two days of inpatient care in a partial hospitalization treatment facility reduces care by one day in a hospital);
- Psychological testing, when authorized by BCBSM.

Mental Health and Substance Abuse Exclusions

In addition to any exclusion listed in the Pre-Medicare Medical Exclusions section (beginning on page 36), benefits are not provided for:

- Services provided at non-approved sites.
- Services provided in excess of the allowed amount or Plan limits.
- Services not ordered by a physician.
- Services not meeting the Plan's medical necessity criteria.
- Routine psychological testing of individuals who are largely symptom free.
- Any therapy that is not conducted in a face-to-face setting.
- Missed appointments.

- Family counseling provided by a provider other than the provider for the family member in the course of treatment (only the individual covered under the Plan receiving services is covered).
- Diversional or recreation therapy, which is an organized program of leisure-based activity programs that may include activities that improve or sustain an individual's skills of self-care and daily living.

Mental Health Exclusions

- Mental health services for mental retardation and mental deficiency, except certain services are covered when performed for evaluation or diagnosis.
- Treatment for mental conditions not classified as emotional or personality disorders.
- Services considered experimental, research and/or investigational in nature.
- Services performed for research and not generally accepted by the medical profession.
- Educational therapy, defined as academic tutoring for children to relieve learning deficits and services intended solely to correct educational deficits, whether developmental or of organic origin. Educational deficits include congenital or developmental learning disturbances, such as dyslexia, mathematics and reading defects, word blindness/deafness, strephosymbolia and speech disturbances, such as stammering, stuttering, cluttering and lisping. Tutorial services include staff training services and services primarily for the advancement of the academic and/or professional education or training of the retired employee, spouse, surviving spouse or dependent, regardless of the diagnosis or symptoms.
- Mental health services for mental disorders and illnesses that, according to generally accepted professional standards, are not amenable to favorable modifications, except certain services are covered when necessary to determine that the disorders and illness are not amenable to favorable modification or for the period necessary for the evaluation and diagnosis of mental deficiency retardation.
- Psychological and laboratory tests billed when used for routine screening of normal range individuals, who are largely symptom free. Only those tests ordered by a physician and authorized by the Plan are considered for reimbursement. The physician should selectively order only those services that are determined to be necessary for each patient.
- Indirect services, such as supervision conferences that take place between the psychiatrist and primary therapist.
- Pre-marital counseling.
- Marriage counseling.
- Relaxation therapy.
- Weight reduction/control.
- Didactics, except didactics benefits from a structured Intensive Outpatient Program (IOP) are covered.
- Services that are not yet accepted by the medical profession.

- Treatment or counseling of patients with sexual dysfunction in the absence of an underlying emotional illness. The patient's record is expected to contain a history and physical examination to rule out any physiological cause and clearly establish the causal factor(s) as psychogenic. The partner may participate in treatment, but payment will be made only for the identified patient.
- L-Tryptophan and vitamins, except thiamine injection (X-1-3) with diagnosed nutritional deficiency states.
- Consultation with a mental health professional for adjudication of marital or child support and custody cases.
- Environmental ecological treatments.
- Megavitamin or orthomolecular therapy.
- Transcendental meditation.
- Rolfing.
- Z therapy.
- EST (Erhard).
- Primal therapy.
- Bioenergetic therapy.
- Carbon dioxide therapy.
- Guided imagery.
- Biofeedback.
- Sedative action electro stimulation therapy.
- Aversion therapy.
- Confrontation therapy.
- Hypobaric or normobaric oxygen therapy.
- Narcotherapy with LSD.
- Hemodialysis for schizophrenia.
- Training analysis (tutorial, orthodox).
- Sensitivity training.
- Crystal healing treatment.
- Poetry, art or music therapy.
- Court ordered treatment.
- Eye Movement Desensitization (EMD) therapy.
- Gambling addiction.
- Psychological testing if used as part of, or in connection with, vocational guidance, training or counseling.

Substance Abuse Exclusions

- Treatment for conditions not classified as substance abuse.
- Methadone treatment.
- Outpatient detoxification.
- Psychological testing only after patient is symptom free from substance abuse for 14 days.
- Professional services such as dispensing methadone, testing urine specimens or performing physical or x-ray examinations or other diagnostic procedures unless therapy, counseling or psychological testing are provided on the same day.

Other Covered Services

Outpatient Physical, Occupational and Speech Therapy

Outpatient physical, occupational and/or speech therapy are only covered when provided by a BCBSM-approved provider. Contact BCBSM to locate an approved provider.

The Plan covers up to 60 combined visits per qualifying condition per calendar year for outpatient physical, functional occupational and/or speech therapy when provided by a hospital or BCBSM-approved freestanding outpatient therapy facility, home health care agency, skilled nursing facility or independent physician or therapist who is Medicare-approved and, at the time you receive services, is participating in the Plan's network. The 60-visit limit per qualifying condition may be renewed after surgery or a definite aggravation of the condition. Multiple therapy treatments occurring on the same day (whether physical, functional occupational or speech) are considered a single visit.

Coverage for physical therapy is available only if it is provided with the expectation that the condition will improve in a reasonable and generally predictable period or improvement is noted on a periodic basis in the patient's record. Restrictions that are established and periodically revised by BCBSM apply for physical therapy evaluations and re-evaluations.

Speech therapy is covered when related to the treatment of an organic medical condition or to the immediate post-operative or convalescent state of the patient's illness. Speech therapy is not covered for long-standing chronic conditions or inherited speech abnormalities, except for children up to age six with congenital and severe developmental speech disorders.

Durable Medical Equipment and Prosthetic and Orthotic Appliances

The Plan provides coverage, up to the allowed amount, for medically necessary durable medical equipment and prosthetic and orthotic appliances when prescribed by your doctor and obtained from a network provider. When obtaining durable medical equipment, make sure it is from a network durable medical equipment provider. If you receive items from an out-of-network provider, then no benefits are paid.

Durable medical equipment covered by the Plan includes, but is not limited to:

- Equipment that meets standards established and periodically revised by BCBSM, which generally include being approved for reimbursement under Medicare Part B and being appropriate for use in the home.
- Repairs necessary to restore the equipment to a serviceable condition when the equipment is purchased (this does not include routine maintenance).
- Neuromuscular stimulators.
- External electromagnetic bone growth stimulators, in certain approved cases.
- Pressure gradient supports for certain patients.
- Pronged and standard canes (when purchased).
- Hairpieces and/or wigs; however the first purchase is limited to $200 and thereafter an annual limit of $125 applies).

Diabetic test strips, lancets and insulin are covered under the Plan's prescription drug benefits.

Prosthetic and orthotic appliances covered by the Plan include, but are not limited to:

- Prosthetic and orthotic appliances that are provided by an accredited facility and meet Plan standards that are established and periodically revised by BCBSM.
- Appliances that are generally approved for reimbursement under Medicare Part B, including the replacement, repair, fitting and adjustments of the appliance.
- Orthopedic shoes, inserts, arch supports and shoe modifications when the shoes are part of a covered brace.
- Appliances or devices that are surgically implanted permanently within the body (except experimental or research appliances or devices) or those that are used externally while in the hospital as part of regular hospital equipment or when prescribed by a physician for use outside the hospital.

Durable Medical Equipment and Prosthetic and Orthotic Appliance Exclusions

In addition to any exclusion listed in the Pre-Medicare Medical Exclusions section (beginning on page 36), benefits are not provided for:

- Expenses for any items that are not corrective appliances, prosthetic and orthotic appliances or durable medical equipment including, but not limited to, air purifiers, swimming pools, spas, saunas, escalators, motorized modes of transportation, pillows, mattresses, water beds and air conditioners.
- Expenses for replacement of lost, missing or stolen, duplicate or personalized corrective appliances, prosthetic and orthotic appliances or durable medical equipment.
- Expenses for corrective appliances and durable medical equipment to the extent they exceed the cost of standard models of the appliances or equipment, unless determined to be medically necessary.

- Expenses for occupational therapy, orthotic devices and supplies needed to assist a person in performing activities of daily living, including self-help devices, such as feeding utensils, reaching tools and devices to assist in dressing an undressing.
- Expenses for non-durable supplies, unless specifically listed as covered.
- Purchase of durable medical equipment or prosthetic and orthotic appliances ordered before you were covered under the Plan.
- Rental charges for durable medical equipment or prosthetic and orthotic appliances rented before you were covered under the Plan.
- Rental charges for durable medical equipment or prosthetic and orthotic appliances after your Plan coverage ends.

Pre-Medicare Medical Exclusions

Not every medical service or supply is covered by the Plan, even if prescribed, recommended or approved by a physician. The Plan covers only those services and supplies that are medically necessary and specifically listed as covered. Charges made for the following are not covered, except as otherwise listed as covered by the Plan.

You have medical and prescription drug coverage. The exclusions listed below apply to all coverage under the Plan. Additional exclusions apply to specific coverage, such as mental health and substance abuse treatment and prescription drug coverage. Those additional exclusions are listed separately.

Medical services, supplies and other health care expenses not covered under the Plan include, but are not limited to:

- Services, including inpatient hospital days, provided before your coverage was effective or after coverage ends.
- Hospital services related to custodial, domiciliary, convalescent, nursing home or rest care.
- Services consisting principally of dental treatment or extraction of teeth.
- Admissions principally for observation or diagnostic evaluations and examinations, physical therapy, tests or studies, weight reduction by diet control (with or without medication) or environmental control.
- Skilled nursing facility coverage that is principally custodial or domiciliary or care for tuberculosis.
- Hospital admissions and treatment for weight reduction or diet control (except for qualifying gastric by-pass surgery).
- Physician office visits.
- Routine physical, premarital and pre-employment examinations or similar examinations or tests not directly related to diagnosis of illness or injury.
- Psychiatric services for mental health conditions that are not expected to improve with treatment or services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation.

- Services that are not medically necessary.
- Care, services, treatment, supplies, devices and drugs that are experimental, research and/or investigational in nature.
- Hospitalization principally for observation or diagnostic evaluation, diagnostic X-ray, laboratory tests or physical therapy.
- Facility charges for care and urgent care centers or for surgical services provided at non-approved ambulatory surgery centers.
- Hospital services and surgery for cosmetic purposes, except for the correction of congenital abnormalities, traumatic scars and conditions due to accidental injuries.
- Dental services, including dental surgery.
- Hospitalization services consisting principally of dental treatment or extraction of teeth, unless the dental procedure is covered.
- Sterilization reversals.
- Artificial insemination or in vitro fertilization.
- Personal comfort items, which are items for patient convenience, including, but not limited to, care of family members while you are confined to a hospital or other health care facility or to bed at home, guest meals, television, DVD/Compact Disc (CD) and other similar devices, telephone, barber or beautician services, housecleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
- Chiropractic services, except for diagnostic radiological services and emergency first aid related to the spine and related bones and tissues.
- Occupational illness, injury or conditions subject to workers' compensation that arise out of or in the course of employment (including self-employment) if the injury, illness or condition, in whole or in part, is covered under any workers' compensation or occupational disease or similar law or for which the employer makes a settlement payment. This applies even if you were not covered by workers' compensation insurance or if your rights under workers' compensation or occupational disease or similar law were waived or qualified.
- Services not ordered by a physician or other healthcare professional determined acceptable by BCBSM.
- Treatment of jaw joint or jaw hinge problems, including temporomandibular joint syndrome and craniomandibular disorders.
- Expenses incurred for injuries due to or sustained during commission or attempted commission of a felony. If the injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is directly due to an underlying health factor then this exclusion does not apply.
- Expenses for an autopsy.
- Expenses for preparing medical reports/medical records, bills disability/sick leave claim forms, mailing, shipping or handling expenses and charges for broken/missed appointments, telephone call, e-mailing charges, prescription refill charges, automotive forms/interest charges, late fees, mileage costs, provider administration fees concierge/retainer agreement/membership fees and/or photocopying fees.

- Educational services, supplies or equipment, even if they are required because of an injury, illness or disability of a retired employee, spouse, surviving spouse or dependent, including, but not limited to, computers, computer devises/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory aids, speech aids/synthesizers, programs to assist with auditory perception or listening/learning skills, vision therapy, auditory or auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc., special education and associated cost in conjunction with sign language education for a patient or family members and implantable medical identification/tracking devices even if they are required because of an injury, illness or disability of retired employee, spouse, surviving spouse or dependent.
- Expenses for services provided through a medical department, clinic or similar facility provided or maintained by the Trust or if benefits are otherwise provided under this Plan or any other plan that the Trust contributes to or otherwise sponsors.
- Expenses that exceed any Plan benefit maximum.
- Any portion of expenses for covered medical services or supplies that exceed the allowed amount.
- Expenses for services or supplies for which a third party is required to pay.
- Expenses for services to the extent benefits are payable under any health care contract under the coordination of benefits provision of this Plan, Medicare (if you were or would have been eligible for Medicare benefits at the time of service had you enrolled in Medicare as required by this Plan) or any health care program supported in whole or in part by funds of the federal government or any state or political subdivision, except where by law this Plan is primary.
- Services received in a U.S. Department of Veterans Affairs hospital or other military medical facility due to a military service-related illness or injury.
- Expenses for construction or modification to a home, residence or vehicle required due to an injury, illness or disability, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, etc., except as specifically provided for by this Plan.
- Expenses for services rendered or supplies provided for which no payment is required to pay, that are obtained without cost or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
- Expenses that are determined by BCBSM to be unreasonable.
- Expenses for and related to travel or transportation (including lodging and related expenses) of a provider, retired employee, spouse, surviving spouse or dependent, unless covered under the Plan's ambulance transportation services benefit.
- Services of a medical student or intern.

- Expenses for any physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the physician or health care practitioner was available on a stand-by basis.
- Expenses incurred due to failure to comply with medically appropriate treatment, as determined by BCBSM.
- Expenses incurred due to leaving a hospital or other health care facility against the medical advice of the attending physician within 72 hours after admission.
- Expenses incurred during travel if a physician or other health care provider has specifically advised against the travel because of the individual's health condition.
- Expenses for any and all telephone calls between a physician or other health care provider and any patient, other health care provider, utilization management company or any Plan representative for any reason, including, without limitation, communication with any representative of the Plan or BCBSM for any reason related to care or treatment. consultation with any health care provider about medical management or care of a patient, coordinating medical management of a new health care provider regarding medical management or care of a patient, coordinating medical management of a new or established patient, coordinating services of several different health professionals working on different aspects of a patient's care, discussing test results, initiating therapy or a plan of care that can be handled by telephone, providing advice to a new or established patient, providing counseling to anxious or distraught patients or family members.
- Expenses related to an online internet consultation with a physician or other health care practitioner (also known as a virtual office visit/consultation), physician-patient web service or physician-patient email service, including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet out-of-network provider.
- Expenses incurred due to an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, terrorist act, rebellion or invasion, except as required by law.
- Expenses incurred for injury or sickness due to the release of nuclear energy.
- Expenses incurred due to an act of God (i.e., a sudden and violent act of nature that could not have been foreseen or prevented), including, but not limited to, natural disasters such as hurricanes, lightning storms, floods, earthquakes and volcanic eruptions and mass outbreaks of infectious diseases as determined by the U.S. Centers for Disease Control (CDC).
- Expenses related to complications of a non-covered service.
- Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures or the preparation for these procedures or any complications resulting from these procedures.

- Medical treatment (other than hospital services and surgery) to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes, but is not limited to, removal of tattoos, breast augmentation/breast reduction, elimination of redundant skin of the abdomen, surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance, treatment of varicose veins or other medical or surgical treatment intended to restore or improve physical appearance.
- Allergy, alternative or complementary health care services, including expenses for:
  - Allergy testing and treatment.
  - Acupuncture and/or acupressure.
  - Chelation therapy, except as may be medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning and for diseases due to clearly demonstrated excess of copper or iron.
  - Prayer, religious healing or spiritual healing.
  - Naturopathic, naprapathic and/or homeopathic services or treatment/supplies.
- Fertility and infertility services, including:
  - Artificial insemination or in vitro fertilization or similar procedures.
  - Surrogate parenting, cryostorage of eggs or sperm, adoption, infertility donor expenses, fetal implants, reversal of sterilization procedures and fetal reduction.
  - Prenatal, maternity and prescription drug services related to a pregnancy incurred by a covered person acting as a surrogate mother (gestational carrier). For this Plan, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding according to which she relinquishes the child following its birth.
- Expenses for routine foot care, including, but not limited to, trimming of toenails, removal or reduction of corns and calluses, removal of thick/cracked skin on heels, foot massage, preventive care with assessment of pulses, skin condition and sensation or for hand care, including manicure and skin conditioning. Routine foot care from a podiatrist may be covered for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
- Expenses for genetic counseling, except when associated with a covered genetic test.
- Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa or expenses for and related to hair replacement, including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis, except for wigs and related supplies for participants under age 18 who are suffering hair loss from the effects of chemotherapy, radiation or other treatments for cancer.
- Hearing care, including:
  - Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices, including implantable hearing devices, except for medically necessary cochlear implants and as provided under the Plan's hearing aid benefit.

  - Special education and associated costs in conjunction with sign language education for a patient or family members.
  - Hearing aid evaluation expenses are limited and maximum benefits may apply.
- Products and services provided after coverage under the Plan ends, except for hospital, skilled nursing facility or residential treatment facility services for inpatient admissions that occurred before coverage ended.
- Private room in a hospital or health care facility, unless the use of a private room is medically necessary. If, for any reason, accommodations are less expensive than those covered by this Plan, you are not entitled to payment of the difference in charges.
- Drugs, medicines and nutritional supplements, including take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, health care practitioner's office or other health care facility.
- Home hemodialysis, including:
  - Services and products not supplied by a network hospital.
  - Services provided by family members or other individuals trained and assisting in the dialysis procedure.
  - Training of individuals by other than network hospital staff members or individuals other than those with whom the network hospital has contracted.
  - Charges for electricity or water used in the operation or maintenance of the dialysis machine.
  - Physicians' services for direct patient care.
  - After the initial installation, any subsequent costs incurred in moving the dialyzer to another location within the patient's place of residence.
  - Expenses incurred in the installation of a dialysis machine that are not essential to its operation.
  - Services provided by an agency or organization providing back up assistance in home hemodialysis, including the services of hospital personnel sent to the patient's home or for other persons under contract with the network hospital.
- Maternity, family planning and contraceptives, including:
  - Expenses for non-prescription contraceptives, such as condoms, unless obtained through the Plan's prescription drug benefits.
  - Therapeutic abortions unless performed by a physician on a hospital inpatient or outpatient basis. The service must be legal in the state where rendered and provided in an approved hospital consistent with the hospital's rules and regulations; voluntary (i.e., non-therapeutic) abortions are not covered.
  - Medically induced abortion by oral ingestion of medication (Mifeprex or Mifepristone) unless provided in an office location for the termination of an intrauterine pregnancy.
  - Expenses for childbirth education, Lamaze classes and breast feeding classes.
  - Expenses related to the maternity care and delivery expenses associated with a pregnant dependent child.

  - Expenses related to cryostorage of umbilical cord blood or other tissue or organs.
  - Reversal of voluntary sterilization.
  - Infertility services.
- Expenses for massage therapy or prolotherapy (injection of sclerosing solutions into joints, muscles or ligaments) and related services.
- Professional services of hospital staff or employees, including, but not limited to, services of interns, residents, physicians in training, nursing services, physician assistants and stand-by physicians.
- Prophylactic surgery or treatment.
- Expenses for all medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery when the services, procedures, prescription drugs or prophylactic surgery is prescribed or performed to avoid the possibility of risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results or to treat the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, except in the case of prophylactic mastectomies or when the services or procedures are based on the results of amniocentesis, Chorionic Villus Sampling (CVS) or Alphafetoprotein (AFP) analysis.
- Smoking cessation or tobacco withdrawal, including:
  - Expenses for tobacco/smoking cessation products, such as nicotine gum or patches or other services or programs.
  - Expenses for over-the-counter tobacco/smoking cessation products even if prescribed by a physician.
- Vision care, including:
  - Routine vision care services and supplies.
  - Expenses for surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), Laser In Situ Keratomileusis (LASIK) or Implantable Contact Lenses (ICL).
  - Vision therapy (orthoptics) and supplies.
- Removal of wax from the ear.
- Weight management and physical fitness, including:
  - Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums and /or any other facility for physical fitness programs, including exercise equipment.
  - Expenses for medical or surgical treatment of severe underweight, including, but not limited to, high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25% under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by physicians to determine normal body weight.
- Inpatient respite care of more than five days per episode.

Medicare-Eligible Medical Benefits

The Fund provides medical and prescription drug benefits for Medicare-eligible participants through BlueCross BlueShield of Michigan's Medicare Plus Blue Group PPO, which is a Medicare Advantage Preferred Provider Organization (PPO) plan.

For more information about this Plan, contact BeneSys or BlueCross BlueShield of Michigan (BCBSM):

- Online at www.bcbsm.com; or
- By phone at (866) 684-8216; Member Services representatives are available Monday through Friday, from 8:30 a.m. to 5 p.m., ET (TTY/TDD users call (800) 579-0235).

For more information about Medicare, you can:

- Call (800) MEDICARE (633-4227), TTY users call (877) 486-2048); available 24 hours a day, 7 days a week; or
- Online at www.medicare.gov.

How the Plan Works for Medicare-Eligible Participants

- **Medicare Premiums and Contributions:** To be covered under the Plan, you must make your contributions to the Trust, which are then used to pay the premiums for this Plan.
- **Providers:** The Plan includes a Preferred Provider Organization (PPO) network, the Blue/Blue Preferred Network, administered by Blue Cross Blue Shield of Michigan (BCBSM). BCBSM's network contracts with physicians, hospitals and other medical facilities. Providers in the network, which can change at any time, have agreed to accept this Plan's terms. Every time you need care, you have the option of using a provider in the Plan's network (network provider) or one that does not participate in the network (out-of-network provider). What the Plan pays for most covered services depends on if you use a network or out-of-network provider. Generally, the Plan pays a higher percentage when you use network providers. See the Preferred Provider Organization (PPO) section (beginning on page 44) for more information.
- **Annual Deductible:** Each year, between January 1 and December 31, you are responsible for paying a certain amount of covered expenses before the Plan begins to pay most benefits.
  - The deductible applies separately to each person.
  - The annual deductible applies to network and out-of-network care combined.
  - All covered expenses are subject to the deductible unless specifically noted otherwise, such as preventive services, which are not subject to the deductible.
- **Copayment:** A copayment is a flat dollar amount that you pay for certain covered services, such as physician office and emergency room visits and prescription drugs.

- **Coinsurance:** Once you meet your deductible, you and the Plan share the cost of covered services.
  - The amount the Plan pays varies depending on the service and whether you use network or out-of-network providers.
  - The percent the Plan pays for network providers is generally higher than what is paid for out-of-network providers.
  - For out-of-network providers, the Plan pays a percent of the allowed amount. The allowed amount is the maximum amount the Plan will pay for a covered service, according to certain standards and considerations established and periodically revised by BCBSM. Network providers have agreed to accept the allowed amount as payment in full, even if their billed charge is more. You are responsible for any charges that exceed the allowed amount.
- **Annual Out-of-Pocket Maximum:** Once amounts you pay for covered expenses reach the out-of-pocket maximum, the Plan pays 100% of most covered expenses for the remainder of the calendar year.
  - The out-of-pocket maximum applies separately to each person.
  - Deductible, copayment and coinsurance amounts apply toward meeting your out-of-pocket maximum.
  - Copayments, charges for non-covered services and amounts over the allowed amount do not count toward the out-of-pocket maximum.
  - Only network expenses apply toward the network maximum; however, network and out-of-network expenses apply toward meeting the out-of-network maximum.
  - Some expenses may not be paid at 100% even after you meet your out-of-pocket maximum.
- **Maximum Benefits:** Certain covered expenses may be limited to a specific maximum, as described in the Summary of Medicare-Eligible Medical Benefits section (beginning on page 46).
  - Lifetime maximums refer to the maximum the Plan will pay for a covered service for a covered person during his or her lifetime.
  - Plan payments for network and out-of-network expenses apply to any maximum.

Preferred Provider Organization (PPO)

With a Preferred Provider Organization (PPO) network, you have access to a network of hospitals, physicians, specialists and other health care providers (network providers) who have agreed to charge negotiated rates. When you use a network provider, you save money for yourself and the Trust because the negotiated rates are generally less than what the provider usually charges. In addition, when you use a network provider, you save money because the Plan generally pays a higher percentage of covered expenses.

It is your decision whether to use a network or out-of-network provider. You always have the final say about the providers you and your family use. However, if you use an out-of-network provider and their fee is higher than the allowed amount, you must pay the difference between what the Plan will pay and what the provider charges.

Finding a Network Provider

To find a network provider, contact BCBSM by:

• Going online to www.bcbsm.com/medicare; or

• Calling the phone number on the back of your ID card.

Remember that if you receive covered services from an out-of-network provider, your out-of-pocket expenses may be higher. So, be sure to contact BCBSM to find out who participates in the network.

Unless specifically noted otherwise, covered services received from an out-of-network provider are always paid at the out-of-network level. If a network provider refers you to an out-of-network provider, this does not mean that benefits will be paid at the network level.

BCBSM contracts with physicians and facilities separately. For example, you could receive covered services at a network hospital by an out-of-network provider. The Plan considers each provider's claim individually. As a result, portions of a claim for a particular covered service may be paid at the network level and others portions at the out-of-network level.

BlueCard Program

The BlueCard Program is a national program comprised of Blue Cross and Blue Shield plans, which allows you to receive covered services from providers who have a contract or agreement with another Blue Cross and/or Blue Shield plan located outside the geographical area served by BCBSM. The local Blue Cross and/or Blue Shield plan that services the geographic area where the covered service is provided is referred to as the host Blue Cross and/or Blue Shield plan. To find a BlueCard Program provider visit www.bcbs.com or call (800) 810-2583.

Finding a Network Health Care Provider

To find a network health care provider, contact BCBSM by:

• Going online to www.bcbsm.com/medicare; or

• Calling (866) 684-8216, TTY users call 711.

Summary of Medicare-Eligible Medical Benefits

The Plan bases payment on the Medicare-approved amount, based on Medicare guidelines. The following services and supplies are covered under this Plan, after any Medicare Part A and/or B deductible or cost sharing.

Plan Feature	Network	Out-of-Network
Annual Deductible (combined in and out-of-network)	$500 per person	$500 per person
Coinsurance (unless noted otherwise)	Plan pays 80%	Plan pays 70%
Out-of-Pocket Maximum *Note: Includes deductible, copayments and coinsurance*	$1,500 per person	$3,000 per person (includes in-network expenses)
Preventive Services	Plan pays 100% of approved amount	Plan pays 100% of approved amount
Emergency Room *Copay is waived if you are admitted within 3 days*	You pay $65 copay per visit	You pay $65 copay per visit
Ambulance Services	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Clinical Labs	Plan pays 100%	Plan pays 100%
Physician/Practitioner Services		
Office Visit	You pay $25 copay per visit	Plan pays 70% after your deductible
Urgent Care	You pay $25 copay per visit	Plan pays 70% after your deductible
Chiropractic Services	You pay $20 copay per visit	Plan pays 70% after your deductible
Podiatry Services	You pay $25 copay per visit	Plan pays 70% after your deductible
Specialist Services	You pay $25 copay per visit	Plan pays 70% after your deductible
Facility Evaluation and Management Services	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Other Physician Services	Plan pays 80% after your deductible	Plan pays 70% after your deductible

Plan Feature	Network	Out-of-Network
Other Covered Services		
Inpatient Facility Services	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Skilled Nursing Facility *Limited to 100 days per benefit period**	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Home Health Care	Plan pays 100%	Plan pays 100%
Outpatient Facility Services	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Outpatient Rehabilitation Services *Medicare therapy limits apply.*	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Durable Medical Equipment	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Prosthetic and Orthotic Devices	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Diabetes Programs and Supplies	Plan pays 100% of approved amount	Plan pays 100% of approved amount
Diagnostic Tests, X-rays, Lab and Radiology Services	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Cardiac and Pulmonary Rehabilitation Services	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Kidney Disease and Conditions		
Dialysis Services	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Home Dialysis Equipment and Supplies	Plan pays 100% of approved amount	Plan pays 100% of approved amount
Kidney Disease Education Services	Plan pays 100% of approved amount	Plan pays 100% of approved amount
Hearing Services		
Diagnostic Testing Services	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Diagnostic Hearing Office Visit	You pay $25 copay per visit	Plan pays 70% after your deductible

Plan Feature	Network	Out-of-Network
Vision Services		
Diagnosis and Treatment of Eye Disease and Conditions	Plan pays 80% after your deductible	Plan pays 70% after your deductible
Office Visit Medical Vision Services	You pay $25 copay per visit	Plan pays 70% after your deductible
Corrective Lenses After Cataract Surgery	Plan pays 100% of approved amount	Plan pays 100% of approved amount
Glaucoma Screening (annually for participants at risk)	Plan pays 100% of approved amount	Plan pays 100% of approved amount
Prescription Drug Benefits	**Retail Pharmacy**	**Mail Order**
Maximum Supply	31-day	32 – 90-day
Generic	You pay $15 copay	You pay $30 copay
Preferred Brand Name	You pay $50 copay	You pay $100 copay
Non-Preferred Brand Name	You pay 50% of cost: • Minimum: $70 • Maximum: $100	You pay 50% of cost: • Minimum: $140 • Maximum: $200
Specialty	You pay 50% of cost: • Minimum: $70 • Maximum: $100	Not covered for supplies greater than 31 days
Plan Limits	Once you pay $4,550 out-of-pocket in one year, for the remainder of the year, you generally pay the greater of 5% of the cost of a medication or • $2.55 for a generic medication; or • $6.35 for all other medications.	

** A benefit period starts the day you go into a hospital or skilled nursing facility and ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into a hospital after one benefit period has ended, a new period benefits.*

Medicare-Eligible Medical Covered Expenses

This section describes services and supplies covered under the Plan.

Mental health and substance abuse services are covered the same as other services, depending on where service is provided (inpatient or outpatient) and the type of provider (network or out-of-network).

- Preventive services, including:
  - Abdominal Aortic Aneurysm screening.
  - Bone mass measurement.
  - Cardiovascular screening.
  - Cervical and vaginal cancer screening.
  - Colorectal cancer screening.
  - Diabetes screening.
  - Influenza vaccine.
  - Hepatitis B vaccine for people at risk.
  - HIV screening.
  - Breast cancer screening (mammogram).
  - Medical nutrition therapy services.
  - Personal prevention plan services (annual wellness visits).
  - Pneumococcal vaccine.
  - Prostate cancer screening (Prostate Specific Antigen (PSA) test only).
  - Smoking and tobacco use cessation consulting.
  - Screening and behavioral counseling interventions in primary care to reduce alcohol misuse.
  - Screening for depression in adults.
  - Screening and Sexually Transmitted Infections (STIs) and high-intensity behavioral counseling to prevent STIs.
  - Intensive behavioral counseling for cardiovascular disease.
  - Intensive behavioral counseling for obesity.
  - Welcome to Medicare Preventive Visits (initial preventive physical exam).
- Emergency care; you may go to any emergency room if you reasonably believe you need emergency care. If you receive emergency care at an out-of-network hospital and need inpatient care after the emergency condition is stabilized, covered services provided after stabilization are paid at the out-of-network rate.
- Ambulance services, based on Medicare-covered ambulance services.

- Inpatient facility services, including:
  - Inpatient hospital care, including substance abuse and rehabilitation services.
  - Inpatient mental health and substance abuse hospital care.
  - Home health care, includes medically necessary intermittent skilled nursing care, home health aid services, home infusion and rehabilitation services.
  - Hospice care from a Medicare-certified hospice (when you enroll in a Medicare-certified hospice program, hospice services are paid by original Medicare, not this Plan).
  - Skilled nursing facility in a Medicare-certified nursing facility.
- Outpatient facility services, including:
  - ASC facility.
  - Clinic CORF.
  - Clinic ESRO (dialysis).
  - Clinic outpatient therapy (rehabilitation services).
  - Hospital based outpatient services, including mental health and substance abuse.
  - Religions non-medical health care institutions.
  - Partial hospitalization.
- Physician/practitioner services, including:
  - Office visits and consultations for:
    - Office and non-facility evaluation and management services and home visits.
    - Psychiatric and other services
    - Federally qualified health clinic facility physician services.
    - Rural health clinic facility billed physician services.
    - Routine physical exams (annually).
  - Chiropractic services for manual manipulation of the spine to correct subluxation when you receive services from a chiropractor or other qualified provider.
  - Podiatry services; for some medically necessary foot care services other than office visits, you pay the Plan's coinsurance (network or out-of-network) after your deductible.
  - Diagnostic radiology.
  - Diagnostic ultrasound.
  - Radiologic guidance.
  - Mammography.
  - Bone and joint studies.
  - Facility evaluation and management services.
  - Psychiatric/psychotherapy.

  - Surgical services, anesthesia services, cardiac catherization, cardiovascular and therapeutic.
  - Surgical services, including HOTP, weight loss surgery, medically necessary abortion and medically necessary sterilization
  - Anesthesia services.
  - Cardiac catherization.
  - Cardiovascular therapeutic, including pulmonary medicine (vent management inpatient hospital and other facility).

• Other physician and practitioner services, including:

  - Allergy and clinical immunology.
  - Biofeedback.
  - Cardiograph.
  - Central nervous system assessment and tests.
  - Chemotherpay administration drugs.
  - Clinical laboratory.
  - Diagnostic radiology.
  - Diagnostic ultrasound.
  - Radiographic guidance.
  - Mammography.
  - Bone dialysis.
  - Dialysis.
  - Endocrinology.
  - Gastroenterology.
  - Health and behavior assessments and interventions.
  - Hydration, therapeutic, prophylactic and diagnostic injections and infusions.
  - Immunization administration of vaccines and/or toxoids.
  - Injectables.
  - Neurology and neuromuscular procedures.
  - Noninvasive physiologic studies and procedures.
  - Noninvasive vascular diagnostic studies.
  - Nuclear medicine.
  - Ophthalmology specialized services.
  - Osteopathic manipulative therapy.
  - Pathology laboratory.
  - Photodynamic therapy.

  - Physical medicine and rehabilitation.
  - Pulmonary medicine (other than vent management).
  - Radiation oncology.
  - Special dermatological procedures.
  - Special otorninoleryngologic services.
  - Vaccines and/or toxoids.

- Outpatient rehabilitation services include occupational, physical, speech and language therapy.
- Durable medical equipment, which includes wheelchairs, oxygen, etc.
- Prosthetics and orthotics devices, includes braces, artificial limbs and eyes, etc.
- Diabetes programs and supplies, includes coverage for diabetes screenings, diabetes related durable medical equipment and supplies (such as glucose monitors, test strips, lancets) and self-management training.
- Diagnostic tests, x-rays, lab and radiology services.
- Dental services. This Plan covers only those medically necessary dental services covered by original Medicare. Contact BCBS Member Services for information on what is covered and cost-sharing amounts.
- Hearing services include diagnostic testing services and diagnostic hearing office visits. Routine hearing exams and hearing aids are not covered.
- Vision services include diagnosis and treatment of diseases and conditions of the eye, medical vision services in a doctor's office, corrective lenses after cataract surgery and annual glaucoma screenings for participants at risk. Routine eye exams and eyeglasses are not covered.

Medicare-Eligible Medical Exclusions

Not every medical service or supply is covered by the Plan, even if prescribed, recommended or approved by a physician. The Plan covers only those services and supplies that are covered by Medicare. Any service or supply excluded by Medicare is not covered under this Plan, unless specifically listed otherwise. For additional information contact BCBSM online at www.bcbsm.com or by phone at (866) 684-8216.

Medical Program Compliance

Newborns' and Mothers' Health Protection Act

The Plan does not restrict a mother's or newborn's benefits for a hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The attending provider (who may be a physician or nurse-midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. The Plan will not, under federal law, require that a provider obtain authorization from the Plan or the Claims Administrator for prescribing a length of stay of 48 hours or less for vaginal delivery (or 96 hours for cesarean section).

Women's Health and Cancer Rights Act

The Plan provides mastectomy-related benefits to Plan participants. If you are a covered person who receives benefits for a mastectomy and decide to have breast reconstructive surgery, the Plan will provide coverage in a manner determined in consultation with the attending physician and you for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearances; and
- Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These procedures will be covered the same as any other medical/surgical benefit under your Plan. Certain general coverage limitations may apply, including, but not limited to, deductibles, coinsurance, copayments and covered charges.

Requirements for Coverage

To be covered by the Plan, services, supplies and prescription drugs must:

- Be specifically listed as covered by the Plan.
- Not be a Plan exclusion.
- Not exceed any Plan maximum or limitation.
- Be obtained according to Plan terms.
- Be provided while coverage is in effect.
- Be medically necessary (except for preventive care), which means it is provided by a physician or other health care provider exercising prudent clinical judgment to a patient to prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms.
- Be provided according to generally accepted standards of medical practice.
- Be clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease.

- Not primarily be for the convenience of the patient, physician or other health care provider.
- Not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Prescription Drug Benefits

Prescription drug coverage helps you pay the cost of prescribed medications. The Plan includes both a retail and mail order pharmacy component.

The Plan provides creditable prescription drug coverage for retired employees and dependents who are eligible for Medicare. As a result, if you are eligible for Medicare, you should **not** enroll in a Medicare Part D Prescription Drug Plan. If you do, your prescription drug, and medical, coverage under this Plan will be suspended.

How Prescription Drug Benefits Work

What you pay for your prescription depends on the type of medication (generic or brand name) and where you have your prescription filled (retail pharmacy or mail order program). See the "Prescription Drug Benefits" portion of the Summary of Pre-Medicare Medical Benefits (beginning on page 19) or Summary of Medicare-Eligible Medical Benefits (beginning on page 46) sections, as applicable.

BCBSM has negotiated discounted prices for prescription drugs under the Plan when the prescription is filled at a participating retail or mail order pharmacy. If the discounted price is lower than your copayment, you pay the lower amount.

Types of Medication

Generic and Brand Name Medications

Many prescription medications are available under more than one name; a generic name and a brand name. By law, both generic and brand name medications must meet the same standards for safety, purity and effectiveness. A generic usually serves the same purpose but it is simply a brand name medication that is no longer protected by a patent, which means it generally costs less.

Generic medications help to control the cost of health care while providing quality medications, and can be a significant source of savings for you and the Plan. To encourage you to use generics whenever possible, your copayment is lowest when you have your prescription filled with a generic medication.

If your doctor does **not** indicate "Dispense as Written" (DAW), your prescription is automatically filled with a generic drug.

Dispense as Written (DAW): If you request a brand medication when a generic is available, you pay the brand name copayment plus the difference in cost between the generic and brand name medication. However, if your doctor indicates DAW on a first time brand name prescription when a generic is available, you pay the brand name copayment plus $10 on your first fill. The lower additional amount on the first fill is designed to allow your doctor time to initiate a medical necessity review of the medication. If the review does not indicate that the brand name is required, you pay the brand name copayment plus the difference in cost between the generic and brand name medication on any subsequent fills.

Formulary and Non-Formulary Medications

BCBSM uses a formulary. A formulary is a list of safe, effective and FDA-approved prescription drugs. Medications on the Plan's formulary have a lower copayment than those that are not included on the list.

A copy of the formulary is available at www.bcbsm.com (for pre-Medicare eligible participants or www.bcbsm.com/medicare (for Medicare-eligible participants. Medications on the list may change periodically; new medications added or removed. If a formulary change affects your prescription, you will be notified.

Where to Have Your Prescription Filled

Retail Pharmacy

Filling your prescriptions at a retail pharmacy is most appropriate for your short-term prescription needs. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in the network.

The Plan provides a national network of participating retail pharmacies. When you purchase covered prescription drugs from a participating retail pharmacy, simply present your prescription order and your ID card to the pharmacy and pay your copayment. You do not have to submit any claims when you use a participating retail pharmacy.

Finding a Participating Retail Pharmacy

To find a participating retail pharmacy, contact BCBSM by:

- Going online to www.bcbsm.com (or www.bcbsm.com/medicare/provdirectory.shtml for Medicare-eligible participants); or
- Calling the phone number on the back of your ID card.

Non-Participating Retail Pharmacies: When you purchase covered prescription drugs from a retail pharmacy that does not participate in the network, you must pay the full of the prescription when you pick it up and submit a claim for reimbursement. So, be sure to get a receipt. You will be reimbursed 75% of the allowed amount, after deducting the applicable copayment. You are responsible for any difference in cost between the allowed amount and the amount charged by the pharmacy.

If you need to purchase a prescription from a non-participating pharmacy because you are away from home or due to an emergency, you may be reimbursed 100% of the allowed amount, after deducting the applicable copayment.

Contact BCBSM for information on how to submit a claim for a prescription purchased at a non-participating retail pharmacy. All claims must be submitted within one year of the date purchased to be eligible for reimbursement.

Mail Order Pharmacy

The mail order pharmacy provides a convenient and cost-effective way for you to purchase up to a 90-day supply of your maintenance medication, and have it delivered directly to your home. A maintenance medication is any prescription medication that is taken on a long-term basis for chronic conditions, such as asthma, diabetes, high cholesterol, high blood pressure or arthritis.

Contact BCBSM for specific information on how to use the mail order program. Follow the instruction in the materials you receive.

You can expect to receive your first filled prescription about two weeks from the time you mail your prescription. If you need a medication right away, you may want to ask your physician to write two prescriptions:

- One for up to a 90-day supply, plus refills, to be ordered through the mail order program; and
- One for short-term supply, to be filled immediately at a participating retail pharmacy (for use until you receive your prescription order from the mail order program).

Refills can be ordered using the BCBSM's website, calling BCBSM or by mailing using the refill order slip.

Limited Retail Refills on Certain Maintenance Medications: The Plan has established a list of maintenance medications that are only covered when filled through the mail order pharmacy after initial fills at a retail pharmacy.

Any medication on the maintenance drug list will be limited to a 30-day supply. In addition, only the first three prescriptions fills of that medication (the initial fill and two refills) will be covered at a retail pharmacy. On the fourth fill, you must have the prescription filled through the mail order pharmacy or you will be responsible for the full cost of the medication at a retail pharmacy.

If you begin taking a prescription drug on the maintenance drug list, BCBSM will contact you about using the mail order pharmacy.

This maintenance drug list is subject to change periodically.

Specialty Pharmacy

Specialty medications are injectable, infused, inhaled or oral high-cost biotech products with unique handling and/or dosing requirements. BCBSM has established a list of specialty medications that is periodically revised. Many of these medications are available through your local retail pharmacy and all specialty medications should be available through a designated specialty pharmacy. In most situations, the specialty pharmacy will ship your medication and any required supplies you need for your injection directly to your home.

Utilization Management

BCBSM provides the following utilization management programs designed to help the Plan provide the quality benefits you need in the most cost-effective manner:

- **Quantity Restrictions:** Some medications have limits on the quantities that will be covered under the Plan. Quantity limits are placed on prescriptions to make sure you receive the medications you need in the quantity considered safe. That is, you get the right amount to take the daily dose recommended by the FDA and medical studies. Quantity restrictions may include:
  - ***Dose Duration:*** Provides coverage for specific dosing over a specific period. A coverage review may be needed to continue coverage at a specific dose for a longer period.
  - ***Quantity Duration:*** Provides coverage for a specific quantity of pills dispensed over a specific period.
  - ***Dose Optimization/Tablet Consolidation:*** Alerts physicians and patients to opportunities to simplify dosing regimens, which can decrease the cost of care by reducing the number of dosage units dispensed, while still fully satisfying your therapeutic needs and improving medication compliance. Tablet consolidation means you take one tablet of a higher strength daily rather than two tablets of a lower strength (same total daily dose).
  - ***Dispensing Quantity:*** Limits the quantity dispensed per prescription.
- **Prior Authorization:** Prior authorization requires that you get approval from BCBSM before certain prescription medications will be covered under the Plan. In this way, prior authorization helps you make sure your medications are used correctly and safely and may even keep your costs lower. If you and your physician request a drug that requires a prior authorization, BCBSM will notify you.
- **Step Therapy:** Step therapy is a process for finding the best medication to help treat an ongoing condition such as arthritis, asthma or high blood pressure. Step therapy requires the use of one or more step one medication(s) that has been proven effective for most people with your condition before you can get a similar, more expensive, drug covered. Often a step one medication is a more affordable generic medication. Generally what this means is that a step two medication will not be covered until a step one medication(s) is tried first. BCBSM determines the order of the medications to be taken, based on carefully reviews of medical literature, manufacturer product information and recommendations of the medical community. If you need to skip a step, you or your physician may contact BCBSM and request prior authorization.

Prescription Drug Coverage Expenses

Prescription medications covered under this Plan include:

- Federal legend drugs, which are medicinal substances that the federal Food, Drug and Cosmetic Act requires to be labeled, “Caution – Federal Law prohibits dispensing without prescription;” and
- Compound drugs, which are any drugs that have more than one ingredient and at least one of them is a federal legend drug or a drug that requires a prescription under state law.

Specific prescription drugs that the Plan covers include, but are not limited to:

- Contraceptives;
- Weight loss medications;
- Diaphragms (limited to 1 unit in 30 days);
- Prescription prenatal vitamins (for females only);
- Prescription vitamin D;
- Prescription vitamin K;
- Prescription long acting niacin;
- Prescription folic acid; and
- Diabetic supplies, including needles, syringes and insulin.

Medicare Part B Prescription Drugs

If you are eligible for Medicare, the Plan’s Medicare-eligible prescription drug benefits cover Medicare Part B prescription drugs. Some outpatient prescription drugs that may be covered under Medicare Part B include, but are not limited to:

- Antigens if they are prepared by a physician and administered by a properly instructed person under physician supervision.
- Osteoporosis injectable drugs for certain women.
- Erythropoietin (epoetin alfa or Epogen3), by injection, if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia self-administered clotting factors if you have hemophilia.
- Injectable drugs administered incident to a physician's service.
- Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare or paid by private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some oral cancer drugs if the same drug is available in injectable form.
- Oral anti-nausea drugs if you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs used with durable medical equipment.

Prescription Drug Exclusions

In addition to any exclusions listed in the Pre-Medicare Medical Exclusions (beginning on page 36) or Medicare-Eligible Medical Exclusions (beginning on page 52) section, benefits are not provided for:

- Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA) or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (that is, that are used off-label).
- Drugs available over-the-counter without a prescription, except insulin, which is covered.
- Drugs labeled “Caution: Limited by federal law to investigational use.”
- Any drug being used for cosmetic purposes, even if it contains a federal legend drug, except medically necessary Retin-A and Accutane for participants younger than age 26.
- Medical devices or appliances, except needles, syringes and diaphragms are covered.
- Charges for more refills than your doctor specifies or refills after a year from the original date of the prescription.
- Diabetic supplies that are covered under the Plan’s medical benefits.
- Drugs used for treatment of erectile dysfunction or inadequacy.
- Proton Pump Inhibitor (PPI) class drugs used to treat conditions such as heartburn, acid reflux (GERD) and ulcers, except PPI drugs to treat Barrett's Esophagitis and Zollinger-Ellison Syndrome may be covered with prior authorization.
- Expenses other than those determined to be available under the Plan’s utilization management programs.
- Drugs requiring a prescription by state law, but not by federal law.
- Foods and nutritional supplements, including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during covered hospitalization and prenatal vitamins or minerals requiring a prescription are covered.
- Naturopathic, naprapathic or homeopathic services and substances.
- Drugs to enhance athletic performance, such as anabolic steroids.
- Dental products, such as fluoride preparations and products for periodontal disease.
- Growth hormones.
- Tobacco and/or smoking cessation.
- Vitamins, except prenatal vitamins.
- Weight control or anorexiants (e.g., Meridia, Xenical).
- Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.
- Emergency contraceptives.
- Impotency medications.
- Infertility medications.

Coordination of Benefits

Coordination of Benefits (COB) applies if you or a dependent are covered by more than one health plan. If coverage is provided under two or more plans, COB determines which plan pays first (is primary) and which plan is secondary. The plan considered primary pays its benefits first, without regard to benefits paid by any other plan. Any remaining expenses may be paid under the other plan(s), which is considered secondary. Benefits paid by all plans will not exceed the allowable expense and no plan pays more than it would without this coordination of benefits provision.

Another plan may include health care benefits or services provided by this Plan or:

- A group, blanket or franchise insurance coverage;
- A group practice and other group prepayment coverage;
- Any coverage under labor-management trusted plans, union welfare plans, employer organization plans or employee benefit organization plans;
- Any coverage under governmental programs, such as, but not limited to, Medicare or any coverage required or provided by any statute;
- Individual automobile no-fault and traditional auto insurance;
- Individual or family insurance;
- Subscriber contracts;
- Individual or family coverage through Health Maintenance Organizations (HMO);
- Limited service organizations or any other prepayment;
- Student accident insurance provided through or by an educational institution; or
- Group practice or individual practice plan.

When this Plan and another plan(s) cover you or another family member for the same covered expense, then the COB order of benefit determination rules will determine which plan pays first. If this Plan pays first then it is the primary plan and it will pay the full amount of the Plan benefit. If another plan pays first, this Plan will be the secondary plan and it will review any remaining balance to see if additional benefits are payable after the primary plan has paid. If any amount is payable by this Plan, the total amount paid by both plans will not exceed 100% of the benefit payable under this Plan.

Order of Benefit Determination Rules for Pre-Medicare Participants

If you or a dependent are covered by two or more plans, the order of benefit determination follows the rules below in this order:

- If the other plan does not have coordination of benefits provisions, that plan pays first.
- The benefits of a plan that covers an individual as an employee, member or subscriber (other than as a dependent) are determined before the benefits of a plan that covers the individual as a dependent.
- **Birthday Rule:** The benefits of a plan that covers the person as a dependent are determined according to which parent's birth date occurs first in a calendar year (day and month).

If the birth dates of both parents are the same, the plan that has covered the person for the longer period will be determined first.

  - If the other plan does not contain the birthday rule but has a rule that coordinates benefits based on gender and the plans do not agree on the order of benefit, the rule in the other plan will determine the order of benefits.
  - If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the dependent are determined in this order:
    - If there is a court decree that establishes financial responsibility for the child's health care expenses, the benefits of the plan that covers the child as a dependent of the parent with financial responsibility are determined before the benefits of any other plan that covers the child as a dependent.
    - If there is no court decree, the parents are separated or divorced and the parent with physical custody of the child has not remarried, then the benefits of the plan that covers the child as a dependent of the parent with custody is primary.
    - If there is no court decree, the parents are divorced and the parent with physical custody of the child has remarried, the benefits of the plan that covers the child as a dependent of the parent with custody are determined first, then the benefits of the plan that covers the child as a dependent of the stepparent and then the benefits of the plan that covers that child as a dependent of the parent without custody.
- The benefits of a plan that covers an individual through his or her own present employment or through the present employment of another person are determined before the benefits of a plan that covers the person as a laid-off or retired employee, or as a dependent of such person.
- If the above rules do not establish an order of benefits determination, the benefits of a plan that has covered the person for the longer period are determined before the benefits of a plan that has covered the person for the shorter period.

Coordination with TRICARE

TRICARE is the health care program serving uniformed service members, retirees and their families. If you or your dependent are eligible for TRICARE coverage (formerly known as CHAMPUS or the Civilian Health and Medical Program, TRICARE will be the secondary plan.

Coordination with Medicare

For Medicare-eligible participants, this Plan is a Medicare Advantage Plan (Medicare Part C) for medical coverage and a Medicare Part D plan for prescription drug coverage for retired participants and/or their dependents.

This Plan complies with the rules of the Social Security Act of 1965, as amended. In general, this Plan is primary and will pay benefits first before any other plan for Medicare-eligible participants.

Coordination with No-Fault Auto Insurance

Where covered expenses are payable by a no-fault automobile insurer or other automobile insurer that pays without regard to fault, this Plan will always be the secondary plan.

Coordination with Medicaid

This Plan's benefits will be paid in accordance with any assignment of rights made by, or on behalf of, a covered person as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (Medicaid). The fact that an individual is eligible for or is provided medical assistance under Medicaid will not be taken into account when determining eligibility or payment of benefits. When this Plan has a legal liability to make payment, the Plan will make payment for benefits in accordance with any state laws.

When the Plan Needs to Coordinate Information

This Plan may need to disclose certain information to coordinate benefits with other another plan. To obtain the needed information, this Plan, without your consent, may release to, or obtain from, any insurance company, organization or person, the necessary information. You will be expected to provide any information required for this purpose.

Facility of Payment

Payment made under any other plan that, according to these provisions, should have been made by this Plan, will be adjusted. This Plan may pay to the organization that made a payment the amount that is determined to be payable. Any amount paid is considered a benefit paid under this Plan.

Claims and Appeals

Eligibility Claims and Appeals

BeneSys makes initial determinations regarding the eligibility, continued eligibility and termination of eligibility for Plan coverage. If BeneSys determines that you or a covered dependent are not eligible, you will receive written notice of the determination within 10 days. The notice will include:

- The specific reason or reasons for the denial;
- Specific references to pertinent Plan provisions on which the denial is based; and
- Information on any new or additional evidence considered, relied on or generated by the review process.

If you disagree with an eligibility determination, you or your authorized representative may appeal in writing to the Committee within 180 days after you receive notification of the determination.

The Committee's decision on appeal is final; there are no further appeals for the Committee's (or the designated subcommittee's) decision.

Medical and Prescription Drug Claims and Appeals

You should carry your medical ID card with you at all times, and present it when you go to your physician, hospital, clinic or other medical care provider. Generally, the provider will submit your claim to as indicated on your ID card. However, how the claim is paid may vary depending on if you use a network or out-of-network provider, as follows:

- **Network Provider:** If you receive treatment or services from a network provider, then the network provider will file a claim for you and payment will be made directly to that provider.
- **Out-of-Network Provider:**
  - If you receive treatment or services from an out-of-network provider, the provider may file a claim for you, in which case, payment may be made directly to the provider.
  - If your provider does not file the claim for you or does not have an agreement with the network, payment will be made directly to you and you will be responsible for paying your provider.

Filing a Claim

If you need to file a claim yourself, contact BCBSM at the toll-free customer service number on the back of your medical ID card.

If your Plan benefit is subject to coordination of benefits, you may need to submit a copy of the other plan's Explanation of Benefits with your claim if the other plan is primary. You can do this either when the claim is initially submitted or as soon as possible afterward.

Time Limit for Filing a Claim

You or your provider must file your claim within six months after the date of service or treatment or receipt of supplies. Your claim will not be invalidated or reduced if it is not reasonably possible to provide written proof of the claim within this period. However, no claim is eligible for payment if it is filed more than 12 months from the date the claim was incurred.

Claim Determinations

The time for processing your claim depends on what type of claim it is, as follows:

- **Urgent Care Claims:**
  - An urgent care claim is any claim for care or treatment where using the regular time-frame for processing the claim either:
    - Could seriously jeopardize your life or health or ability to regain maximum function; or
    - Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
  - If your claim is an urgent care claim for which pre-certification is required, you will be notified as soon as possible, taking into account the medical situation. A determination will be sent to you no later than 72 hours after your claim is received.
  - If you or your provider does not provide sufficient information to allow a determination on your urgent care claim, you will be notified as soon as possible, but not later than 24 hours after the claim is received. You will have a reasonable period (not less than 48 hours) to respond. After the additional information is received, you will be notified as soon as possible as to whether the claim is granted or denied.
  - If you do not follow procedures for filing your urgent care claim, you will be notified as soon as possible, but no later than 24 hours. You may be notified by telephone, unless you specifically request that it be in writing.
- **Concurrent Care Claims:**
  - A concurrent care claim is one that is reviewed and possibly changed after a specified period. Usually this occurs if you are receiving ongoing treatment or the treatment is provided over a number of sessions.
  - You will be given notice of any reduction or termination in your benefits sufficiently in advance to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.
  - If you request to extend the course of treatment beyond the period or number of treatments in your initial claim, your request will be decided as soon as possible taking into account the medical situation. You will receive notice of the determination within 24 hours after receipt of the request, as long as the request is received at least 24 hours before the end of the prescribed period or number of treatments.

- **Pre-Certification Claims:**
  - A pre-certification claim is where the Plan requires you to obtain approval before you receive medical care, treatment or supplies.
  - You will be notified of a decision within a reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt of the claim.
  - The 15-day period may be extended for an additional 15 days due to circumstances beyond the Plan's control. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which a decision is expected.
  - If you do not follow procedures for filing your pre-certification claim, you will be notified as soon as possible, but no later than five days. You may be notified by telephone, unless you specifically request that it be in writing.
- **Post-Service Claims:**
  - A post-service claim is any claim that is not one of the types of claims discussed above.
  - You will be notified of a decision within a reasonable period, but not later than 30 days after receipt of the claim.
  - The 30-day period may be extended for an additional 15 days due to circumstances beyond the Plan's control. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which a decision is expected.

Appeal Procedures

If your claim is denied, in whole or in part, you will be provided with a written or electronic notification, which will include all legally required information.

You, or your authorized representative, have the right to appeal an adverse benefit determination. You must file any appeal within 180 days after you received notice of a denial on your claim. To file an appeal:

- **Urgent Care Claims:** You can appeal by telephone, using the customer service number listed on your medical ID card. All necessary information, including the benefit determination on review, will be transmitted to you by telephone, facsimile or by another similar method.
- **All Other Claims:** You can call the toll-free customer service number on your medical ID card for information on filing all other appeals, or you can submit an appeal in writing to:
  BCBSM Grievance and Appeals
  P.O. Box 2667
  Detroit, MI 48231

There are many protections for you in the Plan's appeal procedure. The appeal procedure:

- Provides you or your authorized representative the opportunity to submit written comments, documents, records and other information relating to your claim.
- Allows you or your authorized representative to be given, upon request and free of charge, reasonable access to or copies of all documents, records and other information relevant to your claim.
- Requires that all relevant comments, documents, records and other information submitted in the appeal, regardless of whether such information was submitted or considered in the initial benefit determination, be taken into account.
- Gives you 180 days following receipt of a notification of an adverse benefit determination to appeal the initial adverse determination and 180 days following receipt of the first appeal determination to request a final appeal.
- Requires that no deference will be given to the initial adverse benefit determination and requires that the review on appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual.
- Requires that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment (for example, a determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), the person(s) deciding the appeal consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- Identifies any medical or vocational experts whom the Plan consulted in connection with the denial of your claim (even if their advice was not relied upon in denying the claim), and requires that they not have been consulted in connection with the initial claim denial.

Appeal Determinations

- **Urgent Care Claims:** You will be notified of the decision on review as soon as possible, taking into account the medical situation, but no later than 72 hours after receipt of your appeal.
- **Pre-Service Claims:** You will be notified of the decision on review within a reasonable time appropriate to your medical circumstances, but no later than 15 days after receipt of your appeal.
- **Post-Service Claims:** You will be notified of the decision within a reasonable time, but no later than 30 days after receipt of your appeal.

Final Committee Appeal – For Non-Medicare Eligible Participants Only

If your claim is denied on appeal, in whole or in part, you or your authorized representative may submit a final appeal, in writing, to the Committee within 180 days after you receive notification of the denial. The final written appeal should be directed to the Fund Administrator at:

BeneSys, Inc. (Appeals)
P.O. Box 1708
Troy, Michigan 48099-1708

The Committee (or a subcommittee of Committee members) will process and decide the appeal and notify you or your authorized representative of the decision in writing in accordance with the requirements of all applicable and effective laws and regulations. The Committee's decision is the final level of appeal under the Plan and there are no further appeals from the Committee's (or the designated subcommittee's) decision.

Physical Examination

The Plan has the right to have you examined, at the Plan's expense, for evaluation and verification of an illness or injury as often as required while a claim for benefits is pending.

Plan's Right to Recover Overpayments or Improper Payments

The Plan has the right to recover payments made that exceed the maximum amount required under the Plan. You may be asked to reimburse the Plan for any Plan benefit payment that is later determined to be in excess of the amount required to be paid by the terms of the Plan. In addition, the Plan may reduce future benefits to recover these amounts. The Plan's right of recovery applies against any person to whom, for whom or with respect to whom such payments were made, or against any insurance companies or other organizations, which according to these provisions, provide benefits for the same allowable expense under any other plan.

If you make a material misrepresentation on your application for coverage, the Plan has the right to rescind (retroactively terminate) coverage. A material misrepresentation is an untrue statement that leads the Plan to cover the person or to cover a medical condition of the person when it would not have done so if it had known the truth. For example, if it is determined that an individual has enrolled an ineligible dependent in the Plan, that would constitute an intentional misrepresentation of a material fact and could result in a retroactive termination of that ineligible dependent's coverage. Rescinding coverage means the Plan can cancel coverage effective on the date coverage was granted in reliance on the material misrepresentation. The Plan will provide at least 30 days advance written notice to each participant who would be affected before coverage is rescinded. A retroactive termination is not a rescission to the extent it is attributable to a failure to timely pay required premiums or contributions for the cost of coverage. The Plan will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Plan reserves the right to recover from the covered person or provider the amount paid on claims incurred during the period for which coverage is rescinded.

Claims Administrator and Committee Discretion

The Claims Administrator has the sole and exclusive authority and discretion to interpret and to apply the rules of the Plan and the Committee has sole and exclusive authority and discretion to interpret and apply the rules of the Trust and other rules and regulations of the Trust. Under the law, this authority means that the Claims Administrator's and/or Committee's decision, or that of their designee, will be upheld unless the court finds that it was arbitrary and capricious. No action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Trust, the Committee, any of the Committee members individually, or any agent of any of these under or relating to the Plan, including the Fund Administrator and Claims Administrators, is barred unless the complaint is filed within three years after the right of action accrues, unless a shorter period is established by applicable statute, regulation or case law. You should seek legal advice with respect to these requirements.

Notice of Plan's Privacy Practices

This section describes how health information about you may be used and disclosed and how you can get access to this information. Review it carefully and contact the Plan's Privacy Officer if you have any questions.

The Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to make sure that health information that identifies you is kept private to the extent required by law. This notice gives you information regarding the uses and disclosures of health information that may be made by the Plan and your rights and the Plan's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA. Please be advised, carriers associated with this Plan may issue separate Notices regarding disclosure of health information that they maintain on the Plan's behalf.

The Plan Privacy Officer can be contacted at:

UAW Retirees of ACC Benefit Trust
P.O. Box 1708
Troy, Michigan 48099-1708

How the Plan May Use and Disclose Health Information

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

- **For Payment:** The Plan may use and disclose health information to determine eligibility for Plan benefits, facilitate payment for the treatment and services received from health care providers, determine benefit responsibility under the Plan or coordinate Plan coverage. For example, the Plan may tell a health care provider about eligibility for benefits to confirm whether payment will be made for a particular service. The Plan may also share health information with a utilization review or precertification service provider. Likewise, the Plan may share health information with another entity to assist with the coordination of benefit payments.
- **For Health Care Operations:** The Plan may use and disclose health information for Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use health information in connection with:
  - Conducting quality assessment and improvement activities;
  - Underwriting, premium rating and other activities relating to Plan coverage;
  - Reviewing and responding to appeals;
  - Conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; and
  - General Plan administrative activities.

- **To Inform You of Treatment Alternatives or Other Health Related Benefits:** The Plan may use health information to identify if you may benefit from communications from the Plan regarding:
  - Available provider networks or available Plan products or services;
  - Your treatment;
  - Case management or care coordination; or
  - Recommended alternative treatments, therapies, health care providers or settings of care. For instance, the Plan may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.
- **Use by the Committee:** The Committee may use health information for Plan administration functions, including but not limited to reviewing appeals; however, every effort is made to minimize the disclosure of personal medical information. Summary health information may be used for soliciting premium bids from health insurers or for consideration in decisions whether to modify, amend or terminate the Plan. The Committee also may have access to information on whether you are participating in the Plan.
- **When Legally Required:** The Plan will disclose health information when it is required to do so by any federal, state or local law.
- **For Public Health Activities:** The Plan may disclose health information for public health activities such as the reporting of vital events, such as birth or death or the tracking of products regulated by the Food and Drug Administration.
- **To Conduct Health Oversight Activities:** The Plan may disclose health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, we may not disclose health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.
- **In Connection with Judicial and Administrative Proceedings:** As permitted or required by state law, the Plan may disclose health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to notify you of the request or, if such assurance is not forthcoming, if the Plan has made a reasonable effort to notify you about the request or to obtain an order protecting your health information.
- **For Law Enforcement Purposes:** As permitted or required by state law, the Plan may disclose health information to a law enforcement official for certain law enforcement purposes, including, in an emergency, to report a crime.
- **To Coroners, Medical Examiners and Funeral Directors:** The Plan may release health information to coroners or medical examiners for duties authorized by law or to funeral directors consistent with applicable law.
- **Organ and Tissue Donation:** If you are an organ donor, the Plan may release health information to organizations that handle organ procurement or transplantation.

- **In the Event of a Serious Threat to Health or Safety:** The Plan may disclose health information if necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person.
- **For Specified Government Functions:** In certain circumstances, federal regulations may require the Plan to use or disclose health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others and correctional institutions and inmates.
- **For Workers' Compensation:** The Plan may release health information to the extent necessary to comply with laws related to workers' compensation or similar programs.
- **For Other Purposes:** Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only if you provide a written authorization. If you provide the Plan with written authorization to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made with your permission. The Plan may use or disclose your health information for other purposes not set forth in this Notice when the Plan is permitted to do so without your written authorization or consent.

Your Rights Regarding the Privacy of Personal Health Information

Any of the rights described below that you may exercise may also be exercised by your personal representative. The Plan will require an appointment of the representative that you have signed. You have the following rights:

- **The right to request restrictions or limitations on the health information the Plan uses or discloses about you for treatment, payment or health care operations.** However, the Plan is not required to agree to your request. To request restrictions, you must make your request in writing to the Plan's Privacy Officer. In your request, you must state:
  - What information you want to limit;
  - If you want to limit the Plan's use, disclosure or both; and
  - To whom the limits apply.
- **The right to request to receive confidential communication of your health information by an alternative means or at an alternative location if a disclosure of your health information could endanger you.** The request must be made in writing to the Plan's Privacy Officer and must specify the alternative location or other method of communication that you prefer (for example, using an alternate address). Your request must include a statement that the restriction is necessary to prevent a disclosure that could endanger you. The Plan does not refuse to accommodate such a request unless the request imposes an unreasonable administrative burden. If the request is granted, the documentation of your request will be placed in your record.

- **The right to access documents regarding your eligibility, payment of claims, appeals or other similar documents for inspection and/or copying.** Your request for access to documents with your health information must be in writing to the Plan's Privacy Officer. When a request for access is accepted (in whole or in part), you will be notified of the decisions and you may then inspect the health information, copy it, or both, in the form or format requested at a time and place that is mutually convenient. If you would like, you may receive a summary of the requested health information instead of your entire record, for a reasonable fee. You may also receive a copy of your health information by mail if you prefer. (The Plan charges a reasonable, cost-based fee for copying, including labor and supplies, for instance, paper, computer disks and for postage if you request that the information be mailed. No fee is charged for retrieving or handling the health information or for processing your request for access.) When a request for access is denied in part, the Plan will grant access to the health information for which there is no grounds to deny access. The Plan will also inform you why your request for access was denied, how to appeal the denial (if the denial is reviewable) and how to file complaints with us and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, the Plan will designate a licensed health care professional, not involved in the original denial decision, to serve as a reviewing official and you will be notified in writing of the reviewing official's determination.
- **The right to request that your health information be amended if it is inaccurate or incomplete.** You may request that your health information be amended. That request must be in writing to the Plan's Privacy Officer and include a reason why your health information should be amended. If you do not include a reason, the Plan will not act on the request. When a request for amendment is accepted (in whole or in part), the Plan will inform you that your request for amendment has been accepted. The Plan will request from you permission to contact other individuals or health care entities that you identify that need to be informed of the amendment(s) and the Plan will inform them and other entities with whom the Plan does business who may rely on the disputed health information to your detriment. The Plan will identify the record(s) that are the subject of the amendment request and will append the amendment to the record. When a request for amendment is denied, you will be notified why the request was denied (e.g., the information requested was not created by the Plan, is accurate and complete, is not part of the record or may not legally be changed, such as information compiled in anticipation of a civil, criminal or administrative proceeding), how to file a statement of disagreement or a request that the Plan provide the request for amendment and the denial in any future release of the disputed health information and how to file a complaint with us or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, the Plan may write a rebuttal statement and will provide a copy to you and the Plan will include the request for amendment, denial letter, statement of disagreement and rebuttal (if any), with any future disclosures of the disputed health information. If you do not choose to write a statement of disagreement with the denial decision, the Plan is not required to include the request for amendment and denial decision letter with future disclosures of the disputed health information unless you request the Plan do so. When the Plan is notified that your health information has been amended, it will ensure that the amendment is appended to your records and will inform entities with whom it does business that may use or rely on your health information of the amendment and require them to make the necessary corrections.

- **The right to obtain an accounting of disclosures of your health information.** You have the right to request the Plan to provide you with an accounting of its disclosure of your health information. The right to an accounting extends to disclosures, other than disclosures made:
  - For treatment, payment or health care operations, including those made to business associates;
  - To individuals about their own health information;
  - Incident to an otherwise permitted use or disclosure;
  - Pursuant to an authorization;
  - To persons involved in the patient's care or other notification purposes;
  - As part of a limited data set;
  - For national security or intelligence purposes;
  - To correctional institutions or law enforcement officials; and
  - Those made before April 14, 2003.
  - To request an accounting of disclosures, you must submit your request in writing to the Plan's Privacy Officer. Your request must specify a period, which may not be longer than six years. You may request and receive an accounting of disclosures once during any 12-month period for no charge. If you request more than one accounting within the same 12-month period, a reasonable, cost-based fee may be charged. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **The right to receive a paper copy of this Notice and any revisions to this Notice.** You may request a copy of this Notice in writing to the Plan's Privacy Officer at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Legal Effect of this Notice

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

Plan Privacy Officer

For questions about this Notice, to exercise your privacy rights or to file a complaint, contact:

Steve Kokotovich, Plan Privacy Officer
UAW Retirees of ACC Benefit Trust
P.O. Box 1708
Troy, Michigan 48099-1708

Subrogation and Reimbursement

Any reference in this section to "you" also includes your covered dependent or you or your dependent's assignee or representative.

If the Plan pays benefits for any illness, injury, expense or loss caused by a third party, the Plan is subrogated (acting as a substitute) to all rights you may have against any person, firm, corporation or other entity for any claim related to the illness, injury, expense or loss, including any occupationally related claim or cause of action covered by the any state or federal act, for the full amount of benefits paid by the Plan. All recoveries you receive from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse the Plan for benefits paid.

By accepting benefits provided by this Plan, you agree to reimburse the Plan for any benefits you may receive from a third party due to a judgment, settlement or otherwise, regardless of any offset for expenses, including legal fees, that you may owe, and before you pay any other individual, organization or entity out of that full or partial recovery. In other words, this Plan has first priority with respect to its rights under this subrogation rule. Any money you recover will be considered to be held in a constructive trust for the benefit of the Plan, regardless of who actually holds the money. You may not take any action that would prejudice the Plan's rights, and you are required to take any action, provide any information and assistance and sign any papers required by the Plan for the Plan to be able to enforce its subrogation rights. The Plan (and/or any of the Plan's designees) is not responsible for attorney's fees or costs you may incur or pay unless the Plan agrees in writing to pay these fees or costs in full or in part. If for any reason any of the Plan's subrogation rights are compromised or diminished in any way, the Plan may treat the benefit amounts you received as a debt you have to the Plan and the Plan may pursue recovery of that amount from you and/or reduce or eliminate any future benefits that may be payable on your behalf until this debt is paid.

Before the Plan's payment of benefits for any illness, injury, expense or loss caused by a third party, you may be asked to sign a written assignment to the Plan of your rights, claims, interests or causes of action up to the full amount of Plan benefits. In addition, you may be asked to authorize the Plan, at the Plan's expense, to sue, compromise or settle, in your name or otherwise, all rights, claims, interests or causes of action to the full extent of the benefits paid and to do nothing to prejudice the Plan's subrogation rights. You may be asked to assure the Plan that you have not discharged or released any rights, claims, interests or causes of action. However, the Plan's failure to request or obtain any such document before payment of benefits does not in any way diminish the Plan's subrogation and reimbursement rights.

You are expected to assist or cooperate with the Plan, including, if requested, by bringing legal proceedings against any appropriate persons, firms corporations or other entities. The Plan may withhold benefits if you do not assist or cooperate.

Plan Administrative Information

This section contains important information about the Plan that is described in this SPD. In this section you will find information about the Plan and your legal rights.

Trust Name

UAW Retirees of ACC Benefit Trust

Plan Name

UAW Retirees of ACC Benefit Trust

Plan Sponsor and Plan Administrator

The Plan is sponsored and administered by the Committee. The Committee has seven members, four of whom are independent members and three of whom are appointed by the UAW. The Committee manages the Trust, designs and administers the benefit Plan and serves as the legal Plan Administrator and named Plan fiduciary under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. However, the Committee has delegated administrative responsibility to BeneSys, as the Trust Administrator.

Trust Administrator

The Committee hired BeneSys, Inc. as the Trust Administrator. BeneSys handles general Plan administration, including eligibility, recordkeeping, participant contributions and inquiries. To contact BeneSys:

BeneSys
P.O. Box 1708
Troy, Michigan 48099-1708
(855) 641-4911 (toll-free) or (248) 641-4911
Fax: (248) 813-9898

Plan Sponsor Employer Identification Number (EIN)

27-6927927

Plan Number

501

Plan Year

The Plan Year is January 1 and ending December 31.

Plan Type

This Plan is a welfare plan providing medical and prescription drug coverage for eligible participants.

Plan Funding

The Plan's medical and prescription drug benefits for pre-Medicare participants are paid directly from the Trust out of its assets. No insurance company or other state licensed entity is responsible for the financing of this portion of the Plan and Plan benefits are not guaranteed by a policy of insurance.

Medical and prescription drug benefits for Medicare-eligible participants are provided through a fully insured Medicare Advantage plan, which means these benefits are paid directly from the insurance company.

Participant contributions for coverage are paid to the trust and then benefits or premiums for coverage, as applicable, are paid from the Trust.

Agents for Service of Legal Process

If legal disputes involving the Plan arise, any legal documents may be served on:

Andrew Nickelhoff, Esq.
Sachs Waldman, P.C.
2211 East Jefferson, Suite 200
Detroit, Michigan 48207

Legal process also may be served on the Plan Administrator or on any Committee member at BeneSys.

Legal Actions

No action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under Plan terms, any lawsuit brought against the Plan, Committee, any of the Committee members individually or any agent of any of these under or relating to the Plan, including the Trust Administrator and Claims Administrators, is barred unless the complaint is filed within three years after the right of action accrues, unless a shorter period is established by applicable statute, regulation or case law.

Plan Documents

This Summary Plan Description (SPD) is as accurate and up to date as possible. However, this SPD is only a summary of your benefits; full details of the Plan are included in the legal documents that govern the Plan. If there is a difference between any Plan Document, such as insurance company plans or policies and the SPD, the Plan Document will govern.

In the case of any uncertainty regarding the meaning or intent of any section in the Plan or Summary Plan Description, the interpretation of the Plan Administrator or the Plan Administrator's designee will be final.

Plan Interpretation

Only the full Committee is authorized to interpret the Plan and decide eligibility for the benefits described in this booklet. The Committee's interpretation is final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Committee is challenged in court, that decision will be upheld, under current law, unless it is determined by the court to have been arbitrary and capricious. No agent, representative, officer or other person from Automotive Component Carrier or the UAW has the authority to speak for the Committee or to act contrary to the written terms of the governing Plan Documents.

Plan Changes

The Committee may change the eligibility rules and/or benefit provisions of the Plan at any time. The benefits provided by the Trust are limited to the assets of the Trust that are available to pay benefits. No retiree, surviving spouse or any other covered person has any vested rights to any benefit provided under the Plan, now or at any time in the future. The right to change or eliminate any and all aspects of benefits under the Plan is a right specifically reserved to the Committee.

Plan Discontinuation or Termination

The Trust and the Plan may be discontinued or terminated under certain circumstances, for example if there are insufficient assets in the Trust to continue payment of benefits or administration of the Plan. In this event, benefits for covered expenses incurred on or before the termination date will be paid as long as the Trust's assets are more than the its liabilities. Full benefits may not be paid if the Trust's liabilities are more than its assets and benefit payments will be limited to the funds available. The Committee will not be liable for the adequacy or inadequacy of funds. If the Trust is terminated by action of the Committee, any assets remaining after payment of Trust liabilities will be used for purposes determined by the Committee according to the Trust Agreement.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. ERISA provides that you are entitled to the rights described in this section.

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan. These include insurance contracts, 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 (EBSA).
- Obtain, upon written request to the Plan Administrator's office, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. A reasonable charge may be required for the copies.
- Receive a summary of the Plans' annual financial report (Summary Annual Report), which is required by law to be provided to each participant.

Continue Group Health Plan Coverage

You may also have the right to:

- Continue health care coverage for yourself, spouse or dependents (if eligible) if there is a loss of coverage due to a qualifying event. You or your dependents may have to pay for this coverage.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the Plan if you have creditable coverage from another plan. You will be provided a certificate of creditable coverage, free of charge, from the Plan when:
  - You lose Plan coverage;
  - You become entitled to elect COBRA continuation coverage; or
  - Your COBRA continuation coverage ends.
- You may request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

and beneficiaries. No one, including an employer, 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 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. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claim and appeal procedures.

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

If you have a claim that 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 medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been 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 Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) or the national office at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
(866) 444-3272

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their website at www.dol.gov/ebsa.

Glossary

Allowed Amount

The dollar amount Blue Cross Blue Shield of Michigan and Blue Care network have agreed to pay for health care services covered by the Plan. Allowed amount is sometimes called negotiated rate because of negotiations with providers (for example, doctors and hospitals) to get health care services at discounted rates.

Ambulatory Surgery Facility

A facility, separate from a hospital, that provides outpatient surgical services and meets the standards established, periodically revised and approved by the Claims Administrator.

BlueCard Program

The national program comprised of Blue Cross and Blue Shield plans that allows you to receive covered services from providers who have a contract or agreement with another Blue Cross and/or Blue Shield plan located outside the geographical area served by Blue Cross Blue Shield of Michigan. The local Blue Cross and/or Blue Shield plan that services the geographic area where the covered service is provided is referred to as the host Blue Cross and/or Blue Shield plan.

Claims Administrator

Blue Cross Blue Shield of Michigan for medical and prescription drug benefits.

Committee

A committee that sponsors and administers the Plan.

Custodial Care

Any health care service or supplies provided by health care professionals to people who need help with daily activities, such as cooking and bathing. Custodial care does not require a medical license and is the opposite of skilled care, which includes health care services and supplies that can only be given to you under the supervision of people who have medical licenses.

Experimental or Investigational

A service or supply that meets any of the following conditions, as determined by BCBSM:

- The service or supply is described as an alternative to more conventional therapies in the protocols or consent document of the provider that performs the service or prescribes the supply.
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
- There is an absence of authoritative medical or scientific literature on the subject.
- A significant amount of authoritative medical or scientific literature published in the United States shows that medical or scientific experts classify the service or supply as experimental or investigational or indicate that more research is required.
- The Food and Drug Administration has not granted approval of the service or supply if FDA approval is required.
- The service or supply is available only through participation in clinical trials sponsored by the FDA, National Cancer Institute or National Institutes of Health.

Home Health Aide Services

Services that may be provided by a qualified individual other than a registered nurse that are medically necessary for care and treatment.

Home Health Care

Skilled and therapeutic health care services you receive at home from a home health care agency according to a home health care plan.

Home Health Care Agency

A centrally administered agency providing physician directed nursing and other paramedical services to patients at home that meets the standards established, periodically revised and approved by the Claims Administrator.

Home Health Care Plan

Care and treatment for an illness or injury under a plan of home health care established and approved in writing by an attending physician. The physician must also certify that the treatment for the illness or injury would otherwise require confinement in a hospital or a skilled nursing facility. The home health care plan must be reviewed at least every two months.

Hospital

A hospital is a facility (and by definition, a provider) licensed to provide diagnostic, medical and surgical treatment and nursing care for sick or injured people. This includes observation care, inpatient care and outpatient care to diagnose and treat an individual with a medical, surgical, obstetric, chronic or rehabilitative condition requiring the direction or supervision of a physician.

An institution that is primarily a rest home, nursing home, convalescent home, rehabilitation center, extended care facility or home for the aged is not considered a hospital.

For behavioral health benefits, a facility approved under the laws of the state of its jurisdiction, for the treatment of mental health and substance abuse is considered a hospital for behavioral health treatment.

Illness

Pregnancy or a disease or disturbance in the function or structure of the body that causes physical signs and/or symptoms that, if left untreated, will result in a deterioration of the health state of the structure or systems of the body.

Injury

A condition caused by accidental means and from an external force that results in damage to the body.

Maximum Benefit

The total eligible charges the Plan pays for a participant while covered under the Plan.

Medical Emergency

A health-threatening or disabling condition that requires immediate medical attention and treatment. The condition must be such that if medical treatment is not secured within 72 hours of onset, the patient's permanent health could be in jeopardy or there could be significant impairment of bodily functions. The coverage is administered on the basis of the patient's signs and symptoms, as verified by the physician at the time of treatment, and not on the basis of the final diagnosis.

Medically Necessary or Medical Necessity

A service, treatment, procedure, equipment, drug, device or supply provided by a hospital, physician or other health care provider required to diagnose or treat an illness or injury and that is, as determined by the Claims Administrator and/or Plan Administrator:

- Consistent with the symptoms or diagnosis and treatment of the illness or injury;
- Appropriate under the standards of acceptable medical practice to treat that illness or injury;

- Not solely for the convenience of the patient, physician, hospital or other health care provider; and
- The most appropriate service, treatment, procedure, equipment, drug, device or supply that can be safely provided and that accomplishes the desired end result in the most economical manner.

The fact that a provider may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make that treatment, service or supply medically necessary.

Medicare

The program for health benefits under Title XVIII of the Social Security Act, as amended.

Mental Health

Mental, nervous or emotional disease or disorders of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders, regardless of the original cause of the disorder.

Primary Plan

A plan that determines and pays benefits first, without regard to any other plan.

Provider or Physician

A licensed person, such as a Medical Doctor (MD), Doctor of Osteopathic medicine (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), oral surgeon, gynecologist, pediatrician, psychologist or facility (such as a hospital or clinic) that provides services or supplies related to medical care.

Secondary Plan

A plan that is not a primary plan according to coordination of benefits order of benefit determination rules, and whose benefits are determined after those of another plan and may be reduced because of the other plan's benefits.

Skilled Nursing Facility

A facility providing convalescent and long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and registered nurse that meets the standards established, periodically revised and approved by the Claims Administrator. The facility may be operated either independently or as part of an accredited general hospital.

Substance Abuse

The use of a psychoactive substance in a manner detrimental to society or the individual and that meets, or with continued use may meet, criteria for substance abuse or drug dependency.

Trust

The UAW Retirees of ACC Benefit Trust

Trust Administrator

BeneSys, Inc.
P.O. Box 1708
Troy, Michigan 48099-1708
(855) 641-4911 (toll-free) or (248) 641-4911
Fax: (248) 813-9898

Urgent Care Center or Facility

A public or private hospital-based or freestanding facility licensed or legally operating as an urgent care facility that meets the standards established, periodically revised and approved by the Claims Administrator. The facility primarily provides minor emergency and episodic medical care, in which one or more physicians, nurses and X-ray technicians are in attendance at all times when the facility is open. The facility houses X-ray and laboratory equipment and a life support system.

Usual and Customary or U&C

The fee usually and customarily accepted as payment for the same services within a geographic area in which a provider practices. For a network provider, usual and customary is the negotiated, discount rate for the service or procedure (allowed amount).

Important Notice

The Committee has all powers necessary to administer and enforce Plan provisions. The Committee's decisions are final as to all questions arising in the administration, interpretation and application of the Plan. Any interpretation, determination, rule, regulation or similar action or decision issued by the Committee, or any person acting at the Committee's direction, will be conclusive and binding on all persons, except as otherwise provided, and any such determination, rule, regulation or similar decision may not be set aside unless it is determined by a court of competent jurisdiction that the Committee acted in an arbitrary and capricious manner. Plan benefits are paid only if the Committee or its designee decides, in its discretion, that the applicant is entitled to them.