



**SHEET METAL WORKERS LOCAL 7 ZONE 3  
HEALTH CARE FUND**

**COMBINATION PLAN DOCUMENT  
AND  
SUMMARY PLAN DESCRIPTION**

**JULY 1, 2020 EDITION**



**Sheet Metal Workers Local 7 Zone 3  
Health Care Fund**

**Summary Plan Description**

For further information or claim forms, call or write:

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Health Care Fund**

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# TABLE OF CONTENTS

<b>INTRODUCTION.....</b>	<b>1</b>
<b>IMPORTANT NOTICE .....</b>	<b>2</b>
<b>PREFERRED PROVIDER ORGANIZATION.....</b>	<b>3</b>
<b>LIFE EVENTS AT A GLANCE.....</b>	<b>3</b>
<b>CONFIDENTIAL INFORMATION .....</b>	<b>4</b>
<b>ARTICLE I - ACTIVE ELIGIBILITY RULES .....</b>	<b>5</b>
SECTION 1.01 - INITIAL ELIGIBILITY .....	5
SECTION 1.02 - CONTINUATION OF ELIGIBILITY .....	5
SECTION 1.03 - RESERVE HOURS .....	6
SECTION 1.04 - SELF-PAYMENTS.....	7
SECTION 1.05 - REINSTATEMENT OF ELIGIBILITY .....	7
SECTION 1.06 - ELIGIBILITY WHILE DISABLED.....	8
SECTION 1.07 - RECIPROCITY .....	8
SECTION 1.08 - TERMINATION.....	8
SECTION 1.09 - CONTINUATION COVERAGE UNDER COBRA.....	9
SECTION 1.10 - FAMILY MEDICAL LEAVE ACT.....	14
SECTION 1.11 - UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA).....	14
SECTION 1.12 - QUALIFIED MEDICAL CHILD SUPPORT ORDER .....	15
SECTION 1.13 - SPECIAL ENROLLMENT PROVISIONS.....	16
<b>ARTICLE II - SCHEDULE OF BENEFITS.....</b>	<b>17</b>
<b>ARTICLE III - MEDICAL BENEFIT COST-SHARING .....</b>	<b>19</b>
SECTION 3.01 - IN-NETWORK PROVIDERS.....	19
SECTION 3.02 - OUT-OF-NETWORK PROVIDERS.....	21
SECTION 3.03 - BENEFIT-SPECIFIC COST-SHARING REQUIREMENTS .....	23
<b>ARTICLE IV - DESCRIPTION OF MEDICAL BENEFITS.....</b>	<b>25</b>
SECTION 4.01 - ALLERGY TESTING AND THERAPY .....	25
SECTION 4.02 - AMBULANCE SERVICES.....	25
SECTION 4.03 - ANESTHESIOLOGY SERVICES .....	26
SECTION 4.04 - AUDIOLOGIST SERVICES .....	26
SECTION 4.05 - AUTISM DISORDERS.....	26
SECTION 4.06 - CARDIAC REHABILITATION .....	28
SECTION 4.07 - CHEMOTHERAPY .....	29
SECTION 4.08 - CHIROPRACTIC SERVICES AND OSTEOPATHIC MANIPULATIVE THERAPY.....	29
SECTION 4.09 - CHRONIC DISEASE MANAGEMENT.....	30
SECTION 4.10 - CLINICAL TRIALS (ROUTINE PATIENT COSTS).....	30
SECTION 4.11 - CONTRACEPTIVE SERVICES .....	31
SECTION 4.12 - DENTAL SERVICES COVERED UNDER MEDICAL.....	31
SECTION 4.13 - DIAGNOSTIC SERVICES .....	32
SECTION 4.14 - DIALYSIS SERVICES.....	32
SECTION 4.15 - DURABLE MEDICAL EQUIPMENT.....	34
SECTION 4.16 - EMERGENCY TREATMENT .....	35
SECTION 4.17 - GENDER DYSPHORIA TREATMENT .....	35

SECTION 4.18 - GENE THERAPY.....	35
SECTION 4.19 - HEARING CARE.....	35
SECTION 4.20 - HOME HEALTH CARE SERVICES.....	37
SECTION 4.21 - HOSPICE CARE SERVICES.....	38
SECTION 4.22 - HOSPITAL SERVICES.....	40
SECTION 4.23 - INFUSION THERAPY.....	41
SECTION 4.24 - LONG-TERM ACUTE CARE HOSPITAL SERVICES.....	41
SECTION 4.25 - MATERNITY CARE.....	42
SECTION 4.26 - MEDICAL SUPPLIES.....	42
SECTION 4.27 - MENTAL HEALTH SERVICES.....	43
SECTION 4.28 - NEWBORN CARE.....	46
SECTION 4.29 - OCCUPATIONAL THERAPY.....	46
SECTION 4.30 - OFFICE, OUTPATIENT AND HOME MEDICAL CARE VISITS.....	47
SECTION 4.31 - ONCOLOGY CLINICAL TRIALS.....	48
SECTION 4.32 - OPTOMETRIST SERVICES.....	51
SECTION 4.33 - OUTPATIENT DIABETES MANAGEMENT PROGRAM.....	51
SECTION 4.34 - PAIN MANAGEMENT.....	52
SECTION 4.35 - PHYSICAL THERAPY.....	52
SECTION 4.36 - PRESCRIPTION DRUGS (UNDER MEDICAL PROGRAM).....	54
SECTION 4.37 - PREVENTIVE CARE SERVICES.....	55
SECTION 4.38 - PRIVATE DUTY NURSING SERVICES.....	58
SECTION 4.39 - PROFESSIONAL SERVICES.....	58
SECTION 4.40 - PROSTHETIC AND ORTHOTIC DEVICES.....	58
SECTION 4.41 - RADIOLOGY SERVICES.....	60
SECTION 4.42 - SKILLED NURSING FACILITY SERVICES.....	60
SECTION 4.43 - SPECIAL MEDICAL FOODS FOR INBORN ERRORS OF METABOLISM.....	61
SECTION 4.44 - SPEECH AND LANGUAGE PATHOLOGY.....	62
SECTION 4.45 - SUBSTANCE USE DISORDER TREATMENT SERVICES.....	63
SECTION 4.46 - SURGERY.....	65
SECTION 4.47 - TEMPORARY BENEFITS FOR OUT-OF-NETWORK HOSPITAL SERVICES.....	66
SECTION 4.48 - TRANSPLANT SERVICES.....	69
SECTION 4.49 - URGENT CARE SERVICES.....	72
SECTION 4.50 - VALUE BASED PROGRAMS.....	72
<b>ARTICLE V - ADDITIONAL BENEFITS.....</b>	<b>75</b>
SECTION 5.01 - DEATH BENEFIT.....	75
SECTION 5.02 - DISABILITY BENEFIT – WEEKLY (ACTIVE ELIGIBLE PARTICIPANTS ONLY).....	75
SECTION 5.03 - PRESCRIPTION DRUG BENEFIT.....	76
SECTION 5.04 - DENTAL BENEFIT.....	78
<b>ARTICLE VI - BENEFIT EXCLUSIONS &amp; LIMITATIONS.....</b>	<b>81</b>
<b>ARTICLE VII - CLAIMS &amp; APPEALS PROCEDURE.....</b>	<b>83</b>
SECTION 7.01 - CLAIMS AND APPEALS GENERALLY.....	83
SECTION 7.02 - CLAIM SUBMISSIONS.....	83
SECTION 7.03 - CLAIM FORMS.....	83
SECTION 7.04 - EXHAUSTION OF CLAIMS & APPEALS PROCEDURES.....	83
SECTION 7.05 - CLAIM TYPES & DECISION TIMEFRAMES.....	84
SECTION 7.06 - IF YOUR CLAIM IS DENIED.....	85
SECTION 7.07 - INTERNAL APPEAL.....	86

SECTION 7.08 - EXTERNAL APPEALS .....	89
SECTION 7.09 - EXPEDITED EXTERNAL REVIEW .....	90
SECTION 7.10 - ADDITIONAL RIGHTS.....	91
<b>ARTICLE VIII - MISCELLANEOUS PROVISIONS.....</b>	<b>92</b>
SECTION 8.01 - PAYMENT OF BENEFITS .....	92
SECTION 8.02 - MEDICAL EXAMINATION .....	92
SECTION 8.03 - CONSTRUCTION BY TRUSTEES.....	92
SECTION 8.04 - TERMINATION OF COVERAGE .....	92
SECTION 8.05 - COORDINATION OF BENEFITS .....	92
SECTION 8.06 - SUBROGATION .....	93
SECTION 8.07 - HEALTH CARE FRAUD .....	96
SECTION 8.08 - RIGHT OF RECOVERY .....	96
SECTION 8.09 - HIPAA PRIVACY RULE .....	96
SECTION 8.10 - HIPAA SECURITY RULE .....	99
<b>ARTICLE IX - RETIREE PROGRAM.....</b>	<b>101</b>
SECTION 9.01 - ELIGIBILITY TO PARTICIPATE .....	101
SECTION 9.02 - FAILURE OF INITIAL PARTICIPATION.....	101
SECTION 9.03 - RETIREE SELF- PAYMENTS .....	101
SECTION 9.04 - MEDICAL AND PRESCRIPTION BENEFITS.....	102
SECTION 9.05 - DEATH BENEFITS.....	102
SECTION 9.06 - DENTAL BENEFITS.....	102
SECTION 9.07 - TERMINATION OF BENEFITS .....	102
SECTION 9.08 - ELIGIBILITY FOR MEDICARE .....	102
SECTION 9.09 - OPTING OUT AND RE-ENROLLMENT .....	103
<b>ARTICLE X - SURVIVING SPOUSE PROGRAM.....</b>	<b>104</b>
SECTION 10.01 - ELIGIBILITY AND ENROLLMENT.....	104
SECTION 10.02 - BENEFITS AVAILABLE .....	104
SECTION 10.03 - FAILURE OF INITIAL PARTICIPATION.....	105
SECTION 10.04 - SELF-PAYMENTS.....	105
<b>ARTICLE XI - IMPORTANT PLAN INFORMATION.....</b>	<b>106</b>
SECTION 11.01 - NAME OF PLAN .....	106
SECTION 11.02 - BOARD OF TRUSTEES .....	106
SECTION 11.03 - PLAN ADMINISTRATOR .....	106
SECTION 11.04 - PLAN SPONSORS .....	107
SECTION 11.05 - IDENTIFICATION NUMBERS.....	107
SECTION 11.06 - AGENT FOR SERVICE OF LEGAL PROCESS.....	107
SECTION 11.07 - COLLECTIVE BARGAINING AGREEMENT .....	107
SECTION 11.08 - SOURCE OF CONTRIBUTIONS .....	107
SECTION 11.09 - FUNDING MEDIUM FOR THE ACCUMULATION OF PLAN ASSETS .....	107
SECTION 11.10 - PLAN YEAR .....	107
SECTION 11.11 - TYPE OF PLAN.....	107
SECTION 11.12 - ELIGIBILITY RULES.....	108
SECTION 11.13 - LEGAL COUNSEL .....	108
<b>ARTICLE XII - STATEMENT OF ERISA RIGHTS.....</b>	<b>109</b>
<b>ARTICLE XIII - DEFINITIONS</b>	
SECTION 13.01 - ACCIDENTAL INJURY .....	112

SECTION 13.02 - APPROVED AMOUNT .....	112
SECTION 13.03 - BENEFICIARY .....	112
SECTION 13.04 - CHRONIC CONDITION.....	112
SECTION 13.05 - CONGENITAL CONDITION.....	112
SECTION 13.06 – COLLECTIVE BARGAINING AGREEMENT .....	112
SECTION 13.07 - COVERED EMPLOYMENT .....	112
SECTION 13.08 - COVERED CHARGES/COVERED SERVICES.....	113
SECTION 13.09 - CREDITABLE COVERAGE.....	113
SECTION 13.10 - CREDITED RESERVE HOURS.....	113
SECTION 13.11 - DESIGNATED SERVICES.....	113
SECTION 13.12 - DEVELOPMENTAL CONDITION .....	113
SECTION 13.13 – DISABLED/DISABILITY.....	113
SECTION 13.14 - ELIGIBLE DEPENDENT.....	113
SECTION 13.15 - ELIGIBLE PERSON.....	114
SECTION 13.16 - ELIGIBILITY RULES.....	114
SECTION 13.17 - EMERGENCY MEDICAL CONDITION/MEDICAL EMERGENCY .....	114
SECTION 13.18 - EMPLOYEE.....	114
SECTION 13.19 - EMPLOYER.....	115
SECTION 13.20 - EMPLOYER CONTRIBUTIONS .....	115
SECTION 13.21 - EXPERIMENTAL TREATMENT .....	115
SECTION 13.22 - FUND .....	115
SECTION 13.23 - HOSPICE .....	115
SECTION 13.24 - HOSPITAL .....	115
SECTION 13.25 - MEDICALLY NECESSARY .....	115
SECTION 13.26 - NONPARTICIPATING HOSPITAL / PROVIDER.....	116
SECTION 13.27 - OCCUPATIONAL THERAPY .....	116
SECTION 13.28 - OUTPATIENT MENTAL HEALTH FACILITY .....	116
SECTION 13.29 - OUTPATIENT SUBSTANCE ABUSE TREATMENT PROGRAM .....	117
SECTION 13.30 - PARTICIPATING HOSPITAL/PROVIDERS .....	117
SECTION 13.31 - PHYSICAL THERAPY.....	117
SECTION 13.32 - PARTICIPANT .....	117
SECTION 13.33 - PHYSICIAN OR SURGEON .....	117
SECTION 13.34 - PLAN.....	117
SECTION 13.35 - PRACTITIONER.....	117
SECTION 13.36 - PREFERRED PROVIDER ORGANIZATION (PPO).....	117
SECTION 13.37 - PROFESSIONAL PROVIDER.....	117
SECTION 13.38 - RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM .....	118
SECTION 13.39 - SICKNESS.....	118
SECTION 13.40 - SKILLED CARE .....	118
SECTION 13.41 - SKILLED NURSING FACILITY.....	118
SECTION 13.42 - SPOUSE .....	118
SECTION 13.43 - SUBSTANCE ABUSE TREATMENT PROGRAM SERVICES .....	118
SECTION 13.44 - SUBSTANCE USE DISORDER.....	118
SECTION 13.45 - TRUST AGREEMENT .....	119
SECTION 13.46 - TRUSTEES .....	119
SECTION 13.47 - UNION.....	119

## **INTRODUCTION**

The Sheet Metal Workers Local 7 Zone 3 Health Care Fund (the “Plan” or “Fund”) is a valuable benefit provided through the Local Union and Employers. The Benefit Plan is designed to protect Eligible Persons from financial hardship in case of illness or injury. Health care benefits, including major medical coverage, are provided both to the Participant and Eligible Dependents.

The Plan is self-funded. When Employees work in Covered Employment, the Employer makes contributions to the Plan on the Employee’s behalf, as required by collective bargaining agreements and participation agreements. These contributions are used to pay benefit claims and administer the Plan on the Participant’s behalf.

A Board of Trustees, consisting of an equal number of labor and management representatives, is responsible for the financial management and general operation of the Fund. To accomplish these tasks, the Board of Trustees retains the services and advice of various professionals, including certified public accountants, attorneys, and actuaries.

The Trustees strive to maintain and improve the benefits available to Participants and their Eligible Dependents. However, the Trustees reserve the right to amend the Plan in any way they feel necessary or desirable. Proper notice will be given of any changes in the Plan of Benefits.

The Trustees reserve the right to interpret and apply all provisions of the Plan, including those which relate to eligibility for benefits and the proper payment of benefits.

## **IMPORTANT NOTICE**

This Combination Plan Document and Summary Plan Description is intended to describe the benefits adopted by the Trustees. Only the full Board of Trustees has the authority to interpret the provisions in this booklet. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. No Employer or Union nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan nor can any such person act as an agent of the Trustees. Any formal interpretations regarding this Plan must be communicated in writing signed on behalf of the full Board of Trustees either by the Trustees or, if authorized by the Trustees in writing, by the Administrative Manager.

### **Trustee Authority**

The Board of Trustees, as Plan Administrator, has full authority to increase, reduce or eliminate benefits and to change the Eligibility Rules or other provisions of the Plan at any time. However, the Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the Participants and their Eligible Dependents. Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

### **Plan Changes**

The Trustees, consistent with the purpose of this Trust Fund and in accordance with the provisions of the Agreement and Declaration of Trust, have the power and authority to amend the Plan. If changes are made to the provisions of this Plan or the coverage it provides, you will receive a notice from the Administrative Manager. These notices are typically referred to as a "Summary of Material Modifications" or "SMM" for short. Therefore, it is extremely important to keep the Administrative Manager informed regarding any change of address. Plan changes, however, may take effect before notification is received. Therefore, before receiving non-emergency care, contact the Administrative Manager to confirm current health benefits if you are unsure what they are.

### **Termination or Merger**

The Plan, and all benefits that it provides, may also be terminated (in whole or in part) merged, or combined with another plan. The Board may also terminate the Plan when a Collective Bargaining Agreement requiring Employer Contributions no longer exists. In the event of termination of the Plan for any reason all eligibility will cease on the date of termination. The benefits provided under this Plan are NOT vested benefits and the Board has the authority to terminate any benefit, including retiree benefits, or the entire Plan, at any time. In the event the Board of Trustees determines the Plan assets are insufficient to carry out the purposes of the Trust, or if substantially all of the contributing Employers withdraw, then the Board may act to terminate the Plan. Upon termination, all expenses incurred through the date of termination will be paid (to the extent assets are available to make such payments). Following a final audit of the Plan, any remaining assets will be used in a manner consistent with the goals and purposes of the Declaration and Agreement of Trust. Under no circumstances will any portion of the corpus or income of the Plan, directly or indirectly, revert to or accrue to the benefit of the Employers, as defined in this document.

### **Defined Terms**

Certain words have specific meaning and are capitalized when used in the Plan. These words are listed in ARTICLE XIII - DEFINITIONS beginning on page 112. It is important to understand the meanings of the defined terms while using this Booklet.

## PREFERRED PROVIDER ORGANIZATION

The Plan has negotiated special contracts with an organization of area Physicians and Hospitals (“Preferred Providers”) known as the Preferred Provider Organization (“PPO”). The PPO for the Plan is the Blue Cross Community Blue Preferred Provider Organization (“BCBS” or “BCBSM”). Preferred Providers will render services for fees that are in most cases below prevailing prices.

When you receive services from a provider in the Blue Cross Community Blue PPO network, you’ll limit your out-of-pocket expenses. To maximize your benefits, utilize a provider that is currently a part of the Blue Cross Community Blue Preferred Provider Organization. If the Eligible Person uses a Preferred Provider for the Eligible Person’s health care needs, the Plan will generally pay 80% of all Covered Charges, after the annual deductible is satisfied.

All Eligible Active participants, Retired participants not on Medicare, and Surviving Spouses not on Medicare, along with eligible Dependents, are covered under the Blue Cross Community Blue PPO Program.

To access the most up-to-date provider information, contact Blue Cross, using the telephone number on the back of your ID card, for a directory of Community Blue PPO providers in your area. The directory lists the names, addresses and phone numbers of the physicians, specialists and hospitals who participate in the PPO network. Additionally, keep in mind that updates are constantly occurring to the network, so we strongly encourage you to call to verify the network status of the provider before obtaining services.

If you receive a referral, do not assume that the provider is a part of the PPO network. Always check the directory or call the provider to ensure they are part of the Community Blue PPO network.

## LIFE EVENTS AT A GLANCE

There are several significant events that may occur while you are covered under the Plan. Please contact the Administrative Manager, in writing, if any of the following occurs:

- **Your address or telephone number changes.**
- **You marry or divorce your spouse.** You must also submit the appropriate legal documents (for example: marriage certificate, divorce decree, or custody agreement).
- **You change your beneficiary.**
- **The status of a dependent changes.** For example, when your dependent child reaches age 26.
- **You become a parent.** You must also submit the child’s birth certificate, decree of adoption or a Qualified Medical Child Support Order.
- **You go into military service.**
- **You begin receiving Worker’s Compensation benefits.**
- **You become eligible for Medicare.**
- **You return to work after a disability ceases.**
- **You retire.**
- **A death occurs for a covered employee or retiree.**

**CHANGE OF ADDRESS:** The Administrative Manager must have current address information. If you move, make sure to notify the Administrative Manager of the new address. Any change of address must be reported within 60 days.

**NAME CHANGE:** Any name change must be reported within 60 days.

**CHANGE IN MARITAL STATUS:** If your marital status changes, don't forget to notify the Administrative Manager. The Administrative Manager must receive a complete, signed and dated copy of your marriage certificate, divorce decree or Order of Legal Separation. Failure to send copies of these documents will delay the processing of claims for benefits. Divorce must be reported within 30 days. Marriage must be reported within 60 days.

A former spouse is no longer eligible for benefits, except as provided under COBRA. Eligible Dependent children will continue to be covered if they continue to qualify as Dependent children under this Plan.

**DEATHS:** Deaths should be reported immediately. A certified copy of the death certificate is required.

**CHANGE IN BENEFICIARY:** If you wish to change your beneficiary, send the change to the Administrative Manager, in writing. In addition, if you divorce, the previous designation of your former spouse as beneficiary will become null and void. If you want your former spouse to remain as Beneficiary, you must fill out a new Participant Data Card after the date of divorce and turn it in to the Administrative Manager.

**ADD OR REMOVE DEPENDENTS:** If you need to add or remove dependents, you must notify the Administrative Manager, in writing. You should be prepared to provide documentation in the form of a birth certificate, decree of adoption, marriage license, divorce decree, etc. Since the Plan provides Benefits to Eligible Dependents, the Administrative Manager must know who your dependents are at all times. New dependents must be reported within 60 days.

## **CONFIDENTIAL INFORMATION**

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

The Plan's use and disclosures of PHI is set out in detail in the Privacy Notice previously mailed to all Participants. Please contact the Administrative Manager for a copy of the notice.

## ARTICLE I - ACTIVE ELIGIBILITY RULES

**THE TRUSTEES OF THE PLAN HAVE THE AUTHORITY AND ALL DISCRETION TO INTERPRET, CONSTRUE AND APPLY THE PROVISIONS OF THE PLAN IN DETERMINING YOUR ELIGIBILITY FOR ENTITLEMENT TO BENEFITS. BENEFITS UNDER THIS PLAN WILL BE PAID ONLY IF THE PLAN ADMINISTRATOR DECIDES IN ITS DISCRETION THAT THE PARTICIPANT IS ENTITLED TO THEM.**

### *Section 1.01 - Initial Eligibility*

#### Class A

A Class A Employee is any employee employed by a Contributing Employer who is required to make contributions on their behalf to the Sheet Metal Workers Local Union No. 7 Zone 3 Health Care Plan by reason of a Collective Bargaining Agreement by and between such Employer and Sheet Metal Workers Local Union No. 7 Zone 3.

A Class A Employee will first become eligible for benefits on the first day of the second calendar month following the receipt of 500 hours of employment during a period of six (6) consecutive months or less for which contributions have been received by the Fund.

EXAMPLE: You are a new participant who starts work in April. For the period April, May, June, and July, you work 500 hours or more. You will be eligible for benefits for two consecutive months commencing September 1st.

Coverage for Eligible Dependents will begin at the same time as the Employee, provided that the Eligible Dependents are properly enrolled.

#### Class O

A Class O participant is a full-time employee of the Union or a salaried employee of a Contributing Employer who has elected to contribute on behalf of such employee for not less than 160 hours per month multiplied by the Building Trades Journeymen Rate and who has executed a Participation Agreement which has been approved by the Board of Trustees of the Sheet Metal Workers Local Union No. 7 Zone 3 Health and Welfare Plan. A Class O Employee may not contribute less than 160 hours per month and is not eligible for self-pay and cannot accrue reserve hours in a reserve hours bank.

Each Employee who enters Class O shall become eligible for benefits upon receipt of 160 hours in each month of a two month period from a Contributing Employer. Coverage and benefits will be effective on the first day of the third month following the receipt of two months of contributions, provided contributions are received for the third month.

EXAMPLE: A Class O employee has 160 hours paid in July and August. Coverage starts November 1st.

Coverage for Eligible Dependents will begin at the same time as the Employee, provided that the Eligible Dependents are properly enrolled.

### *Section 1.02 - Continuation Of Eligibility*

#### Class A

Once becoming eligible, the eligible participant will remain eligible if the participant meets the minimum hour requirements as set forth in the following schedule:

<b>Work Month</b>	<b>Minimum Number of Hours Required</b>	<b>Month Participant is Eligible for Benefits</b>
June	140	September
July	140	October
August	140	November
September	140	December
October	140	January
November	140	February
December	140	March
January	140	April
February	140	May
March	140	June
April	140	July
May	140	August

Eligibility shall also continue if the employee has been credited with enough reserve hours or if the total hours worked and reserve hours equal or exceed 140.

Class O

A Class O employee will continue coverage as long as 160 hours per month is contributed as set forth in the following schedule:

<b>Work Month</b>	<b>Minimum Number of Hours Required</b>	<b>Month Participant is Eligible for Benefits</b>
June	160	September
July	160	October
August	160	November
September	160	December
October	160	January
November	160	February
December	160	March
January	160	April
February	160	May
March	160	June
April	160	July
May	160	August

***Section 1.03 - Reserve Hours***

Class A

Reserve Hours are credited for:

1. All hours in excess of the 500 hours in the month in which the 500 hours are earned during the Initial Eligibility Period.
2. All hours in excess of 140 credited during any calendar month other than a calendar month during the Initial Eligibility Period.

The maximum number of reserve hours that may be earned is 840.

Class O

Reserve Hours are not allowed for Class O Participants.

***Section 1.04 - Self-Payments***

Class A

Class A Employees are allowed to make self-payments if they are in danger of losing eligibility due to a period of underemployment or temporary unemployment. Acceptance of self-payments is contingent upon the active participant being available for employment within the jurisdiction of the Sheet Metal Workers Local 7 Zone 3 and continuing membership in the Sheet Metal Workers Local 7 Zone 3.

The amount of the self-payment is based on the number of hours the Participant is short of the monthly 140 hour requirement multiplied by the current contribution rate (as determined from time to time by the Board of Trustees).

EXAMPLE: If the participant is credited with only 100 hours for the work month of August, the self-payment due is \$310.00 for November coverage. This is calculated as follows:

140 hours	total monthly hour requirement
- <u>100 hours</u>	total hours worked
40 hours	total hours short
40 hours	total hours short
x <u>\$7.75</u>	current contribution rate *
\$310.00	self-payment amount due

\*NOTE: The contribution rate varies by active employee category. This includes Building Trade Journeyman, Pre-apprentices, Classified Workers, Apprentices, and Specialty Workers. These category and the relevant contribution rate may be revised from time to time by the Board of Trustees.

Self-payments are due on the last day of the month prior to when coverage takes effect. For example, the self-payment for February’s coverage is due by January 31st.

The maximum number of self-payments which may be made by a Class A participant is 24 full, consecutive self-payments. This 24-month period runs concurrently with the Class A Employee’s COBRA eligibility. Self-payment coverage is offered when the Participant would initially lose coverage under the Plan. This is the same time that COBRA Continuation Coverage is offered. The Participant can choose either Self-payments or COBRA Continuation Coverage. The Participant is not entitled to any additional COBRA benefit after exhausting the maximum amount of self-payment, unless required by law.

Class O

Self-payments of Class O Employees are not permitted. However, the Participant may be eligible for continuation of coverage through COBRA.

***Section 1.05 - Reinstatement Of Eligibility***

Class A

A Class A employee who fails to maintain eligibility by meeting hourly requirements and who also fails to make timely or continuous self-payments will become eligible again on the first day of the third month following receipt of 140 hours of contributions for employment with one or more contributing employers within a one month period.

EXAMPLE: The Participant terminates coverage effective July 31st. The Participant then returns to Covered Employment in September of the same year, and works 140 or more hours in the month of September. Coverage will be reinstated effective December 1st.

A Class A employee may also qualify for Reinstatement of Eligibility by meeting the Initial Eligibility Requirements.

If an employee remains ineligible for 12 consecutive months, they can only regain eligibility by meeting the Initial Eligibility Requirements.

#### Class O

A Class O employee whose coverage terminates must meet the Class O Initial Eligibility Requirements to reinstate coverage.

### ***Section 1.06 - Eligibility While Disabled***

#### Class A

A Class A Employee who becomes disabled while eligible will be credited with 35 hours of covered employment for each week of disability. The disability may be a result of a non-occupational or occupational illness or injury. The maximum number of weeks that may be credited is 52 consecutive weeks. Proof of disability must be filed with the Board of Trustees initially, then as often as requested. In the event a disabled Class A Employee continues to be disabled after the completion of the 52-week period, the Participant may then make self-payments for a period of 12 months. Any disability coverage benefit runs currently with the Class A Employee's COBRA eligibility. The Participant is not entitled to any additional COBRA benefit after exhausting the maximum amount of disability benefit, unless required by law.

#### Class O

Hours will not be credited for Class O employees who become disabled.

### ***Section 1.07 - Reciprocity***

#### Class A

The Board of Trustees has signed a "Money-Follows-The-Man" reciprocity agreement with many other local union welfare plans. If a participant worked in the jurisdiction of one of the local unions that has signed such an agreement, that health and welfare plan will transfer the hours at their rate of contribution to the Local No. 7 Zone 3 Health and Welfare Plan. The hours will be pro-rated. The reciprocity hours will be credited to the traveling Participant's record and used towards his/her eligibility in the Local No. 7 Zone 3 Health and Welfare Plan. The hours will be credited in the month the hours were actually worked.

#### Class O

Reciprocity is not offered for Class O employees.

### ***Section 1.08 - Termination***

#### Class A

If a Class A participant has used his or her initial eligibility credits, has not earned more than 140 hours during a month to continue eligibility, does not have enough reserve hours to reach the minimum requirement of 140 hours, and does not or cannot make self-payments, the participant and any covered Dependent's eligibility under the Plan will terminate, subject to self-payments and COBRA rules.

The participant's and any covered dependent's benefits will terminate on the first day of the third month following the work month in which he/she fails to meet the hourly requirement set forth, and has not made the required self-payment.

EXAMPLE: The participant does not earn 140 hours in July. The participant's coverage will terminate effective October 1st.

#### Class O

The benefits of Class O employees and their covered dependents will terminate on the first day of the third month following the month in which the employee fails to be credited with a minimum of 160 hours of contribution by a participating contributing employer.

#### ***Section 1.09 - Continuation Coverage Under COBRA***

In compliance with a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Plan offers certain Employees and Eligible Dependents the opportunity to continue their health benefits and dental benefits, where applicable, by making self-payments in certain instances where the eligibility for these benefits would otherwise terminate. This coverage is "Continuation Coverage."

**You may have other options available to you when you lose your group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

#### ***A. Eligibility For Continuation Coverage***

An Employee or Eligible Dependent who becomes eligible for Continuation Coverage shall be known as a "Qualified Beneficiary." An event that causes a Participant or Eligible Dependent to become a Qualified Beneficiary is known as a "Qualifying Event." In order to become a Qualified Beneficiary, a Participant or Eligible Dependent must be eligible for benefits on the date of the Qualifying Event.

An Employee will become a Qualified Beneficiary on the date eligibility for benefits terminates due to the occurrence of one of the following Qualifying Events:

- 1) A reduction in the hours worked; or
- 2) A termination of employment for any reason other than gross misconduct.

An Eligible Dependent (Spouse and/or dependent child) will become a Qualified Beneficiary on the date their eligibility for benefits terminates due to the occurrence of one of the following Qualifying Events:

- 1) The Employee's death;
- 2) A reduction in the hours worked by the Employee;
- 3) A termination of the Employee's employment for any reason other than gross misconduct;

- 4) The Employee's divorce or legal separation;
- 5) The Employee's entitlement to Medicare; or,
- 6) The loss of a child's Eligible Dependent status as defined on page 113.

**B. *Procedure For Obtaining Continuation Coverage***

When the Administrative Manager receives notice that a Qualifying Event has occurred, the Plan Administrative Manager will send an Election Notice to the Qualified Beneficiary no later than 14 days after the date of the loss of coverage. The Election Notice shall inform the Qualified Beneficiary what coverage may be continued, the cost of the coverage and what the Qualified Beneficiary must do in order to obtain the Continuation Coverage. The Election Notice shall also contain an application form for the Continuation Coverage that must be completed and returned along with the proper payment to the Administrative Manager within the time period set forth in the Election Notice.

The Election Notice shall be sent by first class mail to the Qualified Beneficiary's last known address as listed on the Administrative Manager's records. Therefore, it is important to notify the Administrative Manager, in writing, if your address changes. In the case of multiple Qualified Beneficiaries of the same family, a single Election Notice shall be sent to all Qualified Beneficiaries at that address. It shall be the responsibility of each Qualified Beneficiary to read the Election Notice. However, the parent or guardian of a minor child may read the Election Notice for the minor child and take action on said child's behalf.

Each Qualified Beneficiary shall be entitled to individually elect the Continuation Coverage if the Employee or dependent Spouse rejects coverage for the entire family. If the Qualified Beneficiary, or a parent or guardian acting on behalf of a minor Qualified Beneficiary, elects the Continuation Coverage, the Qualified Beneficiary must make sure that a completed and signed application is returned to the Administrative Manager within 60 days of the date on the Election Notice. Each qualified family member who elects the Continuation Coverage must be named on the application form or a separate application form must be submitted for any person not named. If, for any reason, the completed application is not received by the Administrative Manager within the 60 day period, with respect to any particular Qualified Beneficiary, that Qualified Beneficiary's eligibility for the Continuation Coverage shall expire and the Qualified Beneficiary's health benefits and dental and vision benefits, if any, shall terminate as of the date on which the Qualified Beneficiary first lost coverage. The Administrative Manager shall be held blameless in the event that a parent or guardian, acting on behalf of a minor Qualified Beneficiary, fails to inform the minor Qualified Beneficiary of the minor Qualified Beneficiary's rights to the Continuation Coverage and/or fails to elect the Continuation Coverage for the minor Qualified Beneficiary within the 60 day period.

The monthly self-payment rate for the Continuation Coverage shall be determined by the Trustees from time to time and shall be based upon the cost of the coverage provided by the Plan to a similar group of Participants. The monthly self-payment rate and frequency of payment shall be indicated on the Election Notice at the time it is sent to the Qualified Beneficiary. The self-payment rate may change due to changes in the benefits offered by the Plan and, in certain circumstances, to reflect changes in the cost of the coverage.

The first self-payment shall be due on the first day of the calendar month following the date on which a Qualifying Event occurs. The first self-payment shall cover the Qualified Beneficiary from the date of the Qualifying Event through the last day of the calendar month following the date of the

Qualifying Event. Subsequent self-payments shall be due on the last day of each preceding calendar month in an amount equal to the monthly self-payment rate.

When the Administrative Manager is properly notified of an election to purchase the Continuation Coverage, it will send a bill to the Qualified Beneficiary showing the self-payments due from the date of the Qualifying Event through one month in advance of the month in which the Election Notice was received. The entire amount shown on the bill must be received by the Administrative Manager within 45 days of the date the Qualified Beneficiary first signed the Election Notice. No other bills or invoices will be sent. The Continuation Coverage shall NOT be effective and medical expenses incurred after the Qualifying Event will NOT be paid unless and until the full bill is paid. It shall be the responsibility of each Qualified Beneficiary or each person acting on behalf of a Qualified Beneficiary, to ensure that correct payment is received by the Administrative Manager on a timely basis. The Administrative Manager shall be held blameless by the Qualified Beneficiary in the event that a parent or guardian, acting on behalf of a minor Qualified Beneficiary, causes said person to lose the Continuation Coverage through a failure to submit the correct payment in a timely fashion.

C. ***Maximum Period Of Continuation Coverage***

An Employee or Eligible Dependent who becomes a Qualified Beneficiary due to the Employee's reduction in hours worked or termination of employment (for reasons other than gross misconduct) may elect to make self-payments for the Continuation Coverage for a maximum period of 18 months from the date of the Qualifying Event.

An Eligible Dependent who becomes a Qualified Beneficiary due to any Qualifying Event other than the Employee's reduction in hours worked or termination of employment (for reasons other than gross misconduct) may elect to make self-payments for the Continuation Coverage for a maximum period of 36 months from the date of the Qualifying Event

An Eligible Dependent who qualifies for 18 months of Continuation Coverage, as provided in the first paragraph of this subsection, may also qualify for an additional 18 months of Continuation Coverage. In order to qualify for the additional coverage, the Eligible Dependent must suffer a second Qualifying Event that, in the absence of the first Qualifying Event, would have qualified that person for 36 months of Continuation Coverage. The second Qualifying Event must come after the first Qualifying Event and while the Continuation Coverage is in effect. This additional Continuation Coverage shall be applicable to those individuals who were Qualified Beneficiaries under the Plan on the date the first Qualifying Event occurred and shall run concurrent with the 18-month period of Continuation Coverage attributable to the first Qualifying Event. Under no circumstances shall the total Continuation Coverage for an Eligible Dependent exceed 36 months from the date of the first Qualifying Event by which an Eligible Dependent first became a Qualified Beneficiary. You must provide the Administrative Manager with written notice of the second Qualifying Event within 60-days of the later of: (1) The date of the second Qualifying Event; or (2) The date that your Spouse or Dependent child would lose coverage under the Plan due to the second Qualifying Event (such as turning age 26). If you fail to timely provide the notice, you will not be eligible for the extension. The notice should include the name of the person receiving the coverage and information about the second Qualifying Event.

The maximum period of continuation coverage can be extended an additional 11 months to a maximum period of up to 29 months. The following conditions must be met before the extension

applies the qualifying event must be the covered employee's termination of employment or reduction of hours;

- 1) A qualified beneficiary (who may be the covered employee or his or her spouse or dependent child) must be determined under the Social Security Act to have been disabled at any time during the first 60 days of COBRA coverage;
- 2) The qualified beneficiary must notify the Administrative Manager of the Social Security disability determination within 60 days after the latest of (a) the date of the Social Security disability determination; (b) the date of the qualifying event (i.e., the employee's termination of employment or reduction of hours); (c) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (d) the date on which the qualified beneficiary is informed, through the furnishing of the plan's summary plan description (SPD) or COBRA initial notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the Administrative Manager; and
- 3) The qualified beneficiary must notify the Administrative Manager of the Social Security disability determination before the end of the 18-month period following the qualifying event (i.e., the employee's termination of employment or reduction of hours)

If you are awarded Social Security Disability status, but later the SSA determines that you are no longer disabled, you must notify the Administrative Manager within 30 days from the date the SSA notifies you that it no longer considers you disabled. The notice should include the name of the person receiving the coverage and a copy of the letter from the SSA notifying you that you are no longer considered disabled.

#### D. ***Termination of Continuation Coverage***

With respect to each Qualified Beneficiary, the Continuation Coverage shall terminate on the first date any of the following events occur:

- 1) The Plan Sponsor no longer provides group health coverage to any of its Participants;
- 2) The date on which a self-payment for the Continuation Coverage is not made in a timely manner;
- 3) The date on which a Qualified Beneficiary becomes covered under another group health plan (as a member otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the "other plan" has applicable exclusions or limitations, your Continuation Coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). The rule applies only to the individual who becomes covered by another group health plan. Note that under federal law (the Health Insurance Portability and Accountability Act of 1996), an exclusion, or limitation of the other group health plan might not apply at all to the Qualified Beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan;
- 4) The date on which a Qualified Beneficiary becomes entitled to Medicare benefits after electing Continuation Coverage. This will apply only to the individual who becomes entitled to Medicare;
- 5) The Qualified Beneficiary who became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary is no longer disabled (however, Continuation Coverage will not end until the month that begins more than 30 days after the determination);
- 6) The occurrence of any event that permits termination of coverage for cause (i.e., submission of fraudulent benefit claims) with respect to the Participant or their Eligible

- Dependents who have coverage under the Plan for a reason other than the Continuation Coverage requirements of federal law; or
- 7) The date on which a Qualified Beneficiary completes the maximum period of Continuation Coverage for which the Qualified Beneficiary is eligible.

E. ***COBRA Continuation Coverage Notification Procedures***

Initial (General) COBRA Notice

The general notice required by federal law is provided as part of this Combination Plan Document and Summary Plan Description.

Employer Qualifying Event Notice

The Participant's Employer must notify the Administrative Manager within 30-days of the Qualified Event of termination of employment, reduction in hours of employment, the Employee's death, or the Employee's entitlement to Medicare.

Employee Qualifying Event Notice

A Participant must give written notice to the Administrative Manager within 60 days after a Qualifying Event that is a divorce or legal separation of the Employee (or Retired Participant) and Spouse or a dependent child's ceasing to meet the Plan requirements for Eligible Dependent status.

COBRA Election Notice

The Administrative Manager will furnish notice of a Qualified Beneficiary's eligibility for COBRA Continuation Coverage. The notice will be sent to each Qualified Beneficiary within 14 days after receipt of notice from an Employee of a Qualifying Event that is a divorce or legal separation or a child's ceasing to qualify as an Eligible Dependent under the terms of the Plan.

When a Qualifying Event occurs that is the Employee's termination of employment, reduction of hours, death, or becoming entitled to Medicare, the notice will be sent to each Qualified Beneficiary within 44 days after the earlier of:

- The date on which the Participant or Beneficiary would lose coverage due to a Qualifying Event, or
- The date of the Qualifying Event (if coverage is to terminate immediately as of the Qualifying Event instead of at the end of the coverage period in which the Qualifying Event occurs).

Unavailability of COBRA Notice

When the Administrative Manager receives a notice from an Employee or Beneficiary relating to a Qualifying Event, second Qualifying Event, or determination of disability by the Social Security Administration regarding a Covered Employee, Qualified Beneficiary, or other individual, and the Administrative Manager determines that the individual is not entitled to COBRA Continuation Coverage, the Administrative Manager shall provide a notice explaining why the individual is not entitled to COBRA Continuation Coverage.

The unavailability notice shall be sent within 14 days from receipt of the notice from the Employee or other individual.

Early Termination of COBRA Continuation Coverage Notice

Whenever COBRA Continuation Coverage is terminated prior to the latest date shown on the Election Notice, notice must be sent to all affected Qualified Beneficiaries explaining the reason

for the termination, the date of termination, and any rights the Qualified Beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage, such as a conversion right.

The termination notice will be provided as soon as practicable following the determination that continuation coverage shall terminate.

### ***Section 1.10 - Family Medical Leave Act***

The Family and Medical Leave Act of 1993 (FMLA) creates a federal right for an Employee to take up to 12 weeks of unpaid leave for his serious illness, the birth or adoption of a child, or to care for his seriously ill spouse, parent, or child. A spouse, son, daughter, parent or next of kin of a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness is allowed to take up to 26 weeks of FMLA leave to care for such a family member.

In addition, an employee may take up to 12 weeks of FMLA leave for a “qualifying exigency” arising out of the fact that the employee’s spouse, son, daughter or parent is on active duty in the Armed Forces or has been notified of an impending call or order to active duty. An “exigency” is a state of affairs that makes urgent demands as defined by the regulation.

The FMLA requires Employers to maintain health care coverage under any health plan for the length of the leave as if the Employee were still employed. In addition, the Act states that if an Employee takes a family or medical leave the Employee may not lose any benefits that the Employee had accrued before the leave. The Plan will recognize eligibility for a family medical leave and maintain the Employee’s prior eligible status until the end of the leave, provided the Employer properly grants the leave under the FMLA and the Employer makes the required payments to the Plan.

If you have any questions about the FMLA, you should contact your Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under the U.S. Government, Department of Labor, Employment Standards Administration. You can also visit the Department Labor’s FMLA webpage at: [www.dol.gov/esa/whd/fmla](http://www.dol.gov/esa/whd/fmla).

### ***Section 1.11 - Uniformed Services Employment & Reemployment Rights Act (USERRA)***

#### **Continuation Of Benefits**

The Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) requires that health plans must offer to continue coverage for employees who are absent due to service in the uniformed services and/or their dependents. Coverage may continue for up to 60 months after the date the employee is first absent due to uniformed service. Health coverage means hospital, surgical, medical, dental or vision coverage provided under the Plan. Health coverage is subject to change as a result of plan modification. In the event of a conflict between this provision and USERRA, the provisions of USERRA shall apply. A member’s USERRA rights terminate if his uniformed service ends in an undesirable conduct category of discharge.

#### **Eligibility**

An employee is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States of America in a time of war or national emergency. Duty includes absence

for active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and for the purpose of an examination to determine fitness for duty.

An employee's dependents who have coverage under the Plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

#### Coverage During Leave

If you go on active duty in the military, you must notify the Administrative Manager in writing before you enter active duty to preserve your rights under the Plan. Your rights under the Plan will then continue as long as the following requirements are met:

- 1) Your time on active duty does not exceed five (5) years; and
- 2) You are released from active duty under honorable conditions; and
- 3) You apply for work in covered employment under the Plan and notify the Administrative Manager within ninety (90) days of being released from active duty.

If you meet the above requirements, the following rules will apply:

- 1) You will be treated as if you never left the Plan; and
- 2) Any balance in your Credited Reserve Hours will be held until you return to covered employment under the Plan. At that time the Credited Reserve Hours can be used to maintain your eligibility, and
- 3) You and your eligible dependents will be eligible for continuation coverage on a self-pay basis for twenty-four (24) months at the time you begin active duty. You will be charged the monthly COBRA premium rate unless your period of service is less than 31-days, in which case coverage shall be provided at no additional cost. Credited Reserve Hours may be used to pay for USERRA coverage. Your Credited Reserve Hours balance can be used for the monthly payment if you agree. Please note that continuation of coverage through this provision is in lieu of COBRA coverage. You will have to choose between continued coverage through this provision and COBRA coverage (see pages dealing with COBRA coverage).

#### Duration Of Coverage

Elected continuation coverage under USERRA will end at midnight on the earliest of:

- 1) The day the Plan is terminated;
- 2) The day the premium is due and unpaid;
- 3) The day the employee again becomes covered under the Plan;
- 4) The day health coverage has been continued for the period of time of 24 months, beginning the first day of absence from employment due to service in the uniformed services; or
- 5) The day after the employee fails to apply for or return to employment as required by USERRA, after completion of a period of service.

#### Other Information

The employee should contact the Administrative Manager with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the Administrative Manager of any changes in marital status, or a change of address.

#### ***Section 1.12 - Qualified Medical Child Support Order***

The term "Qualified Medical Child Support Order" ("QMCSO") means a Medical Child Support Order which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits under the Plan and which complies with the requirements of a

QMCSO. An Alternate Recipient under a QMCSO shall be eligible for benefits from the Plan only if the Participant is eligible.

Benefits paid to an Alternate Recipient shall be at the level of benefits available under the Plan at the time the Expense was incurred.

Any payment made by the Plan under a QMCSO or reimbursement for expenses paid by the child or the child's custodial parent or legal guardian will be made in accordance with applicable law.

The Plan has established procedures for the determination of whether a medical child support order is a QMCSO and administration thereto, pursuant to the requirements of federal law.

The procedures followed by the Plan in processing a QMCSO are available from the Administrative Manager at no charge.

### ***Section 1.13 - Special Enrollment Provisions***

If you, or any of your dependents, lose eligibility under another group health plan (or if an Employer stops contributing toward your or your dependent's other coverage), you may be eligible for a special enrollment period. However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your eligible dependent(s). Newly acquired Dependents should be enrolled no later than 60 days following the date of marriage, the birth of a natural born child, the date a child is placed with the Participant for adoption, the date which the Participant incurs a legal obligation for support in anticipation of adoption, or the date coverage for a child is mandated by a Qualified Medical Child Support Order.

Marriage - To add a Spouse and any eligible stepchildren to coverage, the marriage must be reported and a copy of the certificate of marriage must be filed with the Administrative Manager. The Spouse and any eligible stepchildren will then be covered from the date of marriage.

Birth of a Child - To add a child to coverage, the birth must be reported and a copy of the birth certificate must be filed with the Administrative Manager. The child will then be covered from the date of birth.

Adoptions - To add an adopted child to coverage, the adoption or placement of a child must be reported and a copy of the legal adoption papers or court order for placement must be filed with the Administrative Manager. Coverage will then be effective as of the date of the adoption or placement for adoption.

Additionally, a Dependent can be added within 60 days if coverage under a State Children's Health Insurance Program (CHIP) is lost, or if the Dependent becomes eligible for CHIP or Medicaid coverage. Employees should contact the Administrative Manager for more information.

If a Participant fails to timely enroll a new Dependent or provide evidence of a Dependent's eligibility, coverage will begin on the first of the month following the completion of enrollment and will not be retroactive to the date of birth, marriage, adoption or placement for adoption. The Plan will not be responsible for any bills or charges incurred prior to the first of the month following completion of enrollment. Please contact the Administrative Manager for more information.

## ARTICLE II - SCHEDULE OF BENEFITS

Once a Participant becomes eligible under the Plan, the Participant qualifies for a variety of benefits. The following chart highlights the Benefit Plan. Other Plan maximums and limitations may apply to specific benefits. Please refer to the appropriate sections of this Booklet or contact the Administrative Manager for more information.

### Eligible Employee & Dependents

#### Major Medical Benefit

In-Network Deductible	
Individual .....	\$250
Family .....	\$500
Out-of-Network Deductible	
Individual .....	\$500
Family .....	\$1,000
In-Network Out-of-Pocket Limit	
Individual .....	\$3,100
Family .....	\$6,200
Out-of-Network Out-of-Pocket Limit	
Individual .....	\$6,000
Family .....	\$12,000

#### Coinsurance for Most Covered Services

In-Network - Eligible Person pays.....	20% Approved Amt
Out-of-Network - Eligible Person pays .....	40% Approved Amt

#### Private Duty Nursing

In-Network/Out-of-Network - Eligible Person pays.....	50% Approved Amt
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#### In-Network Copayments

Office Visit, Office Consultation, Online Visit, Urgent Care Visit, or Retail Health Clinic Visit - Eligible Person pays.....	\$30
Chiropractic or Osteopathic Manipulative Treatment, Services in a Physician's Office - Eligible Person pays.....	\$20

#### Emergency Room Visit

In-Network/Out-of-Network - Eligible Person pays.....	\$200
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#### Prescription Drug Benefit

##### Out-of-Pocket Limit

Individual .....	\$3,300
Family .....	\$6,600

##### Retail

Generic Drugs - Eligible Person pays.....	\$15
Preferred Brand Name Drug - Eligible Person pays.....	\$35
Non-Preferred Brand Name Drug - Eligible Person pays.....	\$50
Generic/Preferred Specialty - Eligible Person pays.....	20% (max of \$100)

Non-Preferred Specialty – Eligible Person pays.....	20% (max of \$200)
Mail Order	
Generic Drugs - Eligible Person pays.....	\$30
Preferred Brand Name Drug – Eligible Person pays .....	\$50
Non-Preferred Brand Name Drug – Eligible Person pays .....	\$70
Generic/Preferred Specialty – Eligible Person pays .....	20% (max of \$100)
Non-Preferred Specialty – Eligible Person pays.....	20% (max of \$200)
Preventive Care Benefit – In-Network Only .....	Covered 100%

**Eligible Employee, Retirees, & Dependents**

Dental Benefit

Annual Maximum Benefit (Actives & their Dependents) .....	\$1,000 per person
Coinsurance (Actives & Dependents) - Eligible Person pays .....	20% of Approved Amt
Annual Maximum Benefit (Retirees, Surviving Spouses, & their Dependents) .....	\$500 per Person
Coinsurance (Retirees, Surviving Spouses, & their Dependents) - Eligible Person pays.....	50% of Approved Amt

**Eligible Employee & Retirees**

Death Benefit

Active .....	\$25,000
Retired.....	\$1,000

**Eligible Employee Only**

Weekly Disability Benefit (subject to Social Security Taxes)

Maximum Benefit .....	26 weeks per Injury or Sickness
Benefit Amount.....	\$400

## ARTICLE III - MEDICAL BENEFIT COST-SHARING

### *Section 3.01 - In-Network Providers*

#### Deductible

Each calendar year, you must pay a deductible for in-network covered services.

Your deductible for in-network covered services is:

- \$250 for individual
- \$500 for family

Family Deductible:

- Two or more members must meet the family deductible.
- If the one-member deductible has been met, but not the family deductible, the Plan will pay for covered services only for that member who has met the deductible.
- Covered services for the remaining family members will be paid when the full family deductible has been met.

Payments applied to your in-network deductible in the last three months of a calendar year will be applied toward your in-network deductible requirement for the next calendar year.

You are not required to pay a deductible for the following:

- Covered services performed in an in-network physician's office, including mental health and substance use disorder services that are equal to an office visit
- Services subject to a copayment requirement
- Professional services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Osteopathic manipulation
- Chiropractic manipulation
- Prenatal and postnatal care visits
- Allergy testing and therapy
- Therapeutic injections
- Hospice care benefits
- Preventive care services

#### Copayment

You must pay the following copayment for covered services by in-network providers:

- A. Hospital emergency room visit: \$200 per hospital emergency room visit.

The \$200 copayment is waived if:

- The patient is admitted or
- Services were required to treat an accidental injury

Note: You do not have to pay a copayment for in- or out-of-network physician services, for treatment for a medical emergency or accidental injury. However, if you receive services from a non-participating provider, you may have to pay the difference between what the Plan pays and the provider's charge.

- B. Office visit, office consultation, online visit, urgent care visit, or retail health clinic visit: \$30 copayment.

This copayment requirement does not apply to:

- First aid and medical emergency treatment
- Prenatal and postnatal care visits
- Allergy testing and therapy
- Therapeutic injections
- Presurgical consultations

- C. Chiropractic or osteopathic manipulative treatment, when services are given in a physician's office: \$20 copayment.

When an office visit and a manipulative treatment service are billed on the same day, by the same in-network physician, only one copayment will be required for the office visit.

### Coinsurance

In addition to your deductible, you must pay the coinsurance for covered services by in-network providers. The coinsurance is 20% of the approved amount for most covered services. The coinsurance for private duty nursing care is 50% of the approved amount.

This coinsurance does not apply to:

- Services in an in-network physician's office, except mental health and substance use disorder services that are not equal to an office visit. These services will require payment of your coinsurance.
- Services in a retail health clinic
- Services subject to a copayment requirement
- Professional services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Chiropractic and osteopathic manipulation
- Prenatal and postnatal care visits
- Allergy testing and therapy
- Therapeutic injections
- Hospice care benefits
- Preventive care services
- Presurgical consultations

### Annual Out-of-Pocket Maximums

Your annual out-of-pocket maximum for covered in-network services is:

- \$3,100 for individual
- \$6,200 for the family

Family out-of-pocket maximum:

- Two or more members must meet the family out-of-pocket maximum.
- If the individual maximum is met even if the family maximum is not, that member does not pay any more cost sharing for the rest of the calendar year.
- Cost sharing for the remaining family members must still be paid until the annual family maximum is met.

The in-network deductible, copayments and coinsurance that you pay are combined to meet the annual in-network maximum.

Only payments toward your cost-share are applied toward your out-of-pocket maximum. If you receive services from a nonparticipating provider and you are required to pay that provider for the difference between the charge for the services and the approved amount, your payment will not apply to your out-of-pocket maximum.

Once you meet the maximums for the year, the Plan will pay for all covered benefits at 100 percent of the approved amount for the rest of the calendar year.

### ***Section 3.02 - Out-of-Network Providers***

#### Deductible

Each calendar year, you must pay a deductible for out-of-network covered services.

Your deductible for out-of-network covered services is:

- \$500 for individual
- \$1,000 for family

Family deductible:

- Two or more members must meet the family deductible.
- If the one-member deductible has been met, but not the family deductible, the Plan will pay covered services only for that member who has met the deductible.
- Covered services for the remaining family members will be paid when the full family deductible has been met.

Payments applied to your out-of-network deductible also count toward your in-network deductible. However, payments applied to your in-network deductible do not count toward your out-of-network deductible.

You do not have to pay an out-of-network deductible for:

- Services provided by an out-of-network provider, when an in-network provider has referred you
  - You must get the referral prior to receiving the referred services; otherwise, the services will be subject to your out-of-network deductible.
- Professional services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Services from a provider for which there is no PPO network
- Services from an out-of-network provider in a geographic area of Michigan deemed a "low-access area" for that particular provider specialty.

In limited instances, you may not have to pay an out-of-network deductible for:

- Select professional services performed by out-of-network providers in an in-network hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
- The reading and interpretation of a screening mammography when an in-network provider performs the test, but an out-of-network provider does the analysis and interprets the results.

If one of the above applies and you do not have to pay the out-of-network deductible, you may still need to pay the in-network deductible. You may contact BCBSM for more information about these services.

### Copayment

You must pay the following copayment amounts for covered services by out-of-network providers:

- A. Hospital emergency room visit: \$200 per hospital emergency room visit.

The \$200 copayment is waived if:

- The patient is admitted or
- Services were required to treat an accidental injury

You do not have to pay a copayment for in- or out-of-network physician services, for treatment for a medical emergency or accidental injury. However, if you receive services from a non-participating provider, you may have to pay the difference between what the Plan pays and the provider's charge.

### Coinsurance

In addition to your deductible, you must pay the coinsurance for covered services by in-network providers. The coinsurance is 40% of the approved amount for most other covered services. The coinsurance for private duty nursing care is 50% of the approved amount.

Online visits by an out-of-network professional provider will be subject to applicable out-of-network cost-sharing requirements. Online visits by an online vendor will not be covered.

You do not have to pay the out-of-network coinsurance for:

- Services provided by an out-of-network provider, when an in-network provider has referred you
- You must get the referral prior to receiving the referred services; otherwise, the services will be subject to your out-of-network coinsurance.
- Professional services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- A prescription for a contraceptive device obtained from an out-of-network provider
- Services from a provider for which there is no PPO network
- Services from an out-of-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty.

In limited instances, you may not have to pay out-of-network coinsurance for:

- Select professional services performed by out-of-network providers in an in-network hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
- The reading and interpretation of a screening mammography in instances where an in-network provider performs the test, but an out-of-network provider does the analysis and interprets the results.

If one of the above applies and you do not have to pay the out-of-network coinsurance, you may still need to pay the in-network coinsurance (if any). You may contact BCBSM for more information about these services.

### Annual Out-of-Pocket Maximums

Your annual out-of-pocket maximum for covered out-of-network services is:

- \$6,000 for individual
- \$12,000 for the family

Family Out-of-Pocket Maximums:

- Two or more members must meet the family out-of-pocket maximum.
- If the one-member maximum is met even if the family maximum is not, that member does not pay any more cost-sharing for the rest of the calendar year.
- Cost-sharing for the remaining family members must still be paid until the annual family maximum is met.

The out-of-network deductible, copayments and coinsurance that you pay are combined to meet the annual out-of-network maximum.

Only payments toward your cost-share are applied toward your out-of-pocket maximum. If you receive services from a nonparticipating provider and you are required to pay that provider for the difference between the charge for the services and the approved amount, your payment will not apply to your out-of-pocket maximum.

Once you meet the maximums for the year, the Plan will pay for all covered benefits at 100% of the approved amount for the rest of the calendar year.

What you pay in out-of-network cost-sharing also counts toward your in-network out-of-pocket maximum. However, what you pay in in-network cost-sharing does not count toward your out-of-network maximum.

### ***Section 3.03 - Benefit-Specific Cost-Sharing Requirements***

The benefits described below differ in what you pay for them.

#### Chiropractic and Osteopathic Manipulation Therapy

When received in-network, you must pay a \$20 copayment for each chiropractic or osteopathic manipulative treatment in a physician's office. If out-of-network, you pay out-of-network cost-sharing.

When an office visit and manipulative treatment service is billed on the same day, by the same in-network physician, only one copayment will be required for the office visit.

#### Contraceptive Devices

When received in-network, you do not pay any cost-sharing. When out-of-network, you must pay your out-of-network deductible but no other cost-sharing.

#### Contraceptive Injections

When received in-network, you do not pay any cost-sharing. When out-of-network, you must pay your out-of-network cost-sharing.

#### Hospice Services

You do not pay any cost-sharing for hospice services from approved physicians, facilities and other approved providers.

### Mental Health Services and Substance Use Disorder Treatment Services

You pay the same cost-sharing for mental health services and substance use disorder treatment that you would for all other covered services, in-network or out-of-network.

BCBSM considers some mental health and substance use disorder services to be in the same category as a physician's office visit. When that is the case, you only pay what you would for an office visit.

This means that when you go to an in-network provider, you pay your in-network office visit copayment for the visit. Likewise, if you go to an out-of-network provider, you pay your out-of-network office visit deductible and coinsurance.

Once the applicable deductible is met by a participant, both in- and out-of-network inpatient services for both Mental Health Disorders and Substance Abuse Disorders are covered at 80% by the Plan.

### Outpatient Diabetes Management Program (ODMP)

Under the ODMP, the Plan pays to train you to manage your diabetes, when needed.

- When received in-network, you pay no cost-sharing
- When out-of-network, you pay out-of-network cost-sharing.

For all other services and supplies you get under the ODMP, you do pay cost-sharing. You pay either in-network or out-of-network cost-sharing, depending on the provider you choose.

### Presurgical Consultations

When received in-network, you do not pay any cost-sharing for presurgical consultations.

### Specified Organ Transplants

If you need an organ transplant that the Plan covers, you pay no cost share during the benefit period. The benefit period begins five days before the transplant and ends one year after the transplant. During this time, you pay no cost-sharing for the transplant and post-transplant related procedures.

### Value Based Programs

When received in-network, you do not pay a deductible, copayment, or coinsurance for "care management" services. These services include:

- Provider-Delivered Care Management
  - Services obtained only in Michigan from providers designated by BCBSM
- Blue Distinction Total Care
  - Services obtained outside of Michigan from providers designated by the local Blue Cross Blue Shield plan in that state.
  - When received out-of-network, you are responsible for the provider's full charge.

### Voluntary Sterilization for Females

The Plan pays for voluntary sterilizations for females. The Plan covers services from a physician and in a participating hospital. When received in-network, you pay no cost-sharing. When out-of-network, you pay out-of-network cost-sharing.

## ARTICLE IV - DESCRIPTION OF MEDICAL BENEFITS

### ***Section 4.01 - Allergy Testing and Therapy***

The Plan covers allergy testing and therapy provided in a participating hospital, a participating ambulatory surgery facility, or an office.

The Plan covers:

- Allergy Testing
  - Survey, including history, physical exam, and diagnostic laboratory studies
  - Intradermal, scratch and puncture tests
  - Patch and photo tests
  - Double-blind food challenge test and bronchial challenge test
- Allergy Therapy
  - Allergy immunotherapy by injection (allergy shots)
  - Injections of antiallergen, antihistamine, bronchodilator or antispasmodic agents

The Plan does not cover:

- Fungal or bacterial skin tests (such as those given for tuberculosis or diphtheria)
- Self-administered, over-the-counter drugs
- Psychological testing, evaluation, or therapy for allergies
- Environmental studies, evaluation, or control

### ***Section 4.02 - Ambulance Services***

The Plan covers ground and air ambulance services to take a patient to a covered destination. The Plan will also cover services when the ambulance arrives at the scene but transport is not needed or is refused, or the patient has expired.

For ground ambulance, a covered destination may include:

- A hospital
- A skilled nursing facility
- A member's home
- A dialysis center

For air ambulance, a covered destination may include:

- A hospital
- Another covered facility, with BCBSM's preapproval

The Plan will pay for a member to be taken to the nearest approved destination capable of providing the level of care necessary to treat the patient's condition. Transfer of the patient between covered destinations must be prescribed by the attending physician.

The following conditions must be met:

- The service must be medically necessary. Any other means of transport would endanger the patient's health.
- The Plan will only pay for the transportation of the patient and whatever care is required during transport; the Plan will not pay for other services that might be billed with it.
- The service must be provided in a vehicle licensed as a ground or air ambulance and which is part of a licensed ambulance operation.

Air ambulance services must meet these additional conditions:

- No other means of transportation are available
- The patient's condition requires transportation by air ambulance rather than ground ambulance
- The provider is not a commercial airline
- The patient is taken to the nearest facility capable of treating the patient's condition.

Your coverage includes BCBSM's case management program. Air ambulance transportation that does not meet the requirements described above is eligible for review and possible approval under the case management provision of your coverage. Case management may recommend coverage for transportation that positively impacts clinical outcomes, but not for a patient's or family's convenience.

The Plan does not cover:

- Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.
- Air ambulance services when the member's condition does not require air ambulance transport

### ***Section 4.03 - Anesthesiology Services***

The Plan pays for anesthesiology services in a participating hospital, a participating ambulatory surgery facility, or an office

The Plan covers:

- Anesthesiology during surgery. Anesthesia services given to patients undergoing covered surgery are payable to:
  - A physician other than the operating physician.
    - If the operating physician gives the anesthetics, the service is included in the payment for the surgery.
  - A physician who orders and supervises anesthesiology services
  - A certified registered nurse anesthetist (CRNA). CRNA services must be:
    - Directly supervised by the physician performing the surgery or procedure or
    - Under the indirect supervision of the physician responsible for anesthesiology services

If a CRNA is an employee of a hospital or facility, the Plan pays the facility directly for the anesthesia services.
- Anesthesia during infusion therapy
  - The Plan pays for local anesthesia only when needed as part of infusion therapy done in an office.

### ***Section 4.04 - Audiologist Services***

The Plan pays for audiology services performed by an audiologist in an office or other outpatient locations. The Plan covers services performed by an audiologist, if they are prescribed by a provider who is legally authorized to prescribe the services.

### ***Section 4.05 - Autism Disorders***

The Plan covers for treatment of approved autism spectrum disorders in an office, a member's home, or other approved outpatient locations

#### **Covered Autism Spectrum Disorders**

The plan covers for the diagnosis and outpatient treatment of autism spectrum disorders, including:

- Autistic Disorder

- Asperger's Disorder
- Pervasive Developmental Disorder Not Otherwise Specified

A BCBSM-approved autism evaluation center (AAEC) must confirm that the member has one of the covered autism spectrum disorders.

### Covered Services

The plan covers the following services.

Diagnostic services provided by a licensed physician or a licensed psychologist, including:

- Assessments
- Evaluations or tests, including the Autism Diagnostic Observation Schedule

Treatment if prescribed by a physician or licensed psychologist, including:

- Applied Behavior Analysis (ABA) treatment.
  - Subject to the following requirements:
    - Treatment plan – A BCBSM-approved autism evaluation center that evaluates the member will recommend a treatment plan. The plan must include ABA treatment. If BCBSM requests treatment review, BCBSM will pay for it.
    - Preapproval – ABA treatment must be approved by BCBSM before treatment is given. If not, you will have to pay for it. Other autism services do not have to be approved beforehand.
  - Treatment must be provided or supervised by one of the following:
    - A board-certified behavior analyst
      - The Plan does not cover any other services provided by a board-certified behavior analyst including, but not limited to, treatment of traumatic brain injuries.
    - A licensed psychologist
      - The psychologist must have adequate formal university training and supervised experience in ABA
  - Behavioral health treatment (BHT) – Evidence-based counseling is part of BHT. A licensed psychologist must perform or supervise this treatment. The psychologist must have adequate formal university training and supervised experience in BHT.
  - Psychiatric care – It includes a psychiatrist's direct or consulting services. The psychiatrist must be licensed in the state where he/she practices.
  - Psychological care - It includes a psychologist's direct or consulting services. The psychologist must be licensed in the state where he/she practices.
  - Therapeutic care. Evidence-based services from licensed providers, including:
    - Physical therapy
    - Occupational therapy
    - Speech and language pathology
    - Services from a social worker
    - Nutritional therapy from a physician
    - Genetic testing, as recommended in the treatment plan

Benefits for autism treatment are in addition to any other mental health or medical benefits

### Requirements

All autism services and treatment must be:

- Medically necessary and appropriate
- Comprehensive and focused on managing and improving the symptoms directly related to a member's Autism Spectrum Disorder
- Deemed safe and effective by BCBSM
  - Autism treatment or services deemed experimental or investigational by BCBSM, such as ABA treatment, are covered only if:
    - Preapproved by BCBSM
    - Included in the treatment plan recommended by a BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition

### Limitations and Exclusions

The following limitations and exclusions apply:

- The Plan covers ABA treatment for members through the age of 18. This limitation does not apply to:
  - Other mental health services to treat or diagnose autism
  - Medical services, such as physical therapy, occupational therapy, speech and language pathology services, genetic testing or nutritional therapy to treat or diagnose autism
- All covered autism benefits are subject to the cost-sharing requirements in this certificate.
- The Plan does not pay for treatments that are not covered benefits. Examples are:
  - Sensory integration therapy
  - Chelation therapy
- The Plan does not pay for treatment of conditions such as:
  - Rett's Disorder
  - Childhood Disintegrative Disorder
- When a member receives physical therapy, occupational therapy or speech and language pathology for treatment of a covered autism disorder, those services do not apply to the benefit maximums listed in this certificate.
- When a member receives preapproved services for covered autism disorders, coverage for the services under this autism benefit overrides certain exclusions in your certificate such as the exclusion of:
  - Experimental treatment
  - Treatment of chronic, developmental or congenital conditions
  - Treatment of learning disabilities or inherited speech abnormalities
  - Treatment solely to improve cognition, concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought
- The Plan only covers autism services performed in Michigan from participating or nonparticipating providers who are registered with BCBSM.
- The Plan only covers autism services performed outside Michigan from providers who participate with their local Blue Cross/Blue Shield plan.

### ***Section 4.06 - Cardiac Rehabilitation***

The Plan covers cardiac rehabilitation in participating hospitals.

The Plan covers the following services:

- Services that began during a hospital admission for an invasive cardiovascular procedure (e.g., heart surgery) or an acute cardiovascular event (e.g., heart attack)
- Services given when intensive monitoring (i.e., through the use of EKGs) and/or supervision during exercise is required.

The Plan does not cover services that require less than intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable

#### ***Section 4.07 - Chemotherapy***

The Plan covers chemotherapeutic drugs. Since specialty pharmaceuticals may be used in chemotherapy treatment, please see the prior authorization requirement for Chemotherapy Specialty Pharmaceuticals described in Section 4.36 - Prescription Drugs.

In order to be covered, the drugs must meet the following requirements:

- Ordered by a physician for the treatment of a specific type of malignant disease
- Provided as part of a chemotherapy program and
- Approved by the Federal Food and Drug Administration (FDA) for use in chemotherapy treatment

If the FDA has not approved the drug for the specific disease being treated, the appropriateness of the drug is determined by using the following criteria:

- Current medical literature must confirm that the drug is effective for the disease being treated
- Recognized oncology organizations must generally accept the drug as treatment for the specific disease
- The physician must obtain informed consent from the patient for the treatment.

The Plan also covers:

- Physician services for the administration of the chemotherapy drug, except those taken orally
- The chemotherapy drug administered in a medically approved manner
- Other FDA-approved drugs classified as:
  - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
  - Drugs used to enhance chemotherapeutic drugs
  - Drugs to prevent or treat the side effects of chemotherapy treatment
- Infusion pumps used for the administration of chemotherapy, administration sets, refills and maintenance of implantable or portable pumps and ports
  - Infusion pumps used for the administration of chemotherapy are considered durable medical equipment and are subject to the durable medical equipment guidelines described in this document.

The Plan covers the outpatient treatment of breast cancer.

#### ***Section 4.08 - Chiropractic Services and Osteopathic Manipulative Therapy***

The Plan covers chiropractic services and osteopathic manipulative therapy in an office.

The Plan covers:

- Osteopathic manipulation therapy (OMT) on any location of the body.
- Chiropractic spinal manipulation (CSM) to treat misaligned or displaced vertebrae of the spine and chiropractic manipulations (CM) to treat other areas of the body allowed by BCBSM
- Chiropractic office visits:
  - For new patients, the Plan covers one office visit every 36 months. A new patient is one who has not received chiropractic services within the past 36 months.
  - For established patients, the Plan covers medical office visits. An established patient is one who has received chiropractic services within the past 36 months.

- Physical therapy that is part of a physical therapy treatment plan prepared by your chiropractor. The plan must be signed by your M.D. or D.O. before you receive physical therapy services for those services to be covered. If a treatment plan is not signed by your M.D. or D.O. before services are rendered, the services will not be covered and you may have to pay for them.
  - A signed treatment plan is not required for the first physical therapy service your chiropractor performs on you.
  - Visits for physical therapy are applied toward your combined 60-visit benefit limit for physical therapy, speech and language pathology, and occupational therapy services. Any combination of mechanical traction, occupational therapy, physical therapy, and speech and language pathology is limited to a combined maximum of 60-visits (in-network and out-of-network providers combined) per member per calendar year.
- Mechanical traction once per day when it is given with CM or CSM. These visits are applied toward your combined 60-visit limit for occupational therapy, physical therapy, and speech and language pathology therapy services.
  - X-rays when medically necessary.

The Plan pays up to a combined maximum of 24 visits per member per calendar year for OMT, CM and CSM. Visits with in-network and out-of-network providers count toward this maximum.

***Section 4.09 - Chronic Disease Management***

The Plan covers services to manage chronic diseases in a participating hospital, an office, a participating facility or, a member’s home.

The Plan covers chronic disease management services provided by:

- Participating hospitals
- Physicians
- Participating facilities
- Certified nurse practitioner
- Certified licensed social workers
- Psychologists
- Physical therapists

***Section 4.10 - Clinical Trials (Routine Patient Costs)***

For information on oncology clinical trial services, see Section 4.31 - Oncology Clinical Trials.

The Plan pays the routine costs of items and services related to clinical trials. The trials may be Phase I, II, III or IV. The purpose of the trial must be to prevent, detect or treat cancer or another life-threatening disease or condition.

The Plan covers:

- All routine services covered under this Plan that would be covered even if the member were not enrolled in an approved clinical trial

The Plan does not cover:

- The experimental or investigational item, device or service itself
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant, or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

BCBSM may require you to go to a BCBSM-contracted provider who is already part of an approved clinical trial. The provider may be participating or in-network. An exception would be if the trial is conducted outside of Michigan.

#### ***Section 4.11 - Contraceptive Services***

The Plan covers contraceptive services for women as part of your preventive care benefit. Please see the preventive care benefit description of contraceptive services in Section 4.37 - Preventive Care Services for more details.

#### ***Section 4.12 - Dental Services Covered Under Medical***

The Plan covers emergency dental care given in a hospital, an ambulatory surgery facility, a dentist's office (accidental injuries only). The Plan covers other dental services in a participating hospital or a provider's office as described below.

The Plan covers:

- Emergency Dental Care: Emergency dental care is the treatment of accidental injuries within 24 hours of the injury. A dental accidental injury is when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, gums or bone. Treatment is to relieve pain and discomfort. The Plan also covers for follow-up treatment completed within six months of the injury.
- Dental Services in a Participating Hospital
  - The Plan will cover dental treatment for a patient in a participating hospital if the treatment helps improve the medical condition that put the patient in the hospital. The dental condition must be hindering improvement of the medical condition.
  - The Plan may also cover facility and anesthesia services for a patient in a participating hospital if dental treatment would be unsafe in an office setting.
    - In these cases, the Plan does not pay for the services of the dentist. The Plan only pays for the facility and anesthesia services.
  - Examples of such medical conditions are:
    - Bleeding or clotting abnormalities
    - Unstable angina
    - Severe respiratory disease
    - Known reaction to analgesics, anesthetics, etc.
  - Medical records must confirm the need for the dental services above. Procedures that are payable in the circumstances explained above include:
    - Alveoplasty
    - Diagnostic X-rays
    - Multiple extractions or removal of unerupted teeth
- Other Dental Services
  - Services to treat temporomandibular joint dysfunction (TMJ) limited to those described below:
    - Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
    - Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction)
    - Diagnostic X-rays
    - Physical therapy
    - Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint)

The Plan does not cover under the Medical Benefit:

- Routine dental services
- Treatment that was previously paid as a result of an accident
- Dental implants and related services, including repair and maintenance of implants and surrounding tissue
- Dental conditions existing before an accident requiring emergency dental treatment
- Services to treat temporomandibular joint dysfunction (except as described above.)

These services may be covered under the Dental Benefit under this Plan. Please see “Section 5.04 - Dental Benefit” on page 78 and “Section 9.06 - Dental Benefits” on page 102 for more details.

### ***Section 4.13 - Diagnostic Services***

The Plan covers diagnostic services in a participating hospital, a participating ambulatory surgery facility, a participating skilled nursing facility, or an office.

#### Diagnostic Testing

The Plan covers the tests a physician uses to diagnose disease, illness, pregnancy or injury.

Physician services are payable for tests such as:

- Thyroid function
- Electrocardiogram (EKG)
- Electroencephalogram (EEG)
- Pulmonary function studies

Physician and independent physical therapist services are payable for the following tests:

- Electromyogram (EMG)
- Nerve conduction

The test must be prescribed by a physician if performed by an independent physical therapist.

#### Diagnostic Laboratory and Pathology Services

The Plan covers the lab and pathology tests a physician uses to diagnose disease, illness, pregnancy or injury. Services must be provided:

- In a participating hospital (under the direction of a pathologist employed by the hospital), or
- By your in-network physician, or
- By another physician, if your in-network physician refers you to one, or
- By an in-network lab at your in-network physician’s direction.
  - The Plan covers for standard office lab tests in your in-network physician’s office. Other lab tests must be sent to an in-network laboratory.
  - You will need to pay the out-of-network cost-share if tests are done by an out-of-network lab or in an out-of-network hospital.

### ***Section 4.14 - Dialysis Services***

The Plan shares the cost of treating End Stage Renal Disease (ESRD) with Medicare. It is important that you apply for Medicare coverage if you have ESRD.

The Plan covers dialysis services in a participating hospital, a participating freestanding ESRD facility, or a member’s home.

The Plan covers dialysis services (including physician services), supplies and equipment to treat:

- Acute renal (kidney) failure
- Chronic, irreversible kidney failure (End Stage Renal Disease (ESRD))

### End Stage Renal Disease

The Plan covers treatment of ESRD until you become eligible for Medicare. This period is a maximum of three months from when you apply for Medicare. Afterward, the Plan shares the cost of treatment with Medicare.

### Services Provided in a Freestanding ESRD Facility

The Plan covers:

- Use of the freestanding end stage renal disease facility
- Ultrafiltration
- Equipment
- Solutions
- Routine laboratory tests
- Drugs
- Supplies
- Other medically necessary services related to dialysis treatment

The Plan does not cover:

- Services provided by a nonparticipating end stage renal disease facility.
- Services not provided by the employees of the ESRD facility.
- Services not related to the dialysis process.

### Services Provided in the Home

Dialysis services (hemodialysis and peritoneal dialysis) must be billed by a hospital or freestanding ESRD facility participating with the Plan and must meet the following conditions:

- The treatment must be arranged by the member's attending physician and the physician director, or a committee of staff physicians of a self-dialysis training program.
- The owner of the member's home must give the hospital prior written permission to install the equipment.

The Plan covers:

- Home hemodialysis
  - Continuous ambulatory peritoneal dialysis and self-dialysis training with the number of training sessions limited according to Medicare guidelines
  - Continuous cycling peritoneal dialysis (limited to 14 dialysis treatments per month) and self-dialysis training with the number of training sessions limited according to Medicare guidelines
- Placement and maintenance of a dialysis machine in the member's home
- Expenses to train the member and one other person who will assist the member in the home in operating the equipment
- Laboratory tests related to the dialysis
- Supplies required during the dialysis, such as dialysis membrane, solution, tubing and drugs
- Removal of the equipment after it is no longer needed

The Plan does not cover:

- Services provided by persons under contract with the hospital, agencies or organizations assisting in the dialysis or acting as “backups” including hospital personnel sent to the member’s home
- Electricity or water used to operate the dialyzer
- Installation of electric power, a water supply or a sanitary waste disposal system
- Transfer of the dialyzer to another location in the member’s home
- Physician services not paid by the hospital

#### ***Section 4.15 - Durable Medical Equipment***

The Plan covers durable medical equipment in a participating hospital, a participating skilled nursing facility, an office, or a member’s home.

The Plan covers:

- The use of durable medical equipment while you are in the hospital.
- The rental or purchase of durable medical equipment, if prescribed by a physician or other provider licensed to prescribe it You may obtain it from:
  - A participating hospital (when you are discharged)
  - A DME supplier

DME items must meet the following guidelines:

- The prescription includes a description of the equipment, the reason for the need, and the diagnosis.
- The physician or other provider licensed to prescribe it writes a new prescription when the current prescription expires; otherwise, the Plan will stop payment on the current expiration date, or 30 days after the date of the patient’s death, whichever is earlier.
- If the equipment is:
  - Rented: The Plan will not pay for the charges that exceed the BCBSM purchase price. Participating providers cannot bill the member when the total of the rental payments exceeds the BCBSM purchase price.
  - Bought: The Plan will pay to have the equipment repaired and restored to use, but not for routine periodic maintenance

The Plan does not cover:

- Exercise and hygienic equipment, such as exercycles, Moore Wheel, bidet toilet seats and bathtub seats
- Deluxe equipment, such as motorized wheelchairs and beds, unless medically necessary and required so that patients can operate the equipment themselves
- Comfort and convenience items, such as bed boards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners
- Provider’s equipment, such as stethoscopes
- Self-help devices not primarily medical in nature, such as sauna baths and elevators
- Experimental equipment

#### **Continuous Positive Airway Pressure (CPAP)**

When prescribed by a physician or other provider licensed to prescribe it, the CPAP device, humidifier (if needed) and related supplies and accessories are covered as follows:

- The Plan will cover the rental fee only for the CPAP device. The total rental payments will not exceed the approved amount to purchase the device. Once the rental payments equal the

approved purchase price, you will own this equipment and no additional payments will be made by BCBSM for the device.

- The Plan will cover for the rental or purchase of a humidifier for the CPAP device, if needed.
- The Plan will pay for the purchase of any related supplies and accessories.
- After the first 90 days of rental, you are required to show that you have complied with treatment requirements for the Plan to continue to cover the equipment and the purchasing of supplies and accessories. The CPAP device supplier or your prescriber must document your compliance.
- If you fail to comply with treatment requirements, you must return the rented device to the supplier or you may be held liable by the supplier for the cost of continuing to rent the equipment. The Plan will also no longer cover the purchase of supplies and accessories.

#### ***Section 4.16 - Emergency Treatment***

The Plan covers services to treat medical emergencies and accidental injuries in a hospital, an urgent care center, an office, or other approved outpatient locations.

The Plan covers facility and professional services to examine and treat a medical emergency or accidental injury.

#### ***Section 4.17 - Gender Dysphoria Treatment***

The Plan covers medically necessary services for the treatment of gender dysphoria, which includes professional and facility services. The Plan does not cover gender reassignment services that are cosmetic, or treatment that is experimental or investigational.

#### ***Section 4.18 - Gene Therapy***

The Plan covers medically necessary gene therapy services for FDA-approved indications . Gene therapy requires preauthorization.

#### ***Section 4.19 - Hearing Care***

The Plan covers:

- An audiometric examination that
  - Is performed by a participating physician-specialist, audiologist, or hearing aid dealer
  - Includes tests for measuring hearing perception relating to air conduction, bone conduction, speech reception threshold and speech discrimination
  - Includes a summary of findings
- A hearing aid evaluation test and a conformity test:
  - Prescribed by a physician
  - Performed by a participating physician-specialist, audiologist, or hearing aid dealer
- A monaural hearing aid that must be
  - Designed to be worn in the ear, in the ear canal, behind the ear (including air conduction and bone conduction types) or on the body
  - Prescribed by a participating physician-specialist, audiologist, or hearing aid dealer based on the most recent audiometric examination and hearing aid evaluation test
  - The make and model prescribed by the participating physician-specialist, audiologist, or hearing aid dealer
  - Dispensed by a participating hearing aid dealer or participating licensed audiologist when services are obtained in Michigan.

### Participating Providers

In Michigan and outside of Michigan where the Blue Cross and Blue Shield plan contracts with providers for hearing care services, the Plan covers the approved amount for hearing aids and related covered services only when obtained from participating providers.

### Nonparticipating Providers

The Plan does not pay for services performed by nonparticipating providers unless both of the following occur:

- The services are performed outside of Michigan
- The local Blue Cross and/or Blue Shield plan does not contract with providers for hearing care services

In this case, the Plan covers the approved amount for hearing aids and related covered services when obtained from nonparticipating providers. Your provider may participate with BCBSM on a per claim basis. If the provider will not submit a claim for your covered services, you may submit a detailed receipt.

### Requirements

You must obtain a medical evaluation (sometimes called a medical clearance examination) performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation.

If you select a digitally controlled programmable hearing device or a binaural hearing aid, you may be responsible for charges that exceed the cost of a covered hearing aid.

Outside of Michigan, the Blue Cross and Blue Shield plan in a particular state may not contract with providers for hearing care services. In that case you may be responsible for charges that exceed the approved amount.

### Limitations and Exclusions

The plan will cover the audiometric examination, hearing aid evaluation, conformity tests and a hearing aid once every 36 months. The Plan will consider providing additional hearing care benefits within a 36-month period if a physician-specialist sends us documentation of severe hearing loss that has occurred since the last examination. An example of severe hearing loss would be when a person wearing the hearing aid cannot distinguish normal speech 25 percent of the time.

The following are not payable:

- Services performed by nonparticipating providers in Michigan and outside of Michigan where the Blue Cross and Blue Shield plan contracts with providers for hearing care services
- Medical or surgical treatment
- Drugs or other medications
- The trial and testing of different makes and models of hearing aids when the tests are not supported by the results of the most recent audiometric examination
- A medical evaluation by a physician-specialist to determine possible hearing loss
- Hearing aids ordered while you are a BCBSM member, but delivered more than 60 days after coverage ends
- Charges for audiometric examinations, hearing aid evaluation tests, conformity tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not prescribed by the physician-specialist
- Charges for spare hearing aids

- Replacement of hearing aids that are lost or broken, unless you have not used this benefit for at least 36 months
- Replacement parts for and repairs of hearing aids
- Any charges that exceed the approved amount for covered hearing aids if you obtain digitally controlled programmable hearing devices
- Examinations related to medical-surgical procedures such as tonsillectomies or myringotomies
- Hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements.

#### ***Section 4.20 - Home Health Care Services***

The Plan covers care and services provided in a member's home. Home health care provides an alternative to long-term hospital care by offering coverage for care and services in the member's home.

Home health care must be:

- Prescribed by the attending physician
- Provided and billed by a participating home health care agency
- Medically necessary (See "Section 13.25 - Medically Necessary" on page 115 for a definition)
- The following criteria for home health care must be met:
  - The attending physician certifies that the patient is confined to the home because of illness.
    - This means that transporting the patient to a health care facility, an office or hospital for care and services would be difficult due to the nature or degree of the illness
  - The attending physician prescribes home health care services and submits a detailed treatment plan to the home health care agency.
  - The agency accepts the patient into its program.

The Plan covers services provided by health care professionals employed by the home health care agency or by providers who participate with the agency in this program. The agency must bill the Plan for the services. They are:

- Skilled nursing care provided or supervised by a registered nurse employed by the home health care agency
- Social services by a licensed social worker, if requested by the patient's attending physician
- The following when provided for rehabilitation:
  - Occupational therapy
  - Physical therapy
  - Speech and language pathology services

If services in a member's home are billed by a home health care agency, then these services will not count toward the visit maximums.

- If physical therapy, occupational therapy or speech and language pathology services cannot be done in the home, the Plan will cover outpatient therapy. It may be in an outpatient department of a hospital or a physical therapy facility. Benefits are subject to the combined 60-visit maximum. If services in a member's home are billed by a professional provider or independent therapist, they will count toward the visit maximum.
- Part-time health aide services, including preparing meals, laundering, bathing and feeding if:
  - The patient is receiving skilled nursing care or physical therapy or speech and language pathology services
  - The patient's family cannot provide the services and the home health care agency has identified a need for these services for the patient to participate in the program
  - The services are provided by a home health aide and supervised by a registered nurse employed by the agency

The Plan will cover the following services when the home health care is provided by a participating hospital:

- Lab services, prescription drugs, biologicals and solutions related to the condition for which the patient is participating in the program
- Medical and surgical supplies such as catheters, colostomy supplies, hypodermic needles and oxygen needed to effectively administer the medical treatment plan ordered by the physician.

The Plan does not cover:

- General housekeeping services
- Transportation to and from a hospital or other facility
- Private duty nursing
- Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.)
- Durable medical equipment
- Physician services (when billed by the home health care agency)
- Custodial or nonskilled care
- Services performed by a nonparticipating home health care provider.

#### ***Section 4.21 - Hospice Care Services***

The Plan covers hospice care services in a participating hospice facility, a participating hospital, a participating skilled nursing facility, or a member's home.

The Plan covers services to care for the terminally ill. Services must be provided through a participating hospice program. Hospice care services are payable for four 90-day periods.

To be payable, the following criteria must be met:

- The member or his or her representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.
- The following certifications are submitted to the Plan:
  - For the first 90 days of hospice care coverage:
    - A written certification stating that the member is terminally ill, signed by the:
      - Medical director of the hospice program **or**
      - Physician of the hospice interdisciplinary group **and**
      - Attending physician, if the member has one
  - For the second 90-day period (submitted no later than two days after this 90-day period begins):
    - The hospice must submit a second written certification of terminal illness signed by the:
      - Medical director of the hospice **or**
      - Physician of the hospice interdisciplinary group
  - For the third 90-day period (submitted no later than two days after this 90-day period begins):
    - The hospice must submit a third written certification of terminal illness signed by the:
      - Medical director of the hospice **or**
      - Physician of the hospice interdisciplinary group
  - For the fourth 90-day period (submitted no later than two days after this 90-day period begins):
    - The hospice must submit a fourth written certification of terminal illness signed by the:

- Medical director of the hospice **or**
  - Physician of the hospice interdisciplinary group
- The member or his or her representative must sign a “Waiver of Benefits” form acknowledging that hospice care has been fully explained to them. The waiver explains that the Plan does not pay for treatment of the terminal illness itself or related conditions during hospice care.

The Plan covers:

- Counseling, evaluation, education and support services for the member and his or her family from the hospice staff before the member elects to use hospice services. These services are limited to a 28-visit maximum.
- When a member elects to use hospice care services, regular coverage for services in connection with the terminal illness and related conditions are replaced by the following:
  - Home Care Services
    - Up to eight hours of routine home care per day
    - Continuous home care for up to 24 hours per day during periods of crisis
    - Home health aide services provided by qualified aides. These services must be rendered under the general supervision of a registered nurse.
  - Facility Services
    - Inpatient care provided by:
      - A participating hospice inpatient unit
      - A participating hospital contracting with the hospice program or
      - A participating skilled nursing facility contracting with the hospice program
    - Short-term general inpatient care when the member is admitted for pain control or to manage symptoms. (These services are payable if they meet the plan of care established for the member.)
    - Five days of occasional respite care during a 30-day period
  - Hospice Services
    - Physician services by a member of the hospice interdisciplinary team
    - Nursing care provided by, or under the supervision of, a registered nurse
    - Medical social services by a licensed social worker, provided under the direction of a physician
    - Counseling services to the member and to caregivers, when care is provided at home
    - BCBSM-approved medical appliances and supplies (these include drugs and biologicals to provide comfort to the member)
    - BCBSM-approved durable medical equipment furnished by the hospice program for use in a member’s home
    - Physical therapy, speech and language pathology services and occupational therapy when provided to control symptoms and maintain the member’s daily activities and basic functional skills
    - Bereavement counseling for the family after the member’s death
    - Note: Hospice services are limited to a maximum amount. That amount is reviewed and adjusted from time to time. Once you reach the maximum, hospice benefits will still be covered under the case management program. Please call us for information about the current maximum amount.
  - Professional Services
    - Provided by the attending physician to make the member comfortable and to manage the terminal illness and related conditions

- Note: Professional services for hospice care are limited to a maximum amount. This amount is determined by BCBSM and reviewed at times. Once you reach the maximum, professional services will still be covered under the case management program. Please call us for information about the current maximum amount. This amount is separate from, and not included in, the limit for the hospice program services described above.

The Plan does not cover:

- Services other than those furnished by the hospice program.
- Services of a hospice program other than the one designated by the member (if the designated program arranges for the member to receive the services of another hospice program, the services are covered).
- Services that are not part of the plan of care established by the hospice program for the member

#### How to Cancel Hospice Care Services

Hospice care services may be canceled at any time by the member or his or her representative. Simply submit a written statement to the hospice. When the services are canceled, regular Blue Cross Blue Shield coverage will be reinstated.

#### How to Reinstate Hospice Care Services

Hospice care services may be reinstated at any time. The member is reinstated for any remaining period for which he or she is eligible.

#### ***Section 4.22 - Hospital Services***

The services in this section are in addition to all other services listed in this certificate that are payable in a participating hospital. An example would be surgery.

The Plan covers:

- Inpatient hospital services:
  - Medical care by hospital personnel while you are receiving inpatient services.
  - Semiprivate room
  - Nursing services
  - Meals, including special diets
  - Services provided in a special care unit, such as intensive care
  - Oxygen and other therapeutic gases and their administration
  - Inhalation therapy
  - Electroconvulsive Treatment (ECT)
  - Pulmonary function evaluation
  - Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration
  - Hyperbaric oxygenation (therapy given in a pressure chamber)
- Outpatient hospital services:
  - If a service is payable as an inpatient service, it is also payable as an outpatient service (exceptions are services related to inpatient room, board, and inhalation therapy).
- Temporary Benefits for Hospital Services:
  - If you are receiving services from a hospital that ends its contract with BCBSM, you still have benefits. These benefits are for continuity of care, designated services, emergency care, and travel and lodging. Benefits for continuity of care are available for up to six months from the date the hospital ends its participating contract with BCBSM. Benefits

for designated services and emergency care are available for as long as medically necessary. Benefits for travel and lodging are available for the period of time approved by BCBSM.

#### ***Section 4.23 - Infusion Therapy***

BCBSM considers services from a participating infusion provider to be in-network. You will need to pay in-network cost-sharing for these services. What you pay may vary depending on the location where you receive these services. BCBSM may require approval for these services. Your in-network provider is responsible for obtaining approval.

The Plan covers infusion therapy services in a participating ambulatory infusion center, a member's home, an office, a participating hospital.

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

- Prescribed by a physician to manage an incurable or chronic condition or treat a condition that requires acute care. For home infusion therapy, the condition must be able to be safely managed in the home
- Medically necessary
- Given by a **participating** infusion therapy provider

The Plan covers:

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

The Plan will **not** cover services rendered by **nonparticipating** infusion therapy providers.

#### ***Section 4.24 - Long-Term Acute Care Hospital Services***

The Plan covers services provided in a participating long-term acute care hospital (LTACH).

The Plan covers the same services in a participating LTACH that the Plan would pay for in a participating hospital. The services are payable only if the following conditions are met:

- The LTACH must
  - Be located in Michigan
  - Participate with BCBSM, except under extenuating circumstances as determined by BCBSM
- The provider must request and receive preapproval for inpatient services
  - The LTACH is liable for the care if the inpatient services are not preapproved.

The Plan does not cover:

- Services in a nonparticipating LTACH, including emergency services, unless BCBSM determines there are extenuating circumstances
- Inpatient admissions that BCBSM has not preapproved
- LTACH services if the patient's primary diagnosis is a mental health or substance use disorder condition.

### ***Section 4.25 - Maternity Care***

The Plan covers facility and professional services for maternity care and related services in a participating inpatient hospital setting, a participating birthing center, an office.

Under federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother child to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

However, the Plan may pay for a shorter stay if the attending physician or midwife discharges the mother earlier, after consulting the mother.

Federal law requires that the Plan cover the same benefits with the same cost-sharing levels during the 48 or 96 hours.

In addition, the Plan may not require that a physician or other provider get approval for a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain preapproval to use certain providers or to reduce your out-of-pocket costs.

The Plan covers:

- Obstetrics - Covered services provided by a physician or certified nurse midwife attending the delivery. These covered services include but are not limited to:
  - Pre-natal care, including maternity education provided in a physician's office as part of a pre-natal visit
  - Vaginal delivery or cesarean section when provided in:
    - A participating hospital setting
    - A hospital-affiliated birthing center that is owned and operated by a participating state- licensed and accredited hospital, as defined by BCBSM
  - Post-natal care, including a Papanicolaou (PAP) smear during the six-week visit
- Other services - Covered services provided to the mother's newborn only during the 48 or 96 hours when the newborn has not been added to the Plan as a Dependent. These services include:
  - Newborn examination given by a physician other than the anesthesiologist or the mother's attending physician.
  - Routine care during the newborn's eligible hospital stay
  - Services to treat a newborn's injury, sickness, congenital defects or birth abnormalities.

The Plan does not cover:

- Lamaze, parenting or other similar classes
- Services provided to the newborn if one of the following apply:
  - The newborn's mother is not covered under this certificate on the newborn's date of birth
  - The newborn is covered under a BCBSM or other health care benefit plan on his or her date of birth
  - The subscriber directs BCBSM not to cover the newborn's services
- Services provided to the newborn occur after the 48 or 96 hours

### ***Section 4.26 - Medical Supplies***

The plan covers medical supplies in a participating hospital, a participating hospice, a participating outpatient facility, a participating skilled nursing facility, an office, or a member's home.

The Plan covers medical supplies and dressings used for the treatment of a specific medical condition. The quantity of medical supplies and dressings must be medically necessary. They include but are not limited to:

- Gauze, cotton, fabrics, plaster and other materials used in dressings and casts
- Ostomy sets and accessories
- Catherization equipment and urinary sets

#### ***Section 4.27 - Mental Health Services***

The Plan covers mental health services, subject to the conditions described below, in a participating hospital, a participating psychiatric residential treatment facility (PRTF), a participating outpatient psychiatric care (OPC) facility, or an office. Mental health services that are the equivalent of an office visit are covered as an office visit. Please refer to Section 4.30 - Office, Outpatient and Home Medical Care Visits for more information.

The Plan covers medically necessary and medically appropriate services to evaluate, diagnose, and treat mental health conditions that are in accordance with generally accepted standards of practice.

Medically necessary covered services are those considered by a professional provider, exercising prudent clinical judgment, as clinically appropriate, and are considered effective for the member's illness, injury, or disease. The services must not be more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results.

For diagnostic testing, the results must be essential to, and used in the diagnosis or management of, the patient's condition.

The Plan does not cover treatment or services that:

- Have not been determined as medically necessary or appropriate
- Are mainly for the convenience of the member or health care provider
- Are considered experimental or investigational

When you receive mental health or substance use disorder services under a case management agreement that you, your provider and a BCBSM case manager have signed, you will pay your in-network cost-share even if the provider is out-of-network and/or does not participate with BCBSM.

#### Electroconvulsive Therapy (ECT)

Electroconvulsive Therapy (ECT) is covered only in an inpatient or outpatient hospital location.

ECT is covered when administered by, or under the supervision, of a physician. Anesthetics for ECT are covered when administered by, or under the supervision of, a physician other than the physician giving the ECT

#### Inpatient Hospital-Mental Health Services

The following inpatient mental health services are payable when provided by a physician or by a fully licensed psychologist with hospital privileges. If the services are provided by a psychologist, they must be prescribed by a physician:

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

- Psychological testing prescribed or performed by a physician. The tests must be directly related to the condition for which the patient is admitted or have a full role in rehabilitative or psychiatric treatment programs
- Inpatient consultations - If a physician needs help diagnosing or treating a patient's condition, the Plan pays for inpatient consultations. They must be provided by a physician or fully licensed psychologist who has the skills or knowledge needed for the case.
- Psychiatric residential treatment.

The Plan does not cover:

- Consultations required by a facility's or program's rules
- Marital counseling
- Services provided by a nonparticipating hospital.

### Psychiatric Residential Treatment

Psychiatric residential treatment is covered only after it has been preapproved by BCBSM or its representative. Covered services must be provided by a facility that participates with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

Covered out-of-network services performed in a residential psychiatric treatment facility will be covered at the in-network deductible and coinsurance.

The Plan covers:

- Services provided by facility staff
- Individual psychotherapeutic treatment
- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Prescribed drugs given by the facility.

The Plan does not cover:

- Consultations required by a facility's or program's rules
- Marital counseling
- Services provided by a facility located in Michigan that does not participate with BCBSM or by a facility located outside of Michigan that does not participate with its local Blue Cross/Blue Shield plan
- An admission to a psychiatric residential treatment facility or services by the facility that are not preapproved before they occur. BCBSM or its representative must issue the preapproval. If preapproval is not obtained:
  - A participating facility that provided the care cannot bill the member for the cost of the admission or services.
  - A nonparticipating facility that provided the care may require the member to pay for the admission and services.
- Services that are not focused on improving the member's functioning
- Services that are primarily for the purpose of maintaining long-term gains made by the member while in another treatment program
- A residential program that is a long-term substitute for a member's lack of available supportive living environment within the community
- A residential program that serves to protect family members and other individuals in the member's living environment
- Services or treatment that are cognitive in nature or supplies related to such services or treatment

- Treatment or supplies that do not meet BCBSM requirements
- Transitional living centers such as half-way and three-quarter way houses
- Therapeutic boarding schools
- Milieu therapies, such as wilderness program, supportive houses or group homes
- Domiciliary foster care
- Custodial care
- Treatment or programs for sex offenders or perpetrators of sexual or physical violence
- Services to hold or confine a member under chemical influence when the member does not require medical treatment
- A private room or an apartment
- Services provided by a nonparticipating psychiatric residential treatment facility
- Non-medical services including, but not limited to: enrichment programs, dance therapy, art therapy, music therapy, equine therapy, yoga and other movement therapies, ropes courses, guided imagery, consciousness raising, socialization therapy, social outings or preparatory courses or classes. These services may be paid as part of a treatment program but they are not payable separately.

#### Psychiatric Partial Hospitalization (PHP) Treatment Program

Psychiatric partial hospitalizations are covered only in hospitals and outpatient psychiatric care facilities that participate with BCBSM and have a PHP program.

The Plan covers:

- Services provided by the hospital's or facility's staff
- Ancillary services
- Prescribed drugs given by the hospital or facility during the patient's treatment
- Individual psychotherapeutic treatment
- Group psychotherapeutic treatment
- Psychological testing
  - The tests must be directly related to the condition for which the patient is admitted or has a full role in rehabilitative or psychiatric treatment programs.
- Family counseling for members of patient's family.

#### Outpatient Psychiatric Care Facility and Office Setting for Mental Health Services

The Plan only pays for services in a **participating** outpatient psychiatric care facility and office setting for mental health services.

The Plan covers:

- Services provided by the facility's staff
- Services provided by a physician, fully licensed psychologist, certified nurse practitioner, clinical licensed master's social worker, licensed professional counselor, limited licensed psychologist, or licensed marriage and family therapist, or other professional provider, as determined by BCBSM in an office setting or a participating outpatient psychiatric care facility:
  - Individual psychotherapeutic treatment
  - Family counseling for members of a patient's family
  - Group psychotherapeutic treatment
  - Psychological testing - The tests must be directly related to the condition for which the patient is admitted or has a full role in rehabilitative or psychiatric treatment programs.
- Prescribed drugs given by the facility in connection with treatment
- A partial hospitalization program as described in the PHP section of this document

The Plan does not cover:

- Services provided in a skilled nursing facility or through a residential substance abuse treatment program
- Marital counseling
- Consultations required by a facility or program's rules
- Services provided by a nonparticipating outpatient psychiatric care facility.

### ***Section 4.28 - Newborn Care***

If the newborn is not covered as a Dependent, he/she may qualify for coverage under the mother's maternity care benefit.

The Plan covers facility and professional services for routine newborn care during an eligible hospital stay in a participating hospital setting, or a participating birthing center.

Under federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for a newborn child to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending physician or midwife discharges the newborn earlier, after consulting the mother. Federal law requires that the Plan cover the same benefits with the same cost-sharing levels during the 48 or 96 hours. In addition, the Plan may not require that a physician or other provider get approval for a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain preapproval to use certain providers or to reduce your out-of-pocket costs.

The Plan covers:

- Newborn examination – The exam must be given by a physician other than the anesthesiologist or the mother's attending physician.
- Routine care – Routine care during the newborn's eligible hospital stay.

The Plan does not cover:

- Parenting or other similar classes.

### ***Section 4.29 - Occupational Therapy***

The Plan covers facility and professional occupational therapy services—subject to the conditions described below—in a participating hospital, an office, a participating skilled nursing facility, a member's home, or a nursing home (if it's the member's primary residence).

The Plan covers a maximum of 60 outpatient visits per member per calendar year. The 60-visit maximum renews each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for occupational therapy, physical therapy (includes physical therapy by a chiropractor), speech and language pathology, and chiropractic mechanical traction. If services in a member's home are billed by a professional provider, an independent physical therapist or occupational therapist, they will count toward the visit maximums. If services in a member's home are billed by a home health care agency, they will not count toward the visit maximums.

Each **treatment date** counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit. An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit described above.

Occupational therapy must be:

- Prescribed by a professional provider licensed to prescribe occupational therapy services
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning
- Given by:
  - A physician (M.D. or D.O.) in an outpatient setting
  - An occupational therapist
  - An occupational therapy assistant under the indirect supervision of an occupational therapist, who cosigns all assessments and patients' progress notes
  - An athletic trainer under the direct supervision of an occupational therapist in an outpatient setting.

The Plan does not cover:

- More than 60 outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider.
- Therapy to treat long-standing chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without an occupational therapy treatment plan that guides and helps to monitor the provided therapy.
- Services of a freestanding facility provided to you while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program
- Services received from a nonparticipating hospital, nonparticipating freestanding outpatient physical therapy facility, other nonparticipating facilities independent of a hospital
- Services received from an independent sports medicine clinic
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought
  - The Plan may pay for treatment to improve cognition if it is part of a comprehensive rehabilitation plan and medically necessary to treat severe deficits in patients who have certain conditions.
- Recreational therapy
- Patient education and home programs.

#### ***Section 4.30 - Office, Outpatient and Home Medical Care Visits***

The Plan covers the following services when provided by a physician or eligible professional provider when medically necessary:

- Office visits, including:
  - Urgent care visits
  - Office consultations
  - Online visits
  - Retail health clinic visits
- Outpatient visits
- Home medical care visits.

The following are examples of services that will not require any copayments when provided in an in-network physician's office:

- Prenatal and postnatal care
- Allergy testing and therapy
- Therapeutic injections

- Presurgical consultations.

The Plan does not cover routine eye exams and hearing tests, unless they are related to an illness, injury or pregnancy.

#### Mental Health and Substance Use Disorder Treatment Services

Some mental health and substance use disorder services are considered to be the same as an office visit. When a mental health or substance use disorder service is considered to be the same as an office visit, the Plan will consider the claim an office visit.

#### Online Visits

The Plan covers online visits by a professional provider. Online visits by an online visit vendor will not be covered.

The Plan covers the diagnosis of a condition and treatment and consultation recommendations.

The online visit must allow the patient to interact with the professional provider in real time. Treatment and consultation recommendations made online, including issuing a prescription, are to be held to the same standards of appropriate practice as those in traditional settings. Not all services delivered via the internet are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the same cost share as services rendered in an office setting.

The online visit provider must be licensed in the state where the patient is located during the online visit.

Online visits do not include:

- Treatment of substance use disorders
- Reporting of normal test results
- Provision of educational materials
- Handling of administrative issues, such as registration, scheduling of appointments, or updating billing information.

#### ***Section 4.31 - Oncology Clinical Trials***

The Plan covers services performed in a designated cancer center.

Benefits for specified oncology clinical trials provide coverage for:

- Preapproved, specified bone marrow and peripheral blood stem cell transplants and their related services
- FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer
- All stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial.

Benefits are not limited or precluded for antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

The Plan covers:

- Antineoplastic drugs. If Michigan law requires it, the Plan covers these drugs and the reasonable cost of giving them.
- Immunizations. The Plan pays for vaccines against infection during the first 24 months after a transplant as recommended by the ACIP (Advisory Committee on Immunization Practices).

- Autologous Transplants
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell phereses) and storage of bone marrow and/or peripheral blood stem cell
  - Purging or positive stem cell selection of bone marrow or peripheral blood stem cells
  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow and/or peripheral blood stem cells
  - Hospitalization
- Allogeneic Transplants
  - Blood tests to evaluate donors (if not covered by the potential donor's insurance)
  - Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
  - Infusion of colony stimulating growth factor
  - Harvesting and storage (both covered even if it is not covered by the donor's insurance) of the donor's:
    - Bone marrow
    - Peripheral blood stem cell (including peripheral blood stem cell pheresis)
    - Umbilical cord blood
  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
  - T cell depleted infusion
  - Donor lymphocyte infusion
  - Hospitalization
- Travel and Lodging
  - The Plan will pay up to a total of \$5,000 for your travel and lodging expenses. They must be directly related to preapproved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins with the date of preapproval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect.
  - The Plan will cover the expenses of an adult patient and another person. If the patient is under the age of 18, the Plan pays for the expenses of the patient and two additional people. The following per day amounts apply to the combined expenses of the patient and persons eligible to accompany the patient:
    - \$60 per day for travel
    - \$50 per day for lodging
    - These daily allowances may be adjusted from time to time. Please call us to find out the current maximums.

The Plan does not cover:

- An admission to a designated center or a length of stay at a designated center that has not been preapproved
- Services that have not been preapproved
- Services that are not medically necessary (see "Section 13.25 - Medically Necessary" on page 115 for the definition of "medically necessary")
- Services rendered at a nondesignated cancer center
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Donor services for a transplant recipient who is not a BCBSM member
- Services rendered to a donor when the donor's health care coverage will pay for such services

- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year
- More than two single transplants per member for the same condition
- Non-health care related services and/or research management (such as administrative costs)
- Transplants performed at a center that is not a designated cancer center or its affiliate
- Search of an international donor registry
- Experimental treatment not included in this certificate
- Items or services that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)
- Items that are not considered to be directly related to travel and lodging. Examples include, but are not limited to:
  - Alcoholic beverages
  - Car maintenance
  - Clothing, toiletries
  - Dry cleaning or laundry services
  - Flowers, toys, gifts, greeting cards, stationery, stamps, mail/UPS services
  - Furniture rental
  - Household products
  - Household utilities (including cellular telephones)
  - Internet connection, and entertainment (such as cable television, books, magazines and movie rentals)
  - Kennel fees
  - Lost wages
  - Maids, babysitters or day care services
  - Mortgage or rent payments
  - Reimbursement of food stamps
  - Security deposits, cash advances
  - Services provided by family members
  - Tips
- Any other services, admissions or length of stay related to any of the above exclusions.

The limitations and exclusions listed elsewhere in this document, also apply to this benefit.

#### Mandatory Preapproval

All services, admissions or lengths of stay for the services below must be preapproved by BCBSM.

Preapproval ensures that you and your physician know ahead of time that services are covered. If preapproval is not obtained, services will not be covered. This includes:

- Hospital admission
- Length of stay
- All payable medical care and treatment services.

The decision to preapprove hospital and medical services is based on the information your physician submits. The Plan reserves the right to request more information if needed.

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

Preapproval is good only for one year after it is issued. However, preapproved services, admissions or a length of stay will not be paid if you no longer have coverage at the time they occur.

The designated cancer center must submit its written request for preapproval to:

Blue Cross Blue Shield of Michigan  
Human Organ Transplant Program Mail Code 1519  
600 Lafayette East  
Detroit, MI 48226  
Fax: (866) 752-5769

Preapproval will be granted if:

- The patient has BCBSM hospital-medical-surgical coverage.
- The proposed services will be rendered in a designated cancer center or in an affiliate of a designated center.
- The proposed services are medically necessary.
- An inpatient stay at a cancer center if it is medically necessary (in those cases requiring inpatient treatment). The Plan must preapprove the admission before it occurs.
- The length of stay at a designated cancer center is medically necessary. The Plan must preapprove the length of stay before it begins.

#### ***Section 4.32 - Optometrist Services***

The Plan covers services performed by a licensed optometrist within the scope of his or her license and subject to the conditions described below.

- The optometrist must provide the covered services within the state of Michigan.
- The optometrist must be:
  - Licensed in the state of Michigan
  - Certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents
- If you get services from an optometrist who does not participate in BCBSM's vision program, they will be treated as services of a nonparticipating provider.

#### ***Section 4.33 - Outpatient Diabetes Management Program***

All cost-sharing for diabetes self-management training is waived when performed by an in-network provider. The Plan covers services in a home or (for training) in a group setting subject to the conditions described below.

The Plan covers selected services and medical supplies to treat and control diabetes when determined to be medically necessary and prescribed by an M.D. or D.O. The Plan covers:

- Diabetes services and medical supplies include:
  - Blood glucose monitors
  - Blood glucose monitors for the legally blind
  - Insulin pumps
  - Test strips for glucose monitors
  - Visual reading and urine test strips
  - Lancets
  - Spring-powered lancet devices
  - Syringes
  - Insulin
  - Medical supplies required for the use of an insulin pump

- Nonexperimental drugs to control blood sugar
- Medication prescribed by a doctor of podiatric medicine, M.D. or D.O. that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes.

The Plan covers diabetes self-management training conducted in a group setting, whenever practicable, if:

- Self-management training is considered medically necessary upon diagnosis by an M.D. or D.O. who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge
- Your M.D. or D.O. diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment
- The provider of self-management training must be:
  - Certified to receive Medicare or Medicaid reimbursement or
  - Certified by the Michigan Department of Community Health.

You pay no cost-sharing for training from an in-network provider.

#### ***Section 4.34 - Pain Management***

The Plan covers services to manage pain, subject to the conditions described below, in a participating hospital, a participating outpatient facility, or an office.

The Plan covers:

- Covered services and devices for pain management when medically necessary as documented by a physician.
- Covered services performed by a certified registered nurse anesthetist.

The Plan does not cover services and devices for pain management provided by a nonparticipating hospital or facility.

#### ***Section 4.35 - Physical Therapy***

The Plan covers a maximum of 60 outpatient visits per member per calendar year. The 60-visit maximum renews each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for:

- Occupational therapy
- Physical therapy (includes physical therapy by a chiropractor)
- Speech and language pathology
- Chiropractic mechanical traction

If services in a member's home are billed by a professional provider, an independent physical therapist or occupational therapist, they will count toward the visit maximums. If services in a member's home are billed by a home health care agency, they will not count toward the visit maximums.

Each treatment date counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit. An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit (described above).

To be covered, physical therapy must be:

- Prescribed by a professional provider licensed to prescribe it, unless it is performed by a chiropractor
- Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning
- Provided by the following approved location listed below:
  - A hospital, inpatient or outpatient
  - A skilled nursing facility
  - A freestanding outpatient physical therapy facility
  - A provider's office
  - A member's home
  - A nursing home if it is the member's primary residence
- Provided in the following approved providers listed below:
  - A professional provider (M.D., D.O. or a podiatrist)
  - A dentist or optometrist
  - A chiropractor
  - A physical therapist, physical therapist assistant, or athletic trainer
  - A physician's assistant
  - A certified nurse practitioner.

Not all of the providers listed above can perform physical therapy in all of these locations. And some of these providers must be supervised by other types of providers for their services to be covered. Please call Customer Service if you have questions about where physical therapy can be provided or who can provide it.

The Plan does not cover

- More than 60 outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider.
- Services received from a nonparticipating hospital, freestanding outpatient physical therapy facility, skilled nursing facility, or any other facility independent of a hospital
- Services received from an independent sports medicine clinic
- Services of a freestanding facility provided to you in the home or while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program
- Therapy to treat long-standing chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without a physical therapy treatment plan that guides and helps to monitor the provided therapy.
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program.
- Treatment solely to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought without a physical therapy treatment plan that guides and helps to monitor the provided therapy
  - The Plan may pay for treatment to improve cognition if it is part of a comprehensive rehabilitation plan, and medically necessary to treat severe deficits in patients who have certain conditions
- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy.

### ***Section 4.36 - Prescription Drugs (Under Medical Program)***

Please note: This section describes prescription drugs benefits paid through the medical program. Prescription drugs may also be covered under the Prescription Drug Program, described in “Section 5.03 - Prescription Drug Benefit” on page 76.

The Plan covers medically necessary prescription drugs. They can be given in a participating hospital or in other approved locations. Prescription drugs are subject to the conditions described below.

The Plan covers:

- **Drugs Received in a Hospital (Inpatient or Outpatient) –** The Plan covers prescription drugs, biologicals and solutions (such as irrigation and I.V. solutions) administered as part of the treatment for the disease, condition or injury that are:
  - Labeled FDA-approved as defined under the amended Federal Food, Drug and Cosmetic Act and
  - Used during an inpatient hospital stay or dispensed when part of covered outpatient services
- **Drugs Received in Other Locations are also payable:**
  - In a participating freestanding ambulatory surgery facility when directly related to surgery
  - In a participating freestanding ESRD facility in conjunction with dialysis services
  - In a participating skilled nursing facility
  - As part of home health services when services are provided by a participating hospital
  - When required for infusion therapy
  - In a participating hospice for the comfort of the patient
  - In a participating residential substance abuse treatment facility or as part of a participating outpatient substance treatment program
- **Drugs Administered by a Physician:**
  - **Injectable Drugs:** The Plan covers injectable drugs or biologicals, and their administration. The drugs or biologicals must be:
    - FDA approved,
    - Ordered or supplied by a physician, and
    - Administered by the physician or under the physician’s supervision.
  - **Specialty Pharmaceuticals:** The Plan covers approved specialty drugs to be given to you by an in-network or participating provider. This includes:
    - Drugs and their administration when ordered and billed by a physician, or
    - Drugs billed by the specialty pharmacy
    - Physician’s administration of the drug
  - **Hemophilia Medication, provided by**
    - In-network providers
    - Out-of-network providers
    - Participating providers
    - Nonparticipating providers

The Plan covers supplies for the infusion of the hemophilia factor product. If you buy them from a participating provider, the Plan pays the provider directly. If you buy them from a nonparticipating provider, the Plan pays you and you need to pay the nonparticipating provider.

#### Prior Authorization for Specialty Pharmaceuticals

Prior authorization is required for select specialty drugs that will be administered in certain locations. These locations include, but not limited to:

- Office
- Clinic
- Home
- Outpatient Facilities.

The Plan requires prior authorization for specialty drugs for in-state and out-of-state services. Your physician should follow the utilization management processes to get prior authorization for your specialty drug. The Plan will notify your physician if the request is approved. Only FDA-approved drugs can be preauthorized. Of those drugs, only the specialty drugs that meet the Plan's medical policy standards for the treatment of your condition will be preauthorized.

If your physician asks for prior authorization, but it is not approved by BCBSM, you have the right to appeal under applicable law. If the prior authorization is not approved through the appeal, you will be responsible for the full cost of the specialty drug.

If your physician does not get prior authorization, BCBSM will deny the claim and you will be responsible for the full cost of the specialty drug.

If your physician did not get prior authorization and you appeal the denial of the claim, BCBSM will review it to determine if the benefits can be paid. If BCBSM upholds the denial, you have the right to appeal under applicable law.

If Medicare is your primary payer, your physician does not have to get prior authorization.

#### Request for Drugs Not on BCBSM's Drug List

If your prescription drug coverage is limited to an approved drug list, BCBSM must approve coverage of a prescription drug not on the list before it is dispensed. If you or your prescriber do not obtain approval before the drug is dispensed, the drug will not be covered.

To request BCBSM's approval, you, your designee, or the prescriber or the prescriber's designee should contact us and follow the exception request process.

For expedited requests due to exigent circumstances: the Plan will notify the person making the request of the decision (either approval or denial) within 24 hours after the Plan gets all of the information the Plan needs to make the determination.

For requests that are not due to exigent circumstances: If your request is not an exigent circumstance, the Plan will notify you of the decision within 72 hours after the Plan gets all of the information the Plan needs to make the determination.

If the Plan approves the exception request, you will have to pay your deductibles, coinsurances or copayments.

Only FDA-approved drugs are eligible for an exception. Of those drugs, BCBSM will only approve the drugs that meet the Plan's clinical criteria and are effective in treating your condition.

#### ***Section 4.37 - Preventive Care Services***

The Plan covers all preventive and immunization services required under the Patient Protection and Affordable Care Act (PPACA). Because the services required under PPACA change from time- to-time,

only some of them are included in this document. To see a complete list, go to <https://www.healthcare.gov/coverage/preventive-care-benefits/>. You may also contact BCBSM Customer Service.

Most preventive care services are covered only when performed by an in-network provider. But, colonoscopies, mammograms, and women's contraceptive services are covered whether they are done by an in-network or an out-of-network provider. This section describes what the Plan covers for all preventive care services.

The Plan covers facility and professional services for preventive care—subject to the conditions described below— in a participating hospital (inpatient or outpatient), a participating facility (e.g., an ambulatory surgery center), or a professional provider's office. The Plan will also pay an independent laboratory to analyze a test.

The Plan covers:

- Preventive care services
- Related reading and interpretation of your test results  
If an in-network provider does a covered preventive test, and an out-of-network provider reads and interprets the results, the Plan will cover the claim from the out-of-network provider as if it were an in-network claim. This means you will not have to pay your out-of-network cost-share.  
Cost-sharing is not required for these services when performed by an in-network provider.
- Health Maintenance Examination  
One exam per member, per calendar year; this is a full history and physical exam. It includes taking your blood pressure, looking for skin malignancies, a breast exam, a testicular exam, a rectal exam and health counseling about any potential risk factors you may encounter.
- Flexible Sigmoidoscopy Examination  
One routine flexible sigmoidoscopy examination per member, per calendar year.
- Gynecological Examination  
One routine gynecological examination per member, per calendar year.
- Routine Pap Smear  
Laboratory and pathology services for one routine Pap smear per member, per calendar year, when prescribed by a physician.
- Screening Mammography  
The Plan covers one routine mammogram and the related reading, once per member per calendar year to screen for breast cancer. You will not have to pay your cost-share if this service is done by an in-network provider. If the mammogram is done by an out-of-network provider, you will have to pay your out-of-network cost-share.  
The Plan will cover an out-of-network provider to read and interpret your mammogram, but only when the mammogram itself was done by an in-network provider.
- Fecal Occult Blood Screening  
One fecal occult blood screening per member, per calendar year to detect blood in the feces or stool.
- Well-Baby and Child Care Visits  
The Plan covers well-baby and child care visits as follows:
  - Eight visits for children from birth through 12 months
  - Six visits for children 13 months through 23 months
  - Six visits for children 24 months through 35 months
  - Two visits for children 36 months through 47 months

- Child care visits after 47 months are limited to one per member, per calendar year under your health maintenance exam benefit.
- Immunizations
 

The Plan covers childhood and adult immunizations. The Plan follow the recommendations of the Advisory Committee on Immunization Practices. The Plan may also follow other sources as known to BCBSM.

The Plan covers all other immunizations and preventive care benefits ordered by PPACA at the time the services are performed.
- Prostate Specific Antigen Screening
 

The Plan covers one routine prostate specific antigen screening per member, per calendar year.
- Routine Laboratory and Radiology Services
 

The Plan covers the following services once per member, per calendar year, when performed as routine screening:

  - Chemical profile
  - Complete blood count or any of its components
  - Urinalysis
  - Chest X-ray
  - EKG
  - Cholesterol testing
- Colonoscopy
 

Hospital and physician benefits for colonoscopy services are payable at 100 percent of the approved amount as follows:

  - The Plan covers one routine screening colonoscopy once per member per calendar year. It can be done by an in-network or an out-of-network provider.
  - If you have an in-network provider do the screening, you will not have to pay your cost-share.
  - If you have an out-of-network provider do the screening, you will have to pay your out-of-network cost-share.
  - If you need another colonoscopy done in the same calendar year, you will have to pay your cost-share. It can be done by an in-network or out-of-network provider.
- Morbid Obesity Weight Management
 

For a member with a BMI of 30 or above, The Plan covers 26 visits per member per calendar year. Visits can include nutritional counseling, such as dietician services, billed by a physician or other provider recognized by BCBSM.
- Tobacco Cessation Programs
 

The Plan pays for screening, counseling and select prescription drugs to help you stop smoking.
- Women's Preventive Care Contraceptive Services
  - Voluntary Sterilization for Females - The Plan covers hospital, facility, and physician's services for voluntary sterilizations for females.
  - Contraceptive Counseling - The Plan covers contraceptive counseling services provided to females during an annual physical or at a separate counseling session.
  - Contraceptive Devices - The Plan covers a contraceptive device that needs a prescription by a physician, certified nurse midwife, or other legally authorized professional provider. The Plan also covers the provider to put in and take out a device.
  - Contraceptive Injections - The Plan covers contraceptive injections given by a physician, certified nurse midwife, or other legally authorized professional provider. The Plan also pays the provider for the injected medication if the provider supplies it. If a physician, certified nurse midwife, or other legally authorized professional provider injects you

with a contraceptive medication you bought from a pharmacy, the Plan only covers the provider for the injection.

- Genetic Testing - The Plan covers BRCA (counseling about genetic testing) – for women at higher risk.

The Plan does not cover screening and preventive services that are not listed in this document and/or not required to be covered under PPACA. To see a complete list of the services and immunizations that must be covered under PPACA visit <https://www.healthcare.gov/coverage/preventive-care-benefits/>.

#### ***Section 4.38 - Private Duty Nursing Services***

The Plan covers private duty nursing services in your home or in a participating hospital subject to the conditions described below.

The Plan covers skilled care given by a private duty nurse if:

- The patient's medical condition requires 24-hour care
- The patient requires medically necessary skilled care for a portion of the 24-hour period
- The skilled care (for example, ventilator care) is given by a professional registered nurse or licensed practical nurse
- The skilled care is given in a hospital because the hospital lacks intensive or cardiac care units or has no space in such units
- The skilled care is provided by a nurse who is not related to, or living with, the patient.

Private duty nurses may require you to pay for services at the time they are provided. Submit an itemized statement to the Plan for services. All progress notes must be submitted with the claim form.

The Plan does not cover custodial care.

#### ***Section 4.39 - Professional Services***

The services listed in this section are in addition to all of the other services listed in this document. The services in this section are also payable to a professional provider. The plan covers:

- Certified Nurse Practitioner Services - The Plan covers covered services that are provided by a certified nurse practitioner.
- Inpatient and Outpatient Consultation - If a physician needs help diagnosing or treating a patient's condition, the Plan covers inpatient and outpatient consultations. They must be provided by a physician or professional provider who has the skills or knowledge needed for the case. The Plan does not cover staff consultations required by a facility's or program's rules.
- Therapeutic injections.

#### ***Section 4.40 - Prosthetic and Orthotic Devices***

The Plan covers prosthetic and orthotic devices while you are in a participating hospital or for use outside of the hospital. Payment is based on meeting the conditions described below.

The Plan covers prosthetic and orthotic devices:

- Prescribed by a physician or certified nurse practitioner
- And permanently implanted in the body
- Or used externally, such as an artificial eye, leg, arm.

The prescription must include a description of the equipment and the reason for the need or the diagnosis. Covered services include:

- The cost of purchasing, replacing, obtaining, developing and fitting the basic device and any medically necessary special features
- Cost of purchasing or replacing the device
- Cost of developing and fitting the basic device
- Any medically necessary special features
- Repairs, limited to the cost of a new device.

The Plan will cover the cost to replace a prosthetic device due to:

- A change in the patient's condition
- Damage to the device so that it cannot be restored
- Loss of the device.

### Coverage Guidelines

The Plan covers external prosthetic and orthotic devices that are payable by Medicare Part B. They are covered as of the date they were bought or rented. In some cases, the Plan's guidelines may be different from those of Medicare Part B. Please call your local Customer Service center for specific coverage information.

To be covered, custom-made devices must be furnished:

- By a fully accredited provider
- With BCBSM approval, conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc (ABC).

You may call us to confirm a provider's status. Prosthetic and orthotic suppliers may include:

- M.D.s or D.O.s,
- Podiatrists,
- Prosthetists,
- Orthotists.

All suppliers must meet BCBSM qualification standards.

### Provider Limitations

If a provider is participating with BCBSM but is not accredited by ABC, only the following devices are covered:

- External breast prostheses following a mastectomy which include:
  - Two post-surgical brassieres and
  - Two brassieres in any 12-month period thereafter.
  - Additional brassieres are covered if they are required:
    - Because of significant change in body weight
    - For hygienic reasons
- Prefabricated custom-fitted orthotic devices
- Artificial eyes, ears, noses and larynxes
- Ostomy sets and accessories, catheterization equipment and urinary sets
- Prescription eyeglasses or contacts lenses after cataract surgery; the surgery can be for any disease of the eye or to replace a missing organic lens. Optometrists may provide these lenses
- External cardiac pacemakers
- Therapeutic shoes, shoe modifications and inserts for persons with diabetes
- Maxillofacial prostheses that have been approved by BCBSM. Dentists may provide you with these devices.

If you have an urgent need for an item that is not custom-made (e.g., wrist braces, ankle braces, or shoulder immobilizers), the Plan will provide for the item to be provided by an M.D., D.O., or podiatrist. Please call your local Customer Service center for information on which devices are covered.

### Exclusions

The Plan does not cover:

- Hair prostheses such as wigs, hair pieces, hair implants, etc.
- Spare prosthetic devices
- Routine maintenance of a prosthetic device
- Experimental prosthetic devices
- Prosthetic devices ordered or purchased before the effective date of this coverage under this certificate
- Nonrigid devices and supplies such as elastic stockings, garter belts, arch supports, and corsets

### ***Section 4.41 - Radiology Services***

The Plan covers hospital, facility and physician diagnostic and therapeutic radiology services in a participating hospital, a participating facility, or an office.

The Plan covers:

- Diagnostic Radiology Services - These services include facility and physician radiology services used to diagnose disease, illness, pregnancy or injury. The services must be prescribed or provided by your physician or by another physician if agreed on by your physician:
  - X-rays
  - Radioactive isotope studies and use of radium
  - Ultrasound
  - Computerized axial tomography (CAT) scans
  - Magnetic resonance imaging (MRI)
  - Positron emission tomography (PET) scans
  - Medically necessary mammography
- Therapeutic Radiology Services - These services include facility and physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. The services must be prescribed or provided by your physician or, by another physician if agreed on by your physician.

The Plan does not cover procedures not directly related and necessary to diagnose a disease, illness, pregnancy or injury (such as an ultrasound solely to determine the sex of the fetus).

### ***Section 4.42 - Skilled Nursing Facility Services***

The Plan covers facility and professional services in a skilled nursing facility.

The Plan covers:

- A semiprivate room, including general nursing service, meals and special diets
- Special treatment rooms
- Laboratory examinations
- Oxygen and other gas therapy
- Drugs, biologicals and solutions
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
- Durable medical equipment used in the facility or outside the facility when rented or purchased from the skilled nursing facility

- Physician services (up to two visits per week)
- Physical therapy, speech and language pathology services or occupational therapy when medically necessary.

The physical therapy, occupational therapy, or speech and language pathology services that are done in a skilled nursing facility are inpatient benefits. The 60-visit benefit maximums apply only when these services are provided on an outpatient basis.

The Plan does not cover:

- Custodial care
- Care for senility or developmental disability
- Care for substance use disorder
- Care for mental illness (other than for short-term nervous and mental conditions to which the 120- day maximum applies)
- Care provided by a nonparticipating skilled nursing facility.

### Requirements

The Plan covers an admission to a skilled nursing facility when:

- The skilled nursing facility participates with BCBSM
- The admission is ordered by the patient's attending physician.

The Plan requires written confirmation from your physician that skilled care is needed.

### Length of Stay

The Plan pays only for the period that is necessary for the proper care and treatment of the patient. The maximum length of stay is 120 days per member, per calendar year.

### ***Section 4.43 - Special Medical Foods for Inborn Errors of Metabolism***

The Plan covers special medical foods for the dietary treatment of inborn errors of metabolism. These foods must be prescribed by a physician after a complete medical evaluation of the patient's condition has been done.

The following criteria must be met:

- The cost of special medical foods must be higher than the cost of foods or items that are not special medical foods
- Medical documentation must support the diagnosis of a covered condition that requires special medical foods.

To be paid, you must submit the prescription from the treating physician along with receipts for your special medical food purchases to BCBSM. Mail your receipts along with a "Member Application for Payment Consideration" to:

Blue Cross Blue Shield of Michigan  
 600 E. Lafayette Blvd.  
 Imaging & Support Services, MC 0010  
 Detroit, MI 48226-2998

The Plan does not cover:

- Nutritional products, supplements, medical foods or any other items provided to treat medical conditions that are not related to the treatment of inborn errors of metabolism
  - BCBSM determines what conditions are related to inborn errors of metabolism. Diabetes mellitus is excluded as a payable diagnosis for this benefit
- Foods used by patients with inborn errors of metabolism that are not special medical foods, as defined by this certificate
- Nutritional products, supplements or foods used for the patient's convenience or for weight reduction programs.

#### ***Section 4.44 - Speech and Language Pathology***

The Plan covers facility and professional speech and language pathology services in participating hospital (inpatient or outpatient), participating freestanding outpatient physical therapy facility, an office, a member's home, a nursing home (if it's the member's primary residence), or a participating skilled nursing facility.

The Plan covers a maximum of 60 outpatient visits per member calendar year whether obtained from an in-network or out-of-network provider. The 60-visit maximum renews each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for occupational therapy, physical therapy (includes physical therapy by a chiropractor), speech and language pathology, and chiropractic mechanical traction.

If services in a member's home are billed by a professional provider or independent therapist, they will count toward the visit maximums. If services in a member's home are billed by a home health care agency, they will not count toward the visit maximums.

Each **treatment date** counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit. An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit (described above).

Speech and language pathology services must be:

- Prescribed by a professional provider licensed to prescribe speech and language pathology services
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning
- Given by:
  - A speech-language pathologist certified by the American Speech-Language-Hearing Association or
  - By one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist.

The Plan does not cover:

- Treatment solely to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

- The Plan may pay for treatment to improve cognition if the treatment is part of a comprehensive rehabilitation plan. The treatment must be necessary to treat severe speech deficits language and/or voice deficits. This treatment is for patients with certain conditions that have been identified by BCBSM.
- Recreational therapy
- Patient education and home programs
- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities
  - A BCBSM medical consultant may decide that speech and language pathology services can be used to treat chronic, developmental or congenital conditions for some children with severe developmental speech disabilities.
- Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without a speech and language pathology treatment plan that guides and helps to monitor the provided therapy
- Services provided by speech-language pathology assistants or therapy aides.
- Services received from a nonparticipating freestanding outpatient physical therapy facility or a nonparticipating skilled nursing facility or from other nonparticipating facilities independent of a hospital.
- More than 60 outpatient visits per member per calendar year.
- Services of a freestanding facility provided to you in the home or while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program.

***Section 4.45 - Substance Use Disorder Treatment Services***

The Plan will cover substance use disorder treatment services in a participating hospital, a participating residential or outpatient substance abuse rehabilitation facility, a participating outpatient psychiatric care (OPC) facility, or an office. Substance use disorder treatment services that are the equivalent of an office visit are covered as an office visit.

All services are subject to the conditions described below.

Inpatient Hospital Substance Use Disorder Treatment Services

Services must be provided in a participating hospital. The Plan covers acute detoxification, covered and paid as a medical service.

Residential and Outpatient Substance Abuse Rehabilitation Facility Treatment Services

The Plan covers substance use disorder treatment in a:

- A participating residential substance abuse rehabilitation facility or
- A participating outpatient hospital
- A participating outpatient substance abuse rehabilitation facility.

The following criteria must be met:

- A physician must find that you need substance use disorder treatment and note in the medical record if the treatment should be residential or outpatient.
- A physician must:
  - Provide an initial physical exam
  - Diagnose the patient with a substance use disorder condition
  - Certify that the required treatment can be given in a residential or an outpatient substance abuse rehabilitation facility
  - Provide and supervise your care during subacute detoxification and

- Provide follow-up care during rehabilitation
- The services need to be medically necessary to treat your condition.
- The services in a residential substance abuse rehabilitation facility must be preapproved by BCBSM.
- They must also be provided by a participating substance abuse treatment facility.

The Plan covers the following services provided and billed by an approved program:

- Laboratory services
- Diagnostic services
- Supplies and equipment used for subacute detoxification or rehabilitation
- Professional and trained staff services and program services necessary for care and treatment
- Individual and group therapy or counseling
- Therapy or counseling for family members
- Psychological testing
- Outpatient substance use disorder services for the treatment of tobacco dependence.

The Plan also covers the following in a residential substance abuse treatment program:

- Room and board
- General nursing services
- Drugs, biologicals and solutions used in the facility.

The Plan also covers the following in an outpatient substance abuse treatment program:

- Drugs, biologicals and solutions used in the program, including drugs taken home.

Covered out-of-network services performed in a residential substance abuse rehabilitation facility will be covered at in-network deductible and coinsurance.

The Plan does not cover:

- Dispensing methadone or testing of urine specimens unless you are receiving therapy, counseling or psychological testing while in the program
- Diversional therapy
- Services provided beyond the period necessary for care and treatment
- Treatment, or supplies that do not meet BCBSM requirements.

#### Outpatient Psychiatric Care Facility and Office Setting for Substance Use Disorder Services

The Plan only covers services in a participating outpatient psychiatric care (OPC) facility and office setting.

The Plan covers:

- Services provided by the facility's staff
- Services provided by a physician, fully licensed psychologist, certified nurse practitioner, clinical licensed master's social worker, licensed professional counselor, limited licensed psychologist, or licensed marriage and family therapist, or other professional provider as determined by BCBSM
- Prescribed drugs given by the facility in connection with treatment.

The Plan does not cover:

- Services provided in a skilled nursing facility or through a residential substance abuse treatment program

- Marital counseling
- Consultations required by a facility or program's rule
- Services provided by a nonparticipating outpatient psychiatric care facility.

#### ***Section 4.46 - Surgery***

The Plan covers hospital, facility and professional services for surgery in a participating hospital (as an inpatient or an outpatient), a participating freestanding ambulatory surgery facility, or an office.

#### Presurgical Consultations

If your physician tells you that you need surgery, you may choose to have a presurgical consultation with another physician. The consulting physician must be an M.D., D.O., podiatrist, or an oral surgeon. The consultation will be paid if the surgery you plan to have is covered under this Plan and will be done in a covered location. You are limited to three presurgical consultations for each surgical diagnosis. The three consultations consist of a:

- Second opinion – a consultation to confirm the need for surgery
- Third opinion – allowed if the second opinion differs from the initial proposal for surgery
- Nonsurgical opinion – given to determine your medical tolerance for the proposed surgery.

#### Surgery

The Plan covers:

- Physician's surgical fee
- Medical care provided by the surgeon before and after surgery while the patient is in the hospital
- Visits to the attending physician for the usual care before and after surgery
- Operating room services, including delivery and surgical treatment rooms
- Sterilization (whether or not medically necessary)
- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration related to surgery
- Cosmetic surgery and related services are not covered if only to improve your personal appearance. Cosmetic surgery is only payable when medically necessary for:
  - Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
  - Correction of deformities resulting from cancer surgery including reconstructive surgery after a mastectomy
  - Conditions caused by accidental injuries, and
  - Traumatic scars
- Dental surgery is only payable for:
  - Multiple extractions or removal of unerupted teeth or alveoplasty when:
    - A hospitalized patient has a dental condition that is adversely affecting a medical condition, and
    - Treatment of the dental condition is expected to improve the medical condition
    - For surgery and treatment related to the treatment of temporomandibular joint (jaw joint) dysfunction (TMJ).
- Multiple surgeries performed on the same day by the same physician are payable according to national standards recognized by BCBSM.
- Technical surgical assistance (TSA): In some cases, a surgeon will need another physician to give them technical assistance. The Plan pays the approved amount for TSA, according to BCBSM guidelines.
  - The surgery can be done in a:
    - Participating hospital (inpatient or outpatient)

- Participating ambulatory surgery facility
- A list of TSA surgeries that the Plan covers is available from your local Customer Service center. The Plan does not pay for TSA:
  - When services of interns, residents or other physicians employed by the hospital are available at the time of surgery or
  - When services are provided in a location other than a hospital or ambulatory surgery facility.

#### Freestanding Ambulatory Surgery Facility Services

The Plan covers facility services in a BCBSM participating ambulatory surgery center. The services must be medically necessary. You must be a patient of a licensed MD, DO, podiatrist or oral surgeon to be admitted to the center. The services must be directly related to the covered surgery.

The following services are payable:

- Use of ambulatory surgery facility
- Anesthesia services and materials
- Recovery room
- Nursing care by, or under the supervision of, a registered nurse
- Drugs, biologicals, surgical dressings, supplies, splints and casts directly related to providing surgery
- Oxygen and other therapeutic gases
- Skin bank, bone bank and other tissue storage costs for supplies and services for the removal of skin, bone or other tissue, as well as the cost of processing and storage
- Administration of blood
- Routine laboratory services related to the surgery or a concurrent medical condition
- Radiology services performed on equipment owned by, and performed on the premises of, the facility that are necessary to enhance the surgical service
- Housekeeping items and services
- EKGs.

The Plan does not cover services by a nonparticipating ambulatory surgery facility

#### ***Section 4.47 - Temporary Benefits for Out-of-network Hospital Services***

The following rules will apply when a participating hospital ends its contract with BCBSM. These hospitals are sometimes referred to as “noncontracted” hospitals.

The Plan covers temporary benefits for some services of noncontracted hospitals. These benefits are for continuity of care, designated services, emergency care, and travel and lodging. Benefits for continuity of care are available for up to six months from the date the hospital ends its participating contract with BCBSM. Benefits for designated services and emergency care are available for as long as they are medically necessary. Benefits for travel and lodging are available for the period of time approved by BCBSM.

#### Mandatory Preapproval

**You** must obtain preapproval from BCBSM for any travel and lodging expenses before they occur. If you do not obtain preapproval, travel and lodging will not be covered and you will be responsible for these costs.

## Payable Services

### A. Continuity of Care

Requirements - The Plan will cover your continued treatment in a hospital after it ends its participating contract with BCBSM. These benefits are available for up to six (6) months from the date the hospital end its contract with BCBSM when all of the following criteria are met:

- You were undergoing a continued and regular course of treatment for the same condition at the same hospital or by a provider or team of providers on staff at the same hospital before the hospital ended its contract with BCBSM
- BCBSM paid your claims for treatment of the same condition at the hospital before the hospital ended its participating contract with BCBSM
- The services are medically necessary and would be covered if the hospital were a BCBSM in-network or participating hospital.

Payment for Continuity of Care Services – The Plan will cover the approved amount for covered services, less your cost-sharing requirements under this certificate. The approved amount may be less than the hospital’s bill. You may be required to pay the difference.

### B. Designated Services and Emergency Care

#### *Coverage Requirements*

The Plan will cover designated services and emergency care that you receive from a hospital that ends its contract with BCBSM when all the following criteria are met:

- The services are medically necessary and would be covered if the hospital were a BCBSM in-network or participating hospital
- The hospital that ends its contract with BCBSM is within 75 miles of your primary residence (this applies only to designated services).

#### *Payment for Designated Services and Emergency Care*

When the above coverage requirements are met, the Plan will pay you as follows:

- Designated Services – The Plan will pay approved amount, less your cost sharing required. The approved amount may be less than the hospital’s bill. You may be required to pay the difference.
- Emergency Care – The Plan will cover the greater of the:
  - Median in-network rate the Plan pays for accidental injury or emergency service
  - Rate the Plan would pay a nonparticipating, out-of-network hospital for the accidental injury or emergency service. This rate is calculated using the method the Plan generally uses to set rates for these services from these types of providers.
  - Medicare rate to treat the accidental injury or emergency service.

The rate the Plan pays may be less than the hospital’s bill. You may be required to pay the difference.

#### *Transport from a Noncontracted Area Hospital*

If you are receiving designated services or emergency care in a hospital that ended its contract with BCBSM, and your physician says that you are medically stable, you may choose to be transferred to the nearest participating hospital that can treat your condition. The Plan covers the approved amount to transport you by ambulance to that hospital.

If you use a nonparticipating ambulance service to transport you, the bill may be more than the approved amount. You may be required to pay the difference. BCBSM certificates provide only limited coverage for emergency services at nonparticipating hospitals. They provide you with no coverage if you are admitted on a nonemergency basis. If you decide to stay in a noncontracted hospital, the Plan will pay you at the nonparticipating rate. The rate may be less than the hospital charges. You will have to pay the difference.

#### *Limitations and Exclusions*

If you get services from a hospital that ends its contract with BCBSM that are not designated services, the Plan will pay only the amount the Plan pays for nonparticipating hospital services. You will have to pay the difference between what the Plan pays and the hospital's charge. This difference may be substantial since the Plan does not pay for nonemergency services in a nonparticipating hospital.

The Plan will pay for ambulance transport services only if they are for an admission that is covered under this certificate. If your certificate covers nonemergency transports, you will have to pay for your cost share.

#### C. Travel and Lodging

If you need to get services at an out-of-area hospital, the Plan will cover the cost of travel and lodging if all the following are met:

- You live within 75 miles of the noncontracted area hospital
- The travel and lodging are preapproved, as previously described
- You cannot reasonably get covered services from:
  - A contracted hospital in your area or other participating provider within 75 miles of the noncontracted area hospital, and
  - Your physician directs you to an out-of-area hospital.
  - You get services from the out-of-area BCBSM in-network or participating hospital that is closest to the noncontracted area hospital.

#### *Inpatient Services*

If you need inpatient services from an out-of-area hospital, the Plan will pay a maximum of \$250 per day for the reasonable and necessary cost of travel and lodging. The Plan will pay up to a total of \$5,000 for travel and lodging costs for each admission. Both of these maximum payment amounts will cover the combined expenses for you and the person(s) eligible to accompany you. If you spend less than \$250 per day or a total of \$5,000 for all of your travel and lodging, the Plan will pay you the amount you actually spent. If you spend more than \$250 per day or a total of \$5,000, the Plan will only pay you the maximum of \$250 per day or \$5,000 total for your travel and lodging expenses.

Coverage will begin on the day before your admission and end on your date of discharge. The Plan will pay for the following:

- Travel for you and another person (two persons if the patient is a child under the age of 18) to and from the out-of-area hospital
- Lodging for the person(s) eligible to accompany you.

### *Outpatient Services*

If you need outpatient services from an out-of-area hospital or physician, the Plan will pay up to \$125 for travel and lodging each time you need these services.

### *Limitations and Exclusions*

- The Plan does not cover travel and lodging that were not preapproved, as previously described.
- Travel and lodging will be paid only after you submit your original receipts to us.
- Travel does not include an ambulance transport to an out-of-area hospital.
- The Plan will not pay for travel and lodging beyond the maximums stated above.
- The Plan will not pay for items that are not directly related to travel and lodging
- Any other services, admissions or length of stay related to any of the above exclusions
- The deductible, copayment or coinsurance requirements in this certificate do not apply to travel and lodging.

### ***Section 4.48 - Transplant Services***

Kidney, cornea, skin and bone marrow transplants are payable when performed in a participating hospital, or a participating ambulatory surgery facility. The Plan covers transplants of specified organs such as heart or liver only if they are done in a “designated facility.”

The Plan covers organ transplants and bone marrow transplants if the transplant recipient is a BCBSM member. Living donor and recipient transplant services are paid under the recipient’s coverage.

### Organ Transplants

The Plan covers services performed to obtain, test, store and transplant the following human tissues and organs:

- Kidney
- Cornea
- Skin
- Bone marrow (described below).

The Plan covers immunizations against common infectious diseases during the first 24 months after your transplant. The Plan follows the guidelines of the Advisory Committee on Immunization Practices (ACIP). The immunization benefit does not apply to cornea and skin transplants.

### Bone Marrow Transplants

Bone marrow transplants require preapproval. If you do not get preapproval before you receive the transplant, neither it nor any related services will be covered and you will have to pay all costs.

Bone marrow transplants are covered when they are directly related to:

- Two tandem transplants
- Two single transplants
- A single and a tandem transplant.

For each member and for each condition, the Plan pays the following services:

- Allogeneic Transplants
  - Blood tests on first degree relatives to evaluate them as donors
  - Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
  - Infusion of colony stimulating growth factors

- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
  - A first degree relative and matches at least four of the six important HLA genetic markers with the patient or
  - Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.)
- High-dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization
- Autologous Transplants
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
  - Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow and/or peripheral blood stem cells
  - Hospitalization.

Allogeneic transplants and autologous transplants are covered to treat only certain conditions. Please call Customer Service for a list of these conditions.

In addition to the conditions listed above, the Plan will pay for services related to, or for:

- High-dose chemotherapy
- Total body irradiation
- Allogeneic or autologous transplants to treat conditions that are not experimental.

This does not limit or prevent coverage of antineoplastic drugs when Michigan law requires that these drugs be covered. The coverage includes the cost of administering the drugs.

The Plan does not cover the following for bone marrow transplants:

- Services that are not medically necessary
- Services provided in a facility that does not participate with BCBSM
- Services provided by persons or groups that are not legally qualified or licensed to provide such services
- Services provided to a transplant recipient who is not a BCBSM member
- Services provided to a donor when the transplant recipient is not a BCBSM member
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- Expenses related to travel, meals and lodging for donor or recipient
- An autologous tandem transplant for any condition other than germ cell tumors of the testes
- Search of an international donor registry
- An allogeneic tandem transplant
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year
- Experimental treatment
- Any other services or admissions related to any of the above named exclusions.

### Specified Human Organ Transplants

Specified Human Organ Transplants require preapproval. If you do not get preapproval before you receive these services, it will not be covered and you will have to pay for it. However, once you get preapproval for the transplant, any services that you receive within one year from the date of the transplant will be covered as long as those services are medically necessary and related to the preapproved transplant.

When performed in a designated facility the Plan covers transplant of the following organs:

- Combined small intestine-liver
- Heart
- Heart-lung(s)
- Liver
- Lobar lung
- Lung(s)
- Pancreas
- Partial liver
- Kidney-liver
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Multivisceral transplants (as determined by BCBSM)

The Plan also pays for the cost of getting, preserving and storing human skin, bone, blood, and bone marrow that will be used for medically necessary covered services.

All specified human organ transplant services must be provided during the benefit period if they are going to be paid by BCBSM. It begins five days before the transplant and ends one year after the transplant. The only exceptions are anti-rejection drugs and other transplant-related prescription drugs.

When directly related to the transplant, the Plan covers:

- Facility and professional services
- Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed; the payment for these drugs will be based on BCBSM's approved amount.
- During the first 24 months after the transplant, immunizations against certain common infectious diseases are covered. Immunizations that are recommended by the Advisory Committee on Immunization Practices (ACIP) are covered by BCBSM.
- Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition:
  - Occurs during the benefit period and
  - Is a direct result of the organ transplant surgery

The Plan also covers the following:

- Up to \$10,000 for eligible travel and lodging during the initial transplant surgery, including:
  - Cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living-related donor)
- Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient ("lodging" refers to a hotel or motel)
- Cost of acquiring the organ (the organ recipient must be a BCBSM member.) This includes, but is not limited to:
  - Surgery to obtain the organ

- Storage of the organ
- Transportation of the organ
- Living donor transplants such as partial liver, lobar lung, small bowel, and kidney transplants that are part of a simultaneous kidney transplant
- Payment for covered services for a donor if the donor does not have transplant services under any health care plan.

During the benefit period, the deductible and copayments do not apply to the specified human organ transplants and related procedures.

The Plan does not cover the following for specified human organ transplants:

- Services that are not BCBSM benefits
- Services provided to a recipient who is not a BCBSM member
- Living donor transplants not listed in this certificate
- Anti-rejection drugs that do not have Federal Food and Drug Administration approval
- Transplant surgery and related services performed in a nondesignated facility
- Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
- Items that are not considered by BCBSM to be directly related to travel and lodging.
- Routine storage cost of donor organs for the future purpose of transplantation
- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under this certificate
- Experimental transplant procedures.

#### ***Section 4.49 - Urgent Care Services***

The Plan covers physician services provided at an urgent care facility.

#### ***Section 4.50 - Value Based Programs***

##### **Provider-Delivered Care Management (PDCM)**

PDCM services are covered only when they are performed in Michigan by BCBSM designated providers. Under PDCM, a care manager will coordinate your care. This section describes what the Plan covers under PDCM.

The Plan covers services for PDCM in, subject to the conditions described below, in an office, a participating outpatient hospital or participating facility, a member's home, or other locations as designated by BCBSM

The Plan covers care management services identified by BCBSM only when performed by a BCBSM-designated provider in Michigan. PDCM services may include:

- Telephone, individual face-to-face, and group interventions
- Medication assessments to identify:
  - The appropriateness of the drug for your condition
  - The correct dosage
  - When to take the drug
  - Drug Interactions
- Setting goals by your primary care physician (PCP), your care manager, and yourself to help you manage your health better.

Most PDCM services include support for setting goals and ensuring patient participation.

You are eligible to receive PDCM services if you have:

- Agreed to actively participate with PDCM
- A referral for care management services from your physician.

Your physician will determine your eligibility and refer you for care management services based on factors, such as your:

- Diagnosis
- Admission status
- Clinical status.

You may opt-out of PDCM at any time. BCBSM may also terminate PDCM services based on:

- Your nonparticipation in PDCM
- Termination or cancellation of your BCBSM coverage
- Other factors.

The Plan does not cover:

- Services performed by providers who are not designated as PDCM providers
- Services performed by providers outside the state of Michigan.

#### Blue Distinction Total Care (BDTC)

BDTC services are covered only when they are performed by designated providers outside the state of Michigan and the member has an established relationship with the designated provider. Designated providers are identified by the local Blue Cross/Blue Shield plan in the state where the BDTC services are performed.

This section describes what is covered under BDTC.

The Plan covers services for BDTC in, subject to the conditions described below, an office, a participating outpatient hospital or participating facility, a member's home, and other locations as designated by the local Blue Cross/Blue Shield plan in the state where the services are provided.

The Plan covers services of out-of-state, providers who are designated by their local Blue Cross/Blue Shield plan to provide care management services

BDTC services may include:

- Telephone, individual face-to-face, and group interventions
- Medication assessments to identify:
  - The appropriateness of the drug for your condition
  - The correct dosage
  - When to take the drug
  - Drug Interactions
- Setting goals by your primary care physician (PCP), your care manager, and yourself to help you manage your health better.

Most BDTC services include support for setting goals and ensuring patient participation.

Your physician will determine your eligibility and refer you for care management services based on factors, such as your:

- Diagnosis

- Admission status
- Clinical status.

You may opt-out of BDTC at any time. The local Blue Cross/Blue Shield plan may also terminate BDTC services based on:

- Your nonparticipation in BDTC
- Termination or cancellation of your BCBSM coverage
- Other factors.

The Plan does not cover:

- Services performed by providers who are not designated by the local Blue Cross/Blue Shield plan as BDTC providers
- Services performed in Michigan.

## ARTICLE V - ADDITIONAL BENEFITS

### ***Section 5.01 - Death Benefit***

If a Participant dies before retirement while a current member of the Union and an active Bargaining Unit Employee with at least 500 earned hours within 24 months of death, the Plan shall pay a single sum death benefit of \$25,000 to the Participant's designated Beneficiary.

If a Retiree dies and was either eligible for the Plan or had earned at least 500 hours within 24 months of death, the Plan shall pay a single sum death benefit of \$1,000 to the Retiree's designated Beneficiary.

In the event that the deceased Employee dies without designating a Beneficiary or in the event that the designated Beneficiary has predeceased the Employee, the amount of the Death Benefit shall be paid to any one or more of the following surviving individuals, in descending order:

- 1) To your Spouse, if living;
- 2) To your living children in equal shares;
- 3) To your living parents in equal shares;
- 4) To your living brothers and sisters in equal shares;
- 5) To your Estate.

An eligible Employee may designate any natural person or persons or legal entity as the Beneficiary of any Death Benefit payable from the Plan by filing the designation, in writing, with the Administrative Manager. An eligible Employee may designate a new Beneficiary at any time by filing a new Beneficiary Designation Form with the Administrative Manager. Any change shall NOT become effective until it is received by the Administrative Manager, and neither the Plan nor the Trustees shall be liable for any payment made before the change was received by the Administrative Manager.

If an eligible Employee designates more than one Beneficiary without specifying their respective interests, the Death Benefit will be paid in equal shares.

Notwithstanding the foregoing, an Employee's designation of his/her spouse as Beneficiary shall become null and void automatically upon divorce. Should the Employee wish to maintain the Beneficiary designation of an ex-spouse, he/she must fill out a new beneficiary card after the divorce.

### ***Section 5.02 - Disability Benefit – Weekly (Active Eligible Participants Only)***

When an Accident (including a motor vehicle accident) or Sickness shall disable and prevent an eligible Employee from performing any and every duty pertaining to his/her employment, the Plan will pay the weekly benefit as set forth in the Schedule of Benefits with supporting Physician's orders.

Weekly benefits shall be payable only to those employees belonging to a collective bargaining unit who:

1. Are enrolled for employment through the hiring procedures of the Union; and,
2. Are ready, willing, and actively seeking employment under the hiring procedures of the Union, subject only to the contingency of their medical conditions; and,
3. Are not seeking employment and have not been otherwise employed outside the hiring procedures of the Union; and,
4. Are not receiving and have not applied for any benefits from any welfare plan or fund to which an Employer makes contributions; and,
5. Is under direct and continuing care of a Medical Provider.

In the event a participating employee of the Plan who is receiving weekly disability benefits from the Plan ceases to meet all of the tests for continued eligibility under the Plan, including the above tests, the Administrative Manager shall cease in making further weekly disability payments to the employee. The Administrative Manager shall be authorized to require the employee seeking weekly disability payments to supply evidence, satisfactory to the Trustees, of his/her compliance with all of these requirements for eligibility to receive such benefits. An employee claiming disability benefits shall submit to such examinations by physicians engaged by the Trustees who may from time to time be required by rules and regulations duly promulgated by the Trustees.

No benefits shall be payable under this Section unless the eligible Employee is under the regular care and attention of a Physician or Surgeon.

Only non-occupational disability injuries and illnesses are eligible for this benefit. For the purposes of this benefit, any injury which arises out of or in the course of any occupation or employment for wage or profit will be considered an Occupational Disability. All other disabilities will be considered a Non-occupational Disability.

#### Commencement of Benefits

Weekly disability benefits shall begin on the first day of an accident disability, the first day hospitalized, or on the eighth day of sickness.

A continuous period of disability shall include all periods of disability due to the same or related causes or causes separated by less than eight weeks of continuous, full-time active work. Once the employee has returned to continuous, full-time work for a period of at least eight weeks, any subsequent disability shall be deemed a new disability irrespective of how the disability is incurred.

#### Proof of Loss

Written proof of loss under any weekly disability benefit coverage must be given to the Administrative Manager within 90-days after the end of the period for which the disability is claimed. Written proof of loss under any other coverage must be given to the Administrative Manager within 90 days after the loss. Proof of loss must cover the occurrence, the character, and the extent of the loss.

Late proof may be accepted only if, under the particular circumstances, the proof was furnished as soon as was reasonably possible, and in any event, except in the absence of your legal capacity, within one year after the time the proof was otherwise required. However, each case must be presented to the Board of Trustees for their decision.

#### ***Section 5.03 - Prescription Drug Benefit***

The Prescription Drug Plan is administered through EnvisionRx. When a non-occupational injury or Sickness causes an Eligible Person to need prescription drugs, the Plan will pay benefits according to the Schedule of Benefits. Prescription drugs can be legally obtained only by the written prescription of a Physician.

Your prescription coverage, as administered by EnvisionRx, works on a 3 Tier system. Generic equivalents are Tier 1 and are the first choice whenever possible. Tier 2 drugs are a set of preferred brand-name drugs. Tier 3 drugs are non-preferred brand name drugs. The higher Tiers in this structure require higher copayments. For a listing of preferred medications, you may contact EnvisionRx at 1-800-361-4542.

### Retail Prescriptions

Prescriptions purchased at a retail pharmacy are limited to a 34-day supply. To obtain prescriptions at a retail pharmacy, you must present your EnvisionRx prescription drug card. This card indicates an alternative ID number, which is your identification number.

### Mail Order Prescriptions

Mail order prescriptions must be purchased through the EnvisionRx Mail Order system. The Mail Order Program allows for up to a 90-day supply of the prescription, and is usually used for maintenance medications.

Mail order will take approximately seven (7) to 15 days for processing and delivery, so contact your physician as soon as possible if you need a prescription. If you require a maintenance medication right away, have your physician write two prescriptions, one that can be filled immediately at your retail pharmacy for a 34-day supply, and one for a 90-day supply to be submitted to EnvisionMail.

How to Utilize the Mail Order System: You may choose one of two ways to use the Mail Order System:

1. By Mail Upon Completion of a Mail Order Brochure: Contact the Benefit Office for a Mail Order Brochure. Complete and mail to EnvisionMail. You must fill out the patient profile section of the brochure. Each patient must fill out a separate patient profile form. Also include your prescription written for a 90-day supply and your first form of payment, either a check or your credit card information along with the patient profile form(s). Your copayments are listed above and can also be obtained by calling EnvisionRx at 1-800-361-4542 or EnvisionMail at 1-866-909-5170. To assist with proper identification when calling, please identify yourself as a Sheet Metal Workers Local 7 Zone 3 Health Care Plan participant with EnvisionRx.
2. On-Line Via the Web: Go to [www.envisionpharmacies.com](http://www.envisionpharmacies.com). On this page elect the EnvisionMail link at the top of the page. You will be directed to the "Patients" page where you can sign in or enroll if you are new to the plan. You must complete the patient profile information before placing any online prescription order. On the patient profile, you will be asked to provide your prescription insurance information. Once the patient profile has been completed, you will have options on how to place your order and how to submit the new prescription to the pharmacy. Please follow the directions as provided on the website.

### EnvisionRx Website

You will find information about your prescription benefits at [www.envisionrx.com](http://www.envisionrx.com). You must first create an account. Once your account has been created you will have access to the following information:

- Overview of your plan and benefits
- Drug coverage and pricing, including co-pays
- Mail order information
- Direct member reimbursement form
- Prescription history
- Participating pharmacies.

### Glucometer Replacement

EnvisionRx has a program available to members that allows them to receive a free glucometer. Call 1.866.224.8892 for an Abbott Diabetes Care FreeStyle Glucometer (FreeStyle Lite® Meter, FreeStyle Freedom Lite® Meter, and FreeStyle InsuLinx® Meter) or Precision Xtra Blood Glucose & Ketone Monitoring System (Precision Xtra® Meter) or order online at [www.ChooseFreeStyle.com](http://www.ChooseFreeStyle.com) (by selecting EnvisionRx). Or, call 1.866.868.8425 for a OneTouch Glucometer (Verio Meter, Verio IQ Meter, Verio Sync System, Ultra 2 Meter, and Ultra Mini Meter) or visit online at [www.onetouch.orderpoints.com](http://www.onetouch.orderpoints.com)

(order code: 737ERX001). Please identify EnvisionRx as your pharmacy benefits administrator. There is a limit of one glucometer per member.

#### Over-the-Counter Claritin and Prilosec

In an effort to keep prescription drug costs down, certain over-the-counter medications are covered by EnvisionRx; these are Claritin and Prilosec OTC. When these drugs are purchased as a prescription, no copayment is required. This means there is no out-of-pocket cost for the purchase of these prescriptions.

To obtain Claritin and/or Prilosec with no copayment, the following steps must be followed:

1. Obtain a valid prescription from your physician for Claritin or Prilosec.
2. Go to your pharmacy and ask the pharmacist to process the prescription for Claritin or Prilosec using your prescription insurance card.

It is vital that you have the pharmacist process your prescription with your Envision card. If you pay for Claritin or Prilosec out-of-pocket, you will not be reimbursed under any circumstances. The prescription must be processed by the pharmacist, utilizing your EnvisionRx ID card.

#### Non-Reimbursable Prescriptions

The Sheet Metal Workers Local 7 Zone 3 Health Care Fund will not reimburse any prescriptions filled at Wal-Mart or Sam's Club, regardless of their affiliation with the Plan's prescription network. Therefore, any prescriptions filled at Wal-Mart or Sam's Club will be denied for reimbursement.

Your Sheet Metal Workers Local 7 Zone 3 Union is dedicated to advancing the principles and practices of union labor. As you know, your Local consistently works to promote and reward entities which utilize union labor. To be consistent with their policy of promoting union labor, the Board of Trustees has made the decision to discontinue reimbursing any prescriptions obtained at these stores.

#### ***Section 5.04 - Dental Benefit***

##### Schedule of Benefits – Active Employees

The dental program has an 80% co-insurance and a \$1,000 maximum benefit, per calendar year, per eligible participant/eligible dependent.

##### Schedule of Benefits – Retirees and Surviving Spouses

The dental program has a 50% co-insurance and a \$500 maximum benefit per calendar year, per eligible participant/eligible dependent.

#### Benefits

These dental benefits are payable for an examination for check-up purposes, injuries and dental defects or disease, and include the following:

##### *Class I: Diagnostic and Preventative Services*

The following services are Class I services:

- Oral Exams routinely every six (6) months
- Bite wing x-rays routinely every 12 months
- Full mouth x-rays routinely every three (3) years
- Teeth Cleaning every six (6) months
- Sealants: Up to age 19.

*Class II: Restorative, Endodontic and Periodontal Services, Adjunctive Services, Oral Surgery and Limited Prosthodontic Services*

The following services are Class II services:

- Fillings
- Crowns, inlays and onlays
- Root canal therapy
- Pulp capping and pulpotomy
- Periodontitis treatment
- Gingivitis treatment
- General anesthesia
- Extractions: simple and surgical
- Repairs to existing dentures
- Relining and rebasing of dentures
- Occlusal Guards.

*Class III: Extended Prosthodontic Services, Construction and Installation of Complete and Partial Dentures*

The following services are Class III services:

- Removable Dentures
- Fixed bridges
- Bridge pontics
- Abutment crowns, inlays, and onlays

This class includes replacement after five (5) years if unserviceable or cannot be relined for a proper fit.

*Class IV: Orthodontic Services: Interceptive and Comprehensive Treatment*

The following services are Class IV services:

- Habit breaking appliances
- Appliance construction
- Full banding treatment
- Minor tooth guidance appliances
- Application installation
- Monthly active treatment visits.

Dependent children of active employees, up to their 19th birthday, shall be eligible for an additional orthodontic benefit. This benefit will be subject to 80% co-insurance, up to \$1,000 maximum per person per year.

*Complete Dental Replacement Benefit*

Benefits are payable for a portion of the cost, subject to usual dental coinsurance, for replacement of complete dentures, which is not the result of theft or loss of a previous denture, provided the eligible individual was eligible under the dental benefit for six (6) months prior to such replacement.

No benefits will be paid for any replacement of a previous denture which was covered under this dental expense benefit, either as an initial complete denture or as a replacement, which is not separated from such prior treatment by five (5) years in which the individual was eligible for dental benefits.

*Mandibular Staple Procedure – Active Employees and Their Dependents*

This procedure will be paid the same as any other dental expense up to the maximum of \$1,000.00. Charges in excess of the \$1,000.00 maximum benefit may be extended to the Major Medical Benefit up to a maximum of \$3,000.00 to be paid by a combination of both dental and Major Medical Benefits.

No benefits will be paid for any replacement of a previous denture which was covered under the Dental Plan either as an initial complete denture or as a replacement which is not separated from such prior treatment by five (5) years in which the individual was covered by the dental benefits.

*Mandibular Staple Procedure – Retirees, Surviving Spouses, and Their Dependents*

This procedure will be paid the same as any other dental expense up to the maximum of \$500.00.

No benefits will be paid for any replacement of a previous denture which was covered under the Dental Plan, either as an initial complete denture or as a replacement, which is not separated from such prior treatment by five (5) years in which the individual was covered by the dental benefits.

Exceptions

No benefits shall be paid for the following dental care and services which:

1. Resulted from any injury that resulted from or is related to the occupation of the eligible individual, or one for which benefits are payable under any Workers' Compensation Act or similar legislation;
2. Resulted from war, declared or undeclared, or any act of war or aggression;
3. Were paid for, furnished by, or at the direction of any Government Agency, but only to the extent so paid or furnished;
4. Were rendered solely for cosmetic purposes, unless resulting from accidental bodily injuries sustained while covered hereunder;
5. Were paid by the Fund under any other benefit;
6. Was the result of an automobile accident or injury.

Claims Filing Procedures

File your dental claims with the Administrative Manager at:  
Sheet Metal Workers Local 7 Zone 3 Health Care Fund  
P.O. Box 547  
Troy, Michigan 48099-0547.

## ARTICLE VI - BENEFIT EXCLUSIONS & LIMITATIONS

The Plan provides Benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated as such.**

If you are unsure whether a medical service or procedure is excluded, please contact the Administrative Manager for clarification. Failure to do so could result in you being responsible for any non-covered or excluded charges you incur.

In addition to any other limitations, either specific or general, set forth in the Plan, benefits shall **NOT** be paid or payable for any loss caused by, incurred for, or resulting from:

1. Noncontractual services that are described in your case management treatment plan, if the services have not been approved by the Plan.
2. Gender reassignment services that are considered by BCBSM to be cosmetic, or treatment that is experimental or investigational.
3. Court ordered services
4. Hospital admissions for services that are not acute, such as:
  - a. Basal metabolism tests
  - b. Cobalt or ultrasound studies
  - c. Convalescence or rest care
  - d. Convenience items
  - e. Dental treatment, including extraction of teeth, except as otherwise noted in this certificate
  - f. Diagnostic evaluations
  - g. Electrocardiography
  - h. Lab exams
  - i. Observation
  - j. Weight reduction (unless covered elsewhere in this Plan or otherwise required by law)
  - k. X-ray, exams or therapy
  - l. Those mainly for physical therapy, speech and language pathology services or occupational therapy
5. Excluded hospital services:
  - a. Services that may be medically necessary but can be provided safely in an outpatient or office location
  - b. Custodial care or rest therapy
  - c. Psychological tests if used as part of, or in connection with, vocational guidance training or counseling
  - d. Outpatient inhalation therapy
  - e. Sports medicine, patient education or home exercise programs
6. Excluded facility services:
  - a. Facility services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution
    - i. If a nursing home is your primary residence, then the Plan will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.
7. Excluded professional provider services:

- a. Services, care, supplies or devices not prescribed by a physician
  - b. Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or children
  - c. Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed in “Section 4.46 - Surgery” on page 65.
  - d. Weight loss programs (unless covered elsewhere in this Plan or otherwise required by law)
  - e. Services provided during nonemergency medical transport
  - f. Experimental treatment
  - g. Prescription drug compounding kits or services provided to you related to the kits
  - h. Hearing aids or services to examine, prepare, fit or obtain hearing aids
  - i. Services provided by persons who are not eligible for payment or not appropriately credentialed or privileged. Providers who are not legally authorized or licensed to order or provide such services.
  - j. Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
  - k. Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)
  - l. Infertility services that do not treat a medical condition other than infertility. This can include services such as:
    - i. Sperm washing
    - ii. Post-coital test
    - iii. Monitoring of ovarian response to ovulatory stimulants
    - iv. In vitro fertilization
    - v. Ovarian wedge resection or ovarian drilling
    - vi. Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
    - vii. Diagnostic studies done for the sole purpose of infertility assessment
    - viii. Any procedure done to enhance reproductive capacity or fertility
  - m. Sports medicine, patient education (except as otherwise specified) or home exercise programs
  - n. Screening services (except as otherwise stated)
  - o. Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution
  - p. Non-contractual services described in your case management treatment plan when such services have not been approved by BCBSM.
8. Maternity charges incurred by a covered person acting as a surrogate mother are not covered charges. For the purpose of this Plan, “surrogacy” means that the mother has entered into a contract or other understanding pursuant to which she relinquishes a child or children following birth. All expenses paid by the Plan in such cases may be recovered from the Participant, the Participant’s spouse and/or the third party or any related parties. Care, services or treatments required as a result of complications from a surrogate pregnancy by the Participant or Participant’s spouse will not be covered under the Plan;
9. Services or supplies provided to a Participant within any foreign country which is covered at the time of the expense by an active U.S. Department of State Issued Travel Warning.

## **ARTICLE VII - CLAIMS & APPEALS PROCEDURE**

### ***Section 7.01 - Claims and Appeals Generally***

Benefits are paid either directly to the service provider (with your written authorization) who has agreed to accept payment from the Plan, or as a reimbursement to you after you incur a covered expense. Before benefits can be paid to you, you may need to obtain appropriate claim form(s).

Hospital and medical benefits are provided through the Blue Cross Community Blue Preferred Provider Organization (PPO). Prescription benefits are provided through EnvisionRx.

The “Claims Administrator” is the entity that reviews claims for benefits and appeals. For initial claims determinations, the Claims Administrator is Blue Cross Blue Shield of Michigan (BCBSM) for medical claims, EnvisionRx for prescription claims, or the Administrative Manager for all other claims. Humana Medicare Advantage is the Claims Administrator for Medicare-eligible claims. The Board of Trustees is the Claims Administrator for Appeals.

As described in more detail below, certain types of Adverse Benefit Determinations and Final Adverse Benefit Determinations may be eligible for external appeal (review by a third party). You may authorize a representative to submit claims as well as appeals on your behalf.

An Adverse Benefit Determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant’s or Beneficiary’s eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. A retroactive cancellation or rescission of coverage is also included in this definition, even if it has no adverse effect on a particular benefit.

### ***Section 7.02 - Claim Submissions***

Each claim shall be presented within one (1) year of the date charges for the service was incurred. Claims filed later than that date may be declined or reduced. If you were unable to submit a claim within the one (1) year deadline, you may request a waiver by contacting the Administrative Manager. Each request for waiver of the one (1) year deadline will be reviewed on a case-by-case basis. Waivers, if able to be granted under law and/or any applicable contractual restrictions, will only be granted upon a showing of unique and extraordinary circumstances. To be considered a properly submitted claim under this Plan, each claim must generally name a specific person, identify a specific medical condition or symptom, identify a specific treatment, service, or product for which approval is requested, and be received by a person or organizational unit of the Claims Administrator that is customarily responsible for handling benefit matters. If you have questions on how to submit claims, please contact the Administrative Manager.

### ***Section 7.03 - Claim Forms***

The Administrative Manager, upon request, will furnish all necessary forms for the filing of proof of loss.

### ***Section 7.04 - Exhaustion of Claims & Appeals Procedures***

You are generally required to exhaust the internal claims and internal appeals processes of this Plan before you are permitted to seek external review or file a lawsuit with respect to your claim. If the Claims Administrator fails to adhere to the claims and appeals process outlined in this section, and the error is

not minor, you will have been deemed to have exhausted the internal appeals process and can proceed directly to requesting an external appeal or filing a civil action in court under ERISA. You will also be deemed to have exhausted the internal review process if the Plan waives internal appeal or in urgent care situations where simultaneous expedited internal and external review may occur. However, if the Claims Administrator's error is minor or "de minimis" then you will have to complete the internal appeals process before proceeding with an external appeal or filing a lawsuit. This means that if any error of the Claims Administrator is not material and will not prejudice you, and is further part of a good faith exchange of information between you and the Claims Administrator, you must still complete both levels of the internal appeals process before seeking an external appeal or filing a lawsuit. If you believe the claims process has not been strictly adhered to, you may request a statement from the Claims Administrator. The Claims Administrator will provide you with a response within 10 days. If you pursue an external review or a lawsuit, and a Court or IRO rejects your assertion that the Claims Administrator did not strictly adhere to the claims process, you will be able to return to the internal claims and appeals processes of this Plan. The Claims Administrator will provide you with notice of your right to return to the internal claims and appeals process within 10 days of the rejection of the claim for immediate external review.

### ***Section 7.05 - Claim Types & Decision Timeframes***

Claims for payment for services rendered to you are categorized, usually by the urgency of the claim. The types of claims and the rules that apply to each are summarized below. These definitions are summaries only.

#### Urgent Care Claims

These are emergency claims, claims that could jeopardize the health of the patient, or those that would cause the patient to be in severe pain without the care or treatment needed. The Plan will defer to the attending providers as to whether a claim involves urgent care. Urgent care claims will be decided within 72 hours. If more information is needed to decide an urgent care claim, or you failed to follow the Plan's procedures for submitting a claim, you will be notified within 24 hours of the receipt of the claim. This notification may be oral, unless you or your authorized representative requests a written notification. You will then have at least 48 hours to provide the information needed. You will then be notified of the decision within 48 hours of the receipt of the information, or within the 48 hours you had to supply it. You may be notified orally of the decision, but you still will be provided a written decision on the claim within 72 hours of the oral notification.

#### Concurrent Care Decisions

These are claims for an ongoing course of treatment to be provided over a period of time that was approved in advance. If the length of treatment approved is reduced, you will be provided with written notice within a sufficient amount of time for you to appeal that decision before the course of treatment or benefit is reduced or terminated. If you request to extend a previously approved course of treatment, you will be notified within 24 hours of the Claims Administrator's receipt of your request for that extension if you requested the extension at least 24 hours prior to the expiration of the approved length of treatment.

#### Pre-Service Claims

These are claims for care that are approved in advance. If enough information is available, Pre-Service claims will be decided within 15 days of the receipt of the claim. If you failed to follow the Plan's procedures for submitting the claim, you will be notified of the defect. The notice may be oral, unless you or your representative requests written notification. If more time is needed to decide your claim due to circumstances beyond the Claims Administrator's control, the initial 15-day period may be extended by another 15 days. You will be notified prior to the expiration of the initial 15-day period if an extension is needed. The notice will explain the reason for the delay and give an estimate of when a decision will be

made. If additional necessary information is required, you will also have at 45 days to provide it. The claim will then be decided by the first to occur of the following: (a) 15 days of you supplying the information, or (b) by the end of the 45-day period you had to supply the information.

#### Post-Service Claims

These are claims submitted after you have obtained the treatment. If enough information is available, Post-Service claims will be decided within 30 days of the receipt of the claim. If more time is needed, this period can be extended by 15 days. You will be notified prior to the expiration of the initial 30-day period if an extension is needed. The notice will explain the reason for the delay and give an estimate of when a decision will be made. If additional necessary information is required, you will also have at 45 days to provide it. The claim will then be decided by the first to occur of the following: (a) within 15 days of you supplying the information, or (b) by the end of the 45-day period you had to supply the information.

#### Disability Claims

Disability claims will generally be decided within 45 days after the receipt of the claim. If more time is needed to decide your claim due to circumstances beyond the Claims Administrator's control, this period can be extended by 30 days. If this occurs, you will be notified prior to the end of the initial 45-day period. The notice will explain the reasons for the delay and give an estimate of when a decision will be made. If a decision is still not able to be rendered after the 30-day extension, then this period may be extended again for an additional 30 days. If this occurs, you will be given notice of this second extension prior to the end of the first 30-day extension. Once again, the notice will explain the reasons for the delay and give an estimate of when a decision will be made. If more information is required to decide your claim during either extension period, then you will be given at least 45 days to provide that information. The claim will then be decided by the first to occur of the following: (a) within 30 days of you supplying the information, or (b) by the end of the 45-day period you had to supply the information.

#### Death Benefit Claim

If enough information is available, Death Benefit claims will be decided within 30 days of the receipt of the claim. If more time is needed, this period can be extended by 15 days. You will be notified prior to the expiration of the initial 30-day period if an extension is needed. The notice will explain the reason for the delay and give an estimate of when a decision will be made. If additional necessary information is required, you will also have at 45 days to provide it. The claim will then be decided by the first to occur of the following: (a) within 15 days of you supplying the information, or (b) by the end of the 45-day period you had to supply the information.

#### How Time is Calculated

The time periods for review start when a claim is filed correctly (i.e. identifies the claimant & condition and is sent to the proper department of the Claims Administrator), even if some additional information is needed to decide the claim. If an extension of time is needed, the time period to decide a claim is generally suspended until the additional information needed is provided, or the period of time given to you to provide the information expires.

#### ***Section 7.06 - If Your Claim is Denied***

In the event your claim is denied, you will receive a notice of Adverse Benefit Determination from the Claims Administrator that will explain the specific reasons for denying your claim and it will reference the section of the Plan Document or Schedule of Benefits upon which the denial is based. If applicable, the notice will also include information sufficient to identify the claim including the date of service, the health care provider and if applicable the claim amount, diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning. If applicable, the notice will also advise you of any

additional information which is needed to make a further determination of your claim. The notice will explain the Plan's review procedures and time limits applicable to such procedures. It will also explain your rights to file a civil action under ERISA, which is the federal law that regulates employee benefit plans. The notice will also explain to you the process for filing an expedited appeal if the claim is of an urgent nature, as well as your rights to file an external appeal of the Claims Administrator's decision.

If applicable the notice will also include:

1. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or
2. If the denial is based on medical necessity, because a treatment was experimental, or another similar exclusion or limit, either an explanation of the scientific or clinical judgement for the denial, applying the terms of the Plan to the claimant's medical circumstances shall be provided to the claimant, or a statement that such an explanation will be provided free of charge upon request.

In the case of an adverse benefit determination of Disability Claims, the notice shall also include the following in the culturally and linguistically appropriate manner:

1. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - a. The views presented by claimant to the plan of health care professional treating the claimant and vocational professionals who evaluated the claimant;
  - b. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the determination; and
  - c. A disability determination regarding the claimant presented by the Social Security Administration.
2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
3. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and.
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

### ***Section 7.07 - Internal Appeal***

You will have 180 days after receiving the notice of Adverse Benefit Determination to submit your appeal to be reviewed by the Board of Trustees. The written notice only needs to state the claimant's name, address, and the fact that you are appealing from the decision of the Claims Administrator, as well as giving the date of the decision being appealed. You should send a request for an Appeal to the Administrative Manager. You may submit written comments, documents, records, and other information relating to the claim.

Upon request and free of charge, you will be provided reasonable access to, and copies of, all relevant documents, records, and other information. Any new evidence or additional rationale that is considered,

relied upon, generated by (or at the direction of) the Claims Administrator or Board of Trustees will be provided to you, free of charge. This information will further be provided to you before the Board of Trustees will make a decision on your appeal so that you have an opportunity to respond to it. If this new evidence or additional rationale is received too late for you to have a reasonable opportunity to respond to it before the Board of Trustees is required to decide your appeal, the time for issuing a final decision on your claim will be tolled for a reasonable period of time until you have responded to the new evidence or rationale, or failed to respond within the time given to you. In this instance, a decision will be made as soon as possible, taking into account any medical exigencies.

The Board of Trustees will provide for a review that takes into account all comments, documents, records, and other information submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Board’s review will not afford deference to the initial adverse benefit determination.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Claims Administrator will provide identification of medical or vocational experts whose advice was obtained, without regard to whether the advice was relied upon in making the benefit determination. This health care professional will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual

In the event of a denial by the Board of Trustees, you will receive a notice of Final Adverse Benefit Determination explaining the reason for the decision, and advising you of your rights relative to the decision under ERISA, including the right to an external appeal. You will also be notified if your claim is approved. The Trustees shall have full authority to interpret the provisions of this Plan and it is within the sole and absolute discretion of the Trustees to determine if you are entitled to receive a benefit and the amount of the benefit. The decision will be final and binding. You will receive notice of the Board of Trustees’ decision generally within the following time frames:

<b>Type of Appeal</b>	<b>Urgent</b>	<b>Pre-Service</b>	<b>Post-Service*</b>	<b>Disability*</b>
<b>Notification of Decision</b>	72 hours	30 days	5 days after decision made at Board of Trustees meeting	5 days after decision made at Board of Trustees meeting

\* The Trustees shall make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan’s receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan’s receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan’s receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Claims Administrator shall notify the claimant in writing of the extension. The Claims Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

If applicable the notice will include:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan provisions on which the benefit determination is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant documents, records, and other information.
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion shall be provided to the claimant, free of charge and upon request, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or
5. If the denial is based on medical necessity, because a treatment was experimental, or another similar exclusion or limit, either an explanation of the scientific or clinical judgement for the denial, applying the terms of the Plan to the claimant's medical circumstances shall be provided to the claimant, or a statement that such an explanation will be provided free of charge upon request.

In the case of an adverse benefit determination of Disability Claims, the notice shall also include the following in the culturally and linguistically appropriate manner:

1. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - a. The views presented by claimant to the plan of health care professional treating the claimant and vocational professionals who evaluated the claimant;
  - b. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the determination; and
  - c. A disability determination regarding the claimant presented by the Social Security Administration.
2. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; OR; If the denial is based on medical necessity, because a treatment was experimental, or another similar exclusion or limit, either an explanation of the scientific or clinical judgement for the denial, applying the terms of the Plan to the claimant's medical circumstances shall be provided to the claimant, or a statement that such an explanation will be provided free of charge upon request.
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

#### Plan's Failure to Adhere to Procedures

If the Plan fails to strictly adhere to all the requirements of the claims and appeals sections of the Plan with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the Plan, except for de minimis violations explained below. As such, the claimant is entitled to pursue any available remedies under section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

The administrative remedies available under the Plan with respect to claims for disability benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause,

prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the claimant's request for immediate review under this section on the basis that the Plan met the standards for the exception under this paragraph, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

### ***Section 7.08 - External Appeals***

If you receive a Final Adverse Benefit Determination that involved either (1) a rescission of coverage, or (2) the denial of a claim based upon the exercise of medical judgment, you can file what is called an external appeal that will be heard by an accredited independent third party, commonly called an Independent Review Organization or "IRO". The IROs do not have conflicts of interest that influence their independence. This process is explained below.

#### Claims Subject to External Review

Only certain types of claims can be reviewed by an IRO. Specifically, only claims that (1) involved an exercise of medical judgment; (2) a recession of coverage; and (3) incorrect coding, but only to the extent a coding error involved an exercise of medical judgment. Claims regarding the application of other provisions of this Plan, for example, whether or not you met the eligibility requirements, are not subject to external review.

#### Request for External Review

If the Board of Trustees denies your claim (you receive a final Adverse Benefit Determination), you have four (4) months to request an external review. However, only claims involving the exercise of medical judgment or for a retroactive rescission of coverage are eligible for external review. If there is no corresponding date four (4) months after the date of receipt of the denial, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

#### Preliminary review

Within five (5) business days following the receipt of the request for an external review, the Plan will complete a preliminary review of the request to determine the following:

1. Whether the claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
2. Whether the Adverse Benefit Determination or the Final Adverse Benefit Determination relates to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);
3. Whether the claimant has exhausted the Plan's internal appeal process, unless the claimant is not required to exhaust the internal appeals process;
4. Whether the claimant has provided all the information and forms required to process an external review.

### Post-Preliminary Review

Within one (1) business day after completion of the preliminary review, the Plan will issue a written notice to the claimant noting the reasons, if the claim is not eligible for external review, along with contact information for the Employee Benefits Security Administration (EBSA), or, the information needed if the application for the review is not complete. The claimant shall have the latter of (a) the 4-month filing period, or (b) the 48-hour period following the claimant's receipt of the notification to provide any additional information that is needed.

### Referral to Independent Review Organization (IRO)

At the conclusion of the Preliminary Review, the Plan will then refer eligible claims to a randomly selected IRO and immediately provide coverage if the decision of the Board of Trustees is overturned. The IRO's decision is binding on the Plan and the claimant. The Plan shall adhere to all terms of the contract with the IRO. No costs will be imposed on you for filing an external review. The IRO will retain all records for at least three (3) years.

### ***Section 7.09 - Expedited External Review***

This is an option to have your request for external review expedited due to the urgent nature of the claim. A claimant may request an expedited external review at the time the claimant receives either of the following:

1. An Adverse Benefit Determination that involves a medical condition where delay would jeopardize the claimant's health or ability to regain maximum function and the claimant has made a request for an expedited internal appeal;
2. A final internal Adverse Benefit Determination where the claimant has a medical condition where the timeframe for a normal external review would jeopardize the claimant's health or ability to regain maximum function, or, if the determination involves an admission, availability of care, continued stay, or a health care or service for which the claimant received emergency services but has not yet been discharged.

### Preliminary Review

Immediately upon receipt of the request for an expedited review, the Plan shall determine whether the request meets the requirements for external review. This determination is made by applying the criteria for a standard external preliminary review, discussed above.

### Post Preliminary Review

Within one (1) business day after completion of the preliminary review, the Plan will issue a written notice to the claimant noting the reasons, if the claim is not eligible for external review, along with contact information for the Employee Benefits Security Administration (EBSA), or, the information needed if the application for the review is not complete. The claimant shall have the latter of (a) the 4-month filing period, or (b) the 48-hour period following the claimant's receipt of the notification to provide any additional information that is needed.

### Referral to IRO

If the Plan determines the request is eligible for expedited external review, then an IRO will be assigned the claim in the same manner as for a standard external review. The Plan shall provide the IRO with all the information used in making the benefit determination in the most expeditious manner available. If the IRO overturns the decision of the Board of Trustees, the Plan will immediately provide coverage. The IRO's decision is binding on the Plan and the claimant. No costs will be imposed on you for filing an expedited external review. The IRO will retain all records for at least three (3) years.

***Section 7.10 - Additional Rights***

If you have exhausted your claim review and appeals rights under the procedures set forth in this section, you may pursue any other legal remedies available, which may include bringing a civil action under ERISA Section 502(a) for judicial review of the adverse determination regarding your claim in order to recover benefits due to you under the Plan's terms, to enforce your rights under the Plan's terms, or to clarify your rights to future benefits under the Plan. However, there is a three-(3) year limitation period for appeals. This means that if you do not bring legal action within three years from the date that the Board provided you with written notice of a decision on an appeal of an adverse benefit determination, you shall forever be barred from such action. You may only bring an action in connection with the Plan in the United States District Court for the Eastern District of Michigan. You may obtain additional information about your right to pursue other legal remedies from the local office of the United States Department of Labor.

## ARTICLE VIII - MISCELLANEOUS PROVISIONS

### ***Section 8.01 - Payment Of Benefits***

All benefits shall be payable through the employees or agents of the Trustees acting under their authority. The Trustees reserve the right to change, alter or amend the benefits from time to time as the conditions dictate. No benefits shall be payable except those specifically provided under the Plan and no person shall have any claim for any other benefits against either the Union, any Employer Association, any Employer or the Trustees. The Trustees, Employers, or the Union cannot be held liable for any contributions or benefits except those provided for in either the collective bargaining agreement or this Booklet.

### ***Section 8.02 - Medical Examination***

No medical examination shall be required to obtain coverage for benefits initially. However, the Trustees shall have the right, through a medical examiner of their choosing, to examine an Eligible Person as often as they may reasonably require during the pendency of a claim and the right and opportunity to request an autopsy in case of death where it is not forbidden by law.

### ***Section 8.03 - Construction By Trustees***

The Trustees have full authority and discretion to construe the provisions of this Plan and any construction made by the Trustees shall be final and binding on all parties. Benefits under this Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.

### ***Section 8.04 - Termination Of Coverage***

Benefits for an Eligible Person shall terminate on the last day of the calendar month in which the Eligible Person fails to meet the eligibility requirements, or chooses not to elect the Continuation of Coverage, or fails to make a required payment for the Continuation Coverage when due, or exhausts the maximum period of coverage provided under the Continuation of Coverage provisions or when the Plan terminates.

### ***Section 8.05 - Coordination Of Benefits***

All benefits provided under this Plan, with the exception of the Death Benefit and the Weekly Disability Benefit, shall be coordinated with any other plan of health care benefits. The term "other plan" means any plan besides this Plan providing benefits or services for or by reason of medical, dental or vision care or treatment, which benefits or services are provided by: (a) group, blanket, or franchise insurance coverage; (b) service plan contracts, group practice, individual practice, and other prepayment coverage; (c) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; (d) any coverage under governmental programs; and, (e) any coverage required or provided by any statute. Benefits shall be paid in accordance with the following Order of Benefit Determination:

- A. Generally, the plan that covers the person as an employee shall be known as the "Primary Plan" and shall pay its benefits first. The plan that covers the person as a spouse shall be known as the "Secondary Plan" and shall pay its benefits second. Coordination between Eligible Dependent children is as stated below.
- B. For Eligible Dependent children that have insurance coverage through their employer, the dependent child's employer provided coverage will pay as the Primary Plan.

- C. For Eligible Dependent children that do not have coverage through employment, the Primary Plan is the plan of the parent whose birthday (excluding the year of birth) occurs first in a Calendar Year (birthday rule).
- D. For Eligible Dependent biological or adopted children when the parents are separated or divorced: If there is a court decree which establishes the financial responsibility for the health care expenses of the child or children, the benefits shall be determined in accordance with the terms of the court decree, provided that the child meets the definition of Eligible Dependent on page 113. Otherwise, the birthday rule, as described in paragraph B, shall be applied.
- E. For Eligible Dependent step-children: this Plan will pay third after the insurances of both biological parents have been determined. If neither biological parent has insurance, this Plan will pay Primary, provided that the child meets the definition of Eligible Dependent on page 113.
- F. For Eligible Dependent children when both parents are Participants in the Plan, benefits will be paid as the father as Primary and the mother as Secondary.
- G. If the above rules do not establish an Order of Benefit Determination, the plan which has covered the person for the longer period of time shall be the Primary Plan, with the following exception: The benefits of a plan covering the person as a laid-off or retired employee, or a dependent of such person, shall be determined after the benefits of any other plan covering the person as an employee.
- H. Any plan that does not contain a Coordination of Benefits provision shall automatically be considered the Primary Plan.

In addition to the foregoing, if an Eligible Person is eligible to receive benefits or services pursuant to group or individual automobile or homeowners' policy without regard to fault or any other arrangement of insured or self-insured group coverage (other than that provided pursuant to the Eligible Person's own policy of insurance), then this Plan shall be secondary to such coverage.

### ***Section 8.06 - Subrogation***

Subrogation and reimbursement allows the Plan the ability to recoup the value of any benefits (medical, disability, Rx, etc.) paid on behalf of an Eligible Person covered by this Plan who has an Accident or suffers a Sickness through the actions or omissions of a person or entity accountable for the Accident or Sickness (hereinafter called an "Accountable Person"). The subrogation and reimbursement process helps the overall financial stability of the Plan by ensuring the Plan is not the only entity paying for Accidents and Sicknesses caused by an Accountable Person.

#### Right to Subrogate

The Plan is subrogated to any and all rights of recovery and causes of action that the claimant may have against any Accountable Person, whether by suit, settlement, or otherwise, that may be liable for a claimant's Accident or Sickness for which the Plan has paid or is obligated to pay benefits on the claimant's behalf.

Payment of benefits is conditional upon the claimant's written agreement to fully cooperate and reimburse the Plan for any benefits paid should the claimant recover monies or damages, or be compensated for the Sickness or Accident from the Accountable Person or any other source. The claimant must sign forms assigning subrogation and reimbursement rights to the Plan. The Administrative Manager may withhold

payment of any benefits due under the Plan until it receives the signed forms. Payment of Plan benefits before the signed forms are received does not modify or invalidate the Plan's subrogation and reimbursement rights. By accepting benefits from the Plan, every claimant shall be deemed to have conclusively agreed to cooperate with the Plan to enforce its subrogation and reimbursement rights, and to hold any recovery in trust for benefit of the Plan.

#### Rights to Reimbursement With Source of Funds Specifically Identified

In situations where an Accountable Person is liable, the claimant must reimburse the Plan the full value of the claims paid in connection with the Accident or Sickness, but only to the extent he or she recovers settlement, judgment or insurance proceeds (from any source) connected with the Accident or Sickness. A source includes, but is not limited to, an Accountable Person and/or an Accountable Person's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law, an individual policy of insurance maintained by a claimant and organization, corporation or government agency.

The Plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement, or otherwise even though the claimant may not have been fully compensated or "made whole" for all physical, psychological and/or financial damages. This provision rejects any "make whole" doctrine which would require a claimant to be "made whole" before the Plan is entitled to assert its subrogation rights. Even though the subrogation rights of the Plan are specifically unequivocally due from the first dollar received by the claimant or Beneficiary, the Plan reserves the right to exercise judgment as to the facts of each case. In determining each individual case, even though the Plan has the right to recover from the first dollar received, the Trustees may consider and allow for the cost of collection from the Accountable Person, including reasonable attorney's fees incurred by the claimant, in the sole discretion of the Trustees.

The Plan's rights also apply to any recovery made by a claimant regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

#### Equitable Lien by Agreement

Once the Plan makes or is obligated to make payments on behalf of a claimant, the Plan is granted, and the claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the claimant or Beneficiary from any source to the extent of payments made or to be made by the Plan on the claimant's behalf.

#### Claimant Must Set Aside Funds

The claimant shall hold in trust for the Plan's benefit that portion of the total recovery from any source that is due for payments made or to be made. The claimant shall reimburse the Plan immediately upon recovery.

#### Claimant's Duty to Reimburse

The claimant shall immediately notify the Plan if he is involved in or suffers an Accident or Sickness for which an Accountable Person may be liable. The claimant shall again notify the Plan if he or she pursues a claim to recover damages or other relief relating to an Accident or Sickness for which the Plan may make payments on the claimant's behalf. The claimant shall do nothing to impair, release, discharge or prejudice the Plan's rights to subrogation and/or reimbursement.

### Reduction of Future Benefits

The claimant has the responsibility to seek damages for future accident-related benefit expenses. The Plan has the discretion to take into consideration future accident-related medical expenses in negotiating a settlement. The Plan may settle all accident-related claims (past, present and future) in full (meaning that upon settlement, the Plan shall not be responsible for any further accident-related benefit expenses). The Plan reserves the right to deny future accident-related care with the understanding that the claimant shall be responsible for any future accident-related claims, as those benefits should be paid directly from the claimant's settlement proceeds.

### Disavowal of "Common Fund" Doctrine

The claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying Accident, Sickness or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses.

The Plan further asserts that the "Common Fund" doctrine does not apply to any proceeds recovered by an attorney the claimant or the claimant's Eligible Dependents may hire regardless of whether proceeds recovered are used to repay the benefits paid by the Plan.

**The Plan specifically disavows any claims that a claimant or Eligible Dependent may make under any federal or state common law defense including, but not limited to, the make whole doctrine and/or the Common Fund doctrine.**

### Cooperation

The claimant and legal representatives must do whatever is necessary to enable the Plan Administrator and Administrative Manager to exercise the Plan's rights and must do nothing to prejudice the Plan's rights. The Plan Administrator and Administrative Manager may require the claimant to complete and/or execute certain documentation to assist the Plan in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a repayment agreement.

The claimant shall assist and cooperate with representatives the Plan designates. The claimant shall do everything necessary to enable the Plan to enforce its subrogation and reimbursement rights. The claimant shall immediately notify the Plan upon receiving a judgment, settlement offer or compromise offer and shall not settle or compromise any claims without the Plan's consent.

In the event a claimant fails to reimburse the Plan the full value of its subrogated interest or otherwise fails to cooperate, the Plan shall be entitled to recover the Claimant's debt to the Plan in accordance with Plan rules for recovery and overpayments. This means that the Plan may, among other things, suspend all benefit payments due to a Claimant and deduct the amount of the subrogated interest from future benefit payments or to apply employer contributions made to the Claimant's behalf against the amount owed to the Plan. If you fail to disclose the amount of your settlement, the Plan is entitled to deduct the amounts of its lien from any future benefit under the Plan.

### Assignment of Benefits

The Plan reserves the right to make payments directly to the Participant or Eligible Dependent. When this occurs, the Participant or Eligible Dependent must pay the provider and the Plan is not obligated to pay additional amounts. The Participant or Eligible Dependent cannot assign their right to receive payment to anyone else nor can the Participant or Eligible Dependent authorize someone else to receive payments for you, including your provider. The Plan will not honor an assignment of the claim to anyone. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to initiate

any court proceeding. Nothing contained in the written description of the Plan's medical coverage shall be construed to make the Plan liable to any third-party to whom a Participant or Eligible Dependent may be liable for medical care, treatment or services.

***Section 8.07 - Health Care Fraud***

Health care fraud is a felony that can be prosecuted. Any Participant who willfully and knowingly engages in an activity intending to defraud this Plan will face disciplinary action and/or prosecution, including retroactive loss of benefits under the Plan. Furthermore, any Participant who receives money from the Plan to which he is not entitled will be required to fully reimburse the Plan.

***Section 8.08 - Right of Recovery***

If the Plan makes any payment which is determined in excess of the Plan's benefits, the Plan shall have the right to recover the amount determined to be in error. The Plan shall have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from future claim payments.

***Section 8.09 - HIPAA Privacy Rule***

A. Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a "group health plan" within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan sponsor, the Board of Trustees, to take all actions required to be taken by the Plan in connection with the Privacy Rule (i.e., entering into Business Associate contracts; accepting certification from the Plan Sponsor). Such responsibility may be delegated by the Board to the Administrative Manager.

B. Definitions

All terms defined in the Privacy Rule shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this Amendment.

1. "Plan" means this Plan.
2. "Plan Documents" mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to this Plan Document.
3. "Plan Sponsor" means "plan sponsor" as defined at §3(16)(B) of ERISA, 29 U.S.C. §1002(16)(B). The Plan Sponsor is the Board of Trustees of this Plan.

C. The Plan's Disclosure of Protected Health Information to the Plan Sponsor - Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will: (i) disclose Protected Health Information to the Plan Sponsor or (ii) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

1. The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the “504” provisions;
2. The Plan Documents have been amended to incorporate the Plan provisions set forth in this Section; and
3. The Plan Sponsor agrees to comply with the Plan provisions as modified by this Section.

D. Permitted Disclosure of Individuals’ Protected Health Information to the Plan Sponsor

1. The Plan (and any Business Associate acting on behalf of the Plan, or any health insurance issuer, HMO, PPO, health care provider, etc., as applicable, servicing the Plan) will disclose individuals’ Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions. Such disclosure will be consistent with the provisions of this Section.
2. All disclosures of the Protected Health Information of the Plan’s individuals by the Plan’s Business Associate, health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to the Plan Sponsor will comply with the restrictions and requirements set forth in this Section and in the “504” provisions.
3. The Plan (and any Business Associate acting on behalf of the Plan), may not permit a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to disclose individuals’ Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law.
4. The Plan Sponsor will not use or further disclose individuals’ Protected Health Information other than as described in the Plan Documents and permitted by the “504” provisions.
5. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals’ Protected Health Information received from the Plan (or from the Plan’s health insurance issuer, HMO, PPO, health care provider, etc., as applicable), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.
6. The Plan Sponsor will not use or disclose individuals’ Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law.
7. The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the “504” provisions, of which the Plan Sponsor becomes aware.

E. Disclosure of Individuals’ Protected Health Information - Disclosure by the Plan Sponsor

1. The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. §164.524.

2. The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. §164.526.
3. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. §164.528.
4. The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.
5. The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
6. The Plan Sponsor will ensure that the required adequate separation, described in paragraph F below, is established and maintained.

F. Required Separation between the Plan and the Plan Sponsor

1. In accordance with the "504" provisions, this Section describes the employees or classes of employees of workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer, HMO, PPO, etc, as applicable, servicing the Plan.
  - a. Administrative Manager
  - b. Claims Supervisors, Processors and clerical support staff
  - c. Information Technology Personnel
2. This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment, health care operations of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

3. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any harmful effect of the violation or noncompliance.

***Section 8.10 - HIPAA Security Rule***

Under federal law, health plans (like this one) must comply with the HIPAA Security Rule (“Security Rule”) concerning the security of Electronic Protected Health Information (also known as “e-PHI”). This Plan has taken the necessary steps to achieve such compliance.

The Security Rule also requires the Plan to be amended in certain regards. The following portion of this Section is intended to bring the Plan into compliance with the requirements of 45 C.F.R. 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 (“Security Rule”) by establishing the Plan Sponsor’s (the Board of Trustees) obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective on April 21, 2005:

A. *Plan’s Designation Of Person/Entity To Act On Its Behalf*

The Plan has determined that it is a “group health plan” within the meaning of the Security Rule, and the Plan designates the Plan Sponsor, the Board of Trustees, to take all actions required to be taken by the Plan in connection with the Security Rule (i.e., entering into Business Associate contracts, etc.). Such responsibility may be delegated by the Board to the Administrative Manager.

B. *Definitions*

All terms defined in the Security Rule shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this Section.

1. “Plan” means this Plan.
2. “Plan Documents” mean the Plan’s governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to this Plan Document.
3. “Plan Sponsor” means “plan sponsor” as defined at Section 3(16)(B) of ERISA, 29 U.S.C. Section 1002(16)(B). The Plan Sponsor is the Board of Trustees of this Plan.
4. “Electronic Protected Health Information” (or “e-PHI”) shall have meaning as set forth in 45 C.F.R. 160.103, as amended from time to time, and generally means protected health information (“PHI”) that is transmitted or maintained in Electronic Media.
5. “Electronic Media” shall mean:
  - (a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
  - (b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating

parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

6. “Security Incident” shall have the meaning set forth in 45 C.F.R 164:304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

C. Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that the adequate separation required by Section 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
4. Report to the Plan any successful security incident of which it becomes aware within a reasonable time thereafter and report any unsuccessful security incidents quarterly or at such other times as mutually agreed upon between the Plan Sponsor and the Plan.

## ARTICLE IX - RETIREE PROGRAM

### ***Section 9.01 - Eligibility To Participate***

Active eligible participants may continue coverage in the Plan as a Retiree. To qualify as a Retiree, the person must meet all of the following criteria:

1. Was a participant in the Plan for at least any five (5) years prior to retirement (not required to be consecutive or immediately prior to date of retirement).
2. Was an eligible active participant in the Plan at least 12 months of the 36 months immediately prior to retirement
3. Maintains continuous coverage by making the appropriate Retiree self-payments.
4. Makes proper application for retiree coverage.

A disability retiree is eligible to participate in the Plan if the person meets all of the following criteria:

1. Is retired under the Disability Retirement provisions of Local 7 Zone 3 Pension Fund or has evidence of a Social Security Disability Award.
2. Was currently eligible as an active participant at the time of retirement.
3. Maintains continuous coverage by making the appropriate Retiree self-payments.
4. Makes proper application for retiree coverage.

In addition to the above requirements, the Employee must make the required payment on or before the end of the month during the month in which eligibility under the active employee program terminates if the Employee was eligible under the active program at the time of application to the Retiree Program.

To elect to participate in the Retiree Program the retiree must waive all COBRA eligibility resulting from his retirement.

The initial eligibility date under this program shall be the first day of the first benefit month following the date of the Employee's request to be covered and receipt of proper payment by the Administrative Manager.

### ***Section 9.02 - Failure of Initial Participation***

A retired participant will be notified by the Administrative Manager of eligibility and his or her responsibility to enroll and participate in the Retiree program within 30-days from the date of his or her retirement. If the retiree fails to enroll for medical and prescription benefits within the prescribed time, coverage will be terminated and the retiree will not be permitted to enroll and participate in the Retiree program at a future date.

### ***Section 9.03 - Retiree Self- Payments***

The required contribution payments for this program must be made on a monthly basis in advance and will provide one month of continuous benefit coverage. The payments shall be equal to the monthly cost to the Plan, as determined by the Trustees.

To qualify for reduced self-payment, you must be covered under the Plan as an active employee for ten (10) or more years at a contribution rate level equal to the Building Trades Journeymen rate. Reduced self-payment amounts will be determined by Board of Trustees from time to time.

If participation in the Plan was five (5) to nine (9) years, or if participation in the Plan was at an employee classification level other than the Building Trades Journeyman (such as Residential Light Commercial, Classified, Specialty Workers, etc.) the self-pay rate will be equal to the monthly cost to the Plan.

***Section 9.04 - Medical and Prescription Benefits***

Medical and Prescription Benefits payable under the Retiree Program shall be the same as provided to active Employees and their Eligible Dependents, unless the retiree is eligible for Medicare, as described in Section 9.08 - Eligibility for Medicare.

***Section 9.05 - Death Benefits***

Death Benefits payable under the Retiree Program are described in Section 5.01 - Death Benefit.

***Section 9.06 - Dental Benefits***

Dental Benefits payable under the Retiree Program are described in Section 5.04 - Dental Benefit.

***Section 9.07 - Termination Of Benefits***

A retiree who qualifies and elects to be covered under the Retiree program must make the required self-payments on or before the first day of the month for which there will be coverage. To elect to participate in the Retiree medical benefits program the retiree must waive all COBRA eligibility resulting from his retirement. Failure to make timely self-payments will cause the retiree to cease being eligible for coverage the first day of any month for which no payment is received. In the event of a death, coverage will terminate at the end of the month in which the retiree passes away.

If the retired participant does not elect to cover himself and/or his spouse or other eligible dependents within the prescribed time frame, coverage under the Plan will terminate. The coverage will terminate at the end of the month in which the reserve hour bank is exhausted (subject to applicable COBRA regulations).

Any retiree performing work under the jurisdiction of the Sheet Metal Workers with an employer not signatory to the Collective Bargaining Agreement shall have his or her benefits terminated.

Retiree benefits have been granted by the Trustees as a privilege, not a right. No person has any vested right to Retiree benefits. The Trustees may at their option expand, reduce, or cancel the Retiree programs, change eligibility requirements or change the amount of self-payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a retiree, surviving spouse or any other person.

***Section 9.08 - Eligibility for Medicare***

When you reach age 65, you are eligible for Medicare coverage. Medicare coverage has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A coverage is usually provided at no cost to you, but you must pay for Part B coverage.

Benefits will be processed as if you have Medicare on the first day you are eligible for Medicare, whether or not you actually become covered under Parts A and B of Medicare. Therefore, if you are eligible for Part A or Part B of Medicare, and you DO NOT enroll or maintain coverage under Medicare, your benefits under the Fund will be calculated as if you had signed up for both Part A and Part B of Medicare. In other words, the Fund will not pay for any benefits that would have been paid under Medicare, even if you, or your spouse, fail to enroll or maintain coverage under Medicare.

Should you have any questions regarding Medicare, contact your local Social Security Administration Office.

### ***Section 9.09 - Opting Out and Re-enrollment***

All Eligible Retirees have the option to elect out of the Sheet Metal Workers Local 7 Zone 3 Plan and then be given the opportunity to re-enroll in the Plan at a later date. This option is typically taken when you have coverage through another Plan, such as your spouse's.

#### Enrollment Period

If a retiree terminates coverage due to failure to make a self-payment, the retiree has the opportunity to reinstate coverage effective January 1st. If the retiree requests to reinstate coverage January 1st, the retiree must advise the Administrative Manager by the October 30th date prior to January 1st. The notice must be in writing and signed by the retiree.

#### Exceptions

A retiree may re-enroll at a date other than January 1st if there is a life changing event (death of a spouse, divorce). If the spouse's coverage is terminated through no fault of their own, as determined by the Administrative Manager and/or Trustees, the retiree and their eligible dependents may re-enroll. However, if the spouse's termination of coverage is voluntary, the retiree cannot re-enroll until January 1st.

#### Termination of Coverage

Any retiree performing work under the jurisdiction of the Sheet Metal Workers with an employer not signatory to the Collective Bargaining Agreement shall have his or her benefits terminated. Reinstatement for coverage will not be permitted if it is determined that the retiree was performing work as described above.

## **ARTICLE X - SURVIVING SPOUSE PROGRAM**

### ***Section 10.01 - Eligibility and Enrollment***

A Surviving Spouse program is available to the Surviving Spouse and Eligible Dependent children of a deceased eligible Participant (active or retired). A deceased eligible participant is a person who immediately prior to his/her death was a participant in the Sheet Metal Workers Local 7 Zone 3 Health Care Fund.

If the Active Participant passes away while he/she is eligible for benefits under the Plan, his/her surviving spouse, if any, and eligible dependent children, if any, shall be entitled to continued coverage.

If the deceased eligible participant was a participant in the Retiree Program immediately preceding death, the surviving spouse and any other eligible dependents will automatically be eligible for participation in the Surviving Spouse Program.

Dependent children shall be eligible for coverage only while the Surviving Spouse is eligible for coverage, or alternatively, until any reserve hours in the deceased eligible participant's hour bank reach zero.

Coverage must be elected within 30 days from the date of the notification of eligibility for coverage through the Surviving Spouse Program. Eligibility for the program will begin on the first day of the benefit month immediately following the termination of the Spouse's coverage as a result of the Participant's death.

A surviving spouse's participation in the Surviving Spouse Benefit Program runs concurrently with that spouse's and eligible dependent children's COBRA eligibility. The surviving spouse and dependent children will not be allowed to elect COBRA coverage after the exhaustion of the Surviving Spouse benefit, unless required by law.

If a surviving spouse remarries, his or her eligibility under the Plan will end on the first day of the 36th calendar month following the date of marriage.

The Trustees reserve the right to alter and/or terminate the Surviving Spouse program should such action be deemed to be in the best interests of the Fund.

### ***Section 10.02 - Benefits Available***

The Trustees have granted surviving spouse benefits as a privilege, not a right. No person acquires any vested right to such benefits, either before or after the eligible employee's death. The Trustees may expand, reduce, or cancel coverage for surviving spouses, change eligibility requirements or the amount of contributions and otherwise exercise their prudent discretion at any time without legal right or recourse by a surviving spouse or any other person.

Surviving Spouses are not eligible for Death Benefits or Weekly Disability Benefits. Dental Benefits for Surviving Spouses are described in "Section 5.04 - Dental Benefit" on page 78.

The medical and prescription benefits for the Surviving Spouse eligible for Medicare and their Eligible Dependent children shall be the same as that offered to a retiree eligible for Medicare.

The medical and prescription benefits for a Surviving Spouse not eligible for Medicare and their Eligible Dependent children shall be the same as that offered to an active participant or a pre-Medicare retiree.

***Section 10.03 - Failure of Initial Participation***

A surviving spouse will be notified by the Administrative Manager of eligibility to enroll and participate in the Surviving Spouse Program. The surviving spouse must notify the Administrative Manager within 30 days of intent to participate. If the surviving spouse fails to do so, the surviving spouse is then barred from enrollment and participation in the program.

***Section 10.04 - Self-Payments***

The surviving spouse who qualifies and elects to be covered under the Surviving Spouse Benefit Program will be covered for a period of six (6) months immediately following the death of the eligible Active Employee or Retired Participant at no cost. Eligibility during the second six (6) month period following the death of the eligible Active Employee or Retired Participant will be maintained by making monthly payments equal to 50% of the Surviving Spouse self-payment rate. After twelve (12) months of participation in the Surviving Spouse program, continued eligibility will be maintained by making the required monthly self-payments. Surviving Spouses who remarry during the first 12 months are not eligible for no-cost or reduced-cost coverage and instead must pay the full self-payment rate.

Credited Reserve Hours may be used to pay for surviving spouse coverage.

The amount of self-payments required will be determined by the Trustees from time to time and will vary depending on whether the surviving spouse is eligible for Medicare and whether other dependents are covered.

Any eligible dependent of a surviving spouse who becomes ineligible because of age, or other reasons may also contribute for a period not to exceed 36 months at the full contribution rate per month or the rate as determined by the Trustees annually. This 36-month period runs concurrently with COBRA eligibility, if any.

## ARTICLE XI - IMPORTANT PLAN INFORMATION

### ***Section 11.01 - Name of Plan***

This Plan is known as the Sheet Metal Workers Local 7 Zone 3 Health Care Fund..

### ***Section 11.02 - Board of Trustees***

The Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of an equal number of representatives from the sponsoring Union, the Sheet Metal Workers Local 7 Zone 3, and from Employers as well as various Employer associations who contribute to the Fund as required by a Collective Bargaining Agreement

#### **Union Trustees**

Travis Eastman  
Sheet Metal Workers Local 7  
3912 Blair Townhall Road  
Traverse City, MI 49685

Robert Adams  
Sheet Metal Workers Local 7  
1600 Horseshoe Circle  
Saginaw, MI 48609

Wayne Stover  
Sheet Metal Workers Local 7  
P.O. Box 632  
Freeland, MI 48623

Chris McFarland (Alternate)  
Sheet Metal Workers Local 7  
4931 Contec Drive  
Lansing, MI 48910

#### **Employer Trustees**

Clay Cooke  
Cooke Sheet Metal Company  
303 Elm Street, P. O. Box 338  
Kalkaska, MI 49646

Chris Stockwell  
U.S. Sheet Metal, Inc.  
3200 Enterprise Drive  
Saginaw, MI 48603

Susan Leitekt  
K-R Metal Engineers  
815 S. Henry Street  
Bay City, MI 48706

Kevin Wendling (alternate)  
Wendling Sheet Metal, Inc.  
2633 Carrollton Street  
Saginaw, MI 48604

The Board of Trustees may be contacted at the following address and phone number:

Sheet Metal Workers Local 7, Zone 3 Benefit Office  
700 Tower Drive  
Suite 300  
Troy, MI 48098

### ***Section 11.03 - Plan Administrator***

The Plan Administrator is the joint Board of Trustees. The Plan Trustees are known as the “named fiduciaries.” The Plan Trustees are responsible for the administration and operation of the Plan. As Plan Sponsor, the Trustees shall have full discretionary authority to interpret the Plan, decide any questions of eligibility, and determine any benefits which are payable under the Plan.

The Trustees have hired an Administrative Manager to perform the day-to-day operations of the Plan, such as maintaining records, making Benefit payments and handling general administrative matters. The Administrative Manager can be at the following address and phone number:

Sheet Metal Workers Local 7, Zone 3 Benefit Office  
700 Tower Drive  
Suite 300  
Troy, MI 48098

***Section 11.04 - Plan Sponsors***

Plan Participants and Beneficiaries may write to the Plan Administrator to find out if a particular Employer or Union is a sponsor of this Plan and, if so, to find out that Plan sponsor's address.

***Section 11.05 - Identification Numbers***

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 38-1449784. The number assigned to the Plan by the Board of Trustees is 501.

***Section 11.06 - Agent for Service of Legal Process***

**Legal Counsel**

Ledbetter Parisi LLC  
70B Rhoads Center Drive  
Centerville, OH 45458

Service may also be made on any Plan Trustee or the Administrative Manager.

***Section 11.07 - Collective Bargaining Agreement***

This Plan is maintained pursuant to collective bargaining agreements. Plan Participants and Beneficiaries may examine these collective bargaining agreements and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees. This section does not apply to Non-Bargaining Unit Employees.

***Section 11.08 - Source of Contributions***

The Plan's benefits for eligible Employees are provided through Employer contributions. The amount of the Employer contributions is determined by the provisions of the collective bargaining or other agreement. The Plan is financed through employer contributions based on actual hours worked plus self-contributions by participants as required for the maintenance and continuation of eligibility.

***Section 11.09 - Funding Medium for the Accumulation of Plan Assets***

All contributions and investment earnings of the Plan are accumulated in a Trust Fund that is utilized to pay Benefits to eligible individuals and to defray reasonable costs of administration.

***Section 11.10 - Plan Year***

Records are maintained on a 12-month period of time. This is known as the "Plan Year." The Plan Year begins on May 1 and ends on April 30 of each year.

***Section 11.11 - Type of Plan***

This Plan is maintained for the purpose of providing death benefits, weekly loss of time income, medical expense, and dental benefits. Some benefits are provided on a self-funded basis, while other benefits

may be provided through insurance companies. The Trustees reserve the right to modify which part of the benefits schedule are provided on a self-funded basis and which parts, if any, are provided through an insurance carrier. A detailed written description of these Plan benefits appears in this booklet. Unlike a defined benefit pension plan, federal law does not guarantee coverage under this Plan. In other words, the benefits this Plan provides are not vested. The Board of Trustees reserve the right to modify the level of coverage this Plan provides, reduce benefits, or to terminate this Plan entirely at any time.

***Section 11.12 - Eligibility Rules***

The rules regarding eligibility for coverage, termination of eligibility and direct payment of contributions are found in the applicable Sections of the booklet.

***Section 11.13 - Legal Counsel***

The Fund's legal counsel is Ledbetter Parisi, LLC. Their address is 70B Rhoads Center Drive, Centerville, OH 45458. The firm's phone number is 937-619-0900. The Fund's attorneys are responsible for handling all legal matters that affect the Plan and its operation.

## ARTICLE XII - STATEMENT OF ERISA RIGHTS

### **Your Rights**

As a Participant in the Sheet Metal Workers Local 7 Zone 3 Health Care Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

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

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

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

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

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish Eligibility Rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) disability.

Be informed that under the Newborns' and Mothers' Health Protection Act, Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect

to mastectomies shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and coinsurance.

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits 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 it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## ARTICLE XIII - DEFINITIONS

**THE FOLLOWING WORDS HAVE SPECIFIC MEANINGS WHEN USED IN THE PLAN. IT IS IMPORTANT TO UNDERSTAND THE MEANINGS OF THESE DEFINED TERMS WHILE USING THIS BOOKLET.**

### ***Section 13.01 - Accidental Injury***

The term “Accidental Injury” shall mean any physical damage caused by an action, object or substance outside the body. This may include strains, sprains, cuts and bruises; allergic reactions caused by an outside force such as bee stings or another insect bite; extreme frostbite, sunburn, sunstroke; poisoning; drug overdosing; inhaling smoke, carbon monoxide or fumes; a dental accidental injury occurring when an external force to the lower half of the face.

### ***Section 13.02 - Approved Amount***

The term “Approved Amount” shall mean the lower of the billed charge or the Plan’s maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before the Plan makes payment.

### ***Section 13.03 - Beneficiary***

The term “Beneficiary” or “Beneficiaries” means any Eligible Dependent entitled to receive a benefit under the Plan or a person designated to be the recipient of any Death Benefit. The term “Beneficiary” is also used in the phrase “Qualified Beneficiary” to refer to an individual eligible for coverage under COBRA.

### ***Section 13.04 - Chronic Condition***

The term “Chronic Condition” means a condition that recurs frequently or one that may or may not have been present at birth but will last a long time, perhaps throughout the patient’s life. Therapy may not help and the chronic condition may eventually result in significant disability and/or death. Arthritis and heart disease are examples of chronic diseases.

### ***Section 13.05 - Congenital Condition***

The term “Congenital Condition” means a condition that exists at birth.

### ***Section 13.06 – Collective Bargaining Agreement***

The term “Collective Bargaining Agreement” means an agreement between an Employer and the Union that requires fringe benefit contributions.

### ***Section 13.07 - Covered Employment***

The term “Covered Employment” means work that meets two basic requirements: first, the Employer must have signed a collective bargaining agreement with the Union that requires contributions to this Plan, and second, the work you performed for the Employer must be work that is covered by that Collective Bargaining Agreement.

***Section 13.08 - Covered Charges/Covered Services***

The term “Covered Charges” or “Covered Services means services that are identified as payable in this document. Such services must be medically necessary, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, to order or perform the service.

***Section 13.09 - Creditable Coverage***

The term “Creditable Coverage” means Creditable Coverage as defined in the Health Insurance Portability and Accountability Act (“HIPAA”). Generally, Creditable Coverage includes coverage under: 1) a group health plan (including Federal governmental and church plan); 2) hospital or medical service policy certificate or contract; 3) HMO contract; 4) Medicare; 5) Medicaid; or 6) State health benefits risk pool.

Some examples of coverage that do NOT qualify as Creditable Coverage are:

- A. Coverage under accident, disability income, liability, worker’s compensation, automobile medical insurance and other types of insurance which is not considered to be general health insurance; and,
- B. Health coverage for limited benefits, such as limited scope dental or vision benefits or long-term care plans, and plans under which health benefits are secondary or incidental; or,
- C. Supplemental benefits such as Medigap or MedSupp insurance, TriCare supplemental programs and similar supplemental coverage under a group health plan.

***Section 13.10 - Credited Reserve Hours***

Hours credited in excess of those required to meet the requirements for Continuing Eligibility, as described in Section 1.03 - Reserve Hours.

***Section 13.11 - Designated Services***

The term “Designated Services” shall mean services that BCBSM determines only a noncontracted area hospital is equipped to provide.

***Section 13.12 - Developmental Condition***

The term “Developmental Condition” means a condition that can delay or completely stop the normal progression of speech development. Speech and language pathology services may not help these conditions.

***Section 13.13 – Disabled/Disability***

The term “Disabled” means that a physical or mental condition that the Trustees find, on the basis of satisfactory medical evidence, to totally prevent you from engaging in any work for remuneration or profit. You will not be deemed to be permanently and totally disabled if the disability results from the use of narcotics, or if such disability was contracted, suffered, or incurred while you were engaged in or resulted from your participation in any criminal activity that is not domestic violence, or comes from a self-inflicted injury that is not the result of a medical condition.

***Section 13.14 - Eligible Dependent***

The term “Eligible Dependent” shall mean the eligible Employee’s legal Spouse. It shall also include the eligible Employee’s biological children, step-children, legally adopted children, children placed in the home prior to adoption, or foster children that are lawfully placed with the Participant, through the end of the month in which they turn age 26. The child will cease being a Dependent on the last day of the month in which the Dependent child turns 26. Generally, a Dependent remains eligible so long as the Active,

Retired Participant or Surviving Spouse remains eligible, and he or she continues to meet the definition of Dependent

The term “Eligible Dependent” shall also include a child over the age 26 who is 1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; 2) such incapacity commenced prior before the date the child’s coverage would otherwise terminate under the Plan (for example, the disability began before the child was age 26) and 3) the child remains chiefly dependent upon the eligible Employee for support and maintenance. The Plan will continue coverage for the child for as long as the eligible Employee’s coverage remains in force and the incapacity continues, provided that proof of the incapacity is submitted to the Administrative Manager within 31 days of the date the child’s coverage would otherwise terminate. The failure to submit proof of incapacity may result in termination of the child’s coverage.

The Trustees have the authority to request supporting documentation as necessary. However, any child who is eligible for coverage under this Plan as an Employee is excluded from Dependent coverage.

You are responsible for notifying the Administrative Manager of changes in the status regarding your Dependent that would impact their eligibility under the Plan. Providing false statements or documentation with regard to dependent status or failing to notify the Plan regarding a Dependent who is no longer eligible will be considered fraud and may result in retroactive loss of coverage.

***Section 13.15 - Eligible Person***

The term “Eligible Person” shall mean any person who is presently or may become eligible for benefits under this Plan in accordance with the Eligibility Rules adopted by the Trustees.

***Section 13.16 - Eligibility Rules***

The term “Eligibility Rules” shall mean the eligibility rules as established and adopted by the Trustees pursuant to the authority granted to them in the Trust Agreement.

***Section 13.17 - Emergency Medical Condition/Medical Emergency***

The terms “Emergency Medical Condition” and “Medical Emergency” shall mean a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

- The health of the patient (or with respect to a pregnant woman, the health of the woman or her unborn child) to be in serious jeopardy, or
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part (or with respect to a pregnant woman who is having contractions, there is inadequate time for a safe transfer to another hospital before

***Section 13.18 - Employee***

The term “Employee” shall mean all employees employed by parties to the Trust Agreement establishing this Plan, represented by the Union and working for Employers, as defined herein, and in respect of whose employment an Employer is required to make contributions into the Trust Fund. The term Employee shall also mean employees of an Employer covered by the terms of a participation agreement which requires contributions to the Plan. The term “eligible Employee” means an Employee that has met the eligibility requirements set forth in the Rules of Eligibility herein.

### ***Section 13.19 - Employer***

The term “Employer” means all or any of the following:

- A. An employer who is bound by the terms of a Collective Bargaining Agreement or any other written agreement in effect with the Union providing for the establishment and maintenance of a Plan for payment of contributions to said Plan and is employing the services of individuals performing work that is within the trade jurisdiction of the Union.
- B. Any other Employer engaged in work coming within the trade, craft and geographical jurisdiction of the Union, who is obligated by a collective bargaining agreement, or such other written agreement, to make contributions to this Fund on behalf of its Employees, including self-employed persons or sole-proprietors.
- C. The Union, its affiliated Locals or related International bodies, solely to the extent that it acts in the capacity of an Employer of its business representative or its Employees, provided it agrees to make contributions to the Fund on behalf of such Employees.
- D. Any training or other similar program operated in whole or in part by the Union, or with its approval, or in which the Union participates.
- E. An employer who satisfies the requirements for participation as established by the Trustees. Such employer shall, by the making of a payment to the Trust Fund on behalf of an Employee, be deemed to have accepted, be bound by, and become a party to the Trust Agreement.

### ***Section 13.20 - Employer Contributions***

The term “Employer Contributions” means the fringe benefit contributions received by the Fund for each hour worked in Covered Employment. Generally, only contributions received by the Fund will be deemed Employer Contributions for eligibility purposes, except as otherwise provided in this SPD.

### ***Section 13.21 - Experimental Treatment***

The term “Experimental Treatment” shall mean treatment that has not been scientifically proven to be as safe and effective for treatment of the patient’s conditions as conventional treatment. Sometimes it is referred to as “investigational” or “experimental services.”

### ***Section 13.22 - Fund***

The term “Fund” or “Trust Fund” shall mean the Sheet Metal Workers Local 7 Zone 3 Health Care Fund.

### ***Section 13.23 - Hospice***

The term “Hospice” shall mean a public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

### ***Section 13.24 - Hospital***

The term “Hospital” shall mean a facility that

- Provides inpatient or outpatient diagnostic, therapeutic, and surgical services for injured or acutely ill persons, and
- Is fully licensed and certified as a hospital, as required by all applicable laws and
- Complies with all applicable national certification and accreditation standards

Hospital services must be provided by or under the supervision of a professional staff of licensed physicians, surgeons and registered nurses.

### ***Section 13.25 - Medically Necessary***

A service must be “Medically Necessary” to be covered. There are two definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons) and other providers; another applies to hospitals and LTACHs

- Medical necessity for payment of professional provider and other provider services - Health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
  - In accordance with generally accepted standards of medical practice;
  - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member’s illness, injury or disease and
  - Not primarily for the convenience of the member, professional provider, or other health care provider, and not 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 member’s illness, injury or disease.
- Medical necessity for payment of hospital and LTACH services - Determination by BCBSM that allows for the payment of covered hospital services when all of the following conditions are met:
  - The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
  - The service, treatment, or supply is appropriate for the symptoms and is consistent with the diagnosis.
    - Appropriate means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.
      - For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient’s condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
  - The service is not mainly for the convenience of the member or health care provider.
  - The treatment is not generally regarded as experimental by BCBSM.
  - The treatment is not determined to be medically inappropriate by the Utilization.

***Section 13.26 - Nonparticipating Hospital / Provider***

The terms “Nonparticipating Hospital” and “Nonparticipating Provider” means physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with to accept the Plan’s payment as payment in full. Some nonparticipating providers, however, may agree to accept the Plan’s payment on a per claim basis.

***Section 13.27 - Occupational Therapy***

The term “Occupational Therapy” means a rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

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

***Section 13.28 - Outpatient Mental Health Facility***

The term “Outpatient Mental Health Facility” means a facility that provides outpatient mental health services. It must have a participating agreement with BCBSM. Sometimes referred to as an outpatient psychiatric care facility (OPC), it may include centers for mental health care such as clinics and community

mental health centers, as defined in the Federal Community Mental Health Centers Act of 1963, as amended. The facility may or may not be affiliated with a hospital.

***Section 13.29 - Outpatient Substance Abuse Treatment Program***

The term “Outpatient Substance Abuse Treatment Program” means a program that provides medical and other services on an outpatient basis specifically for those with substance use disorder.

***Section 13.30 - Participating Hospital/Providers***

Physicians and other health care professionals, or hospitals and other facilities or programs that have signed a participation agreement to accept the approved amount as payment in full. Any cost-share, which may be required of you, is subtracted from the approved amount before the Plan’s makes payment.

***Section 13.31 - Physical Therapy***

The use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient’s specific muscles or joints to keep, learn, retain or improve muscle strength, joint motion, coordination, and/or general mobility

***Section 13.32 - Participant***

The term “Participant” shall mean any Employee, former Employee of an Employer, or widow or widower, who is eligible to receive benefits from this Plan or whose Beneficiaries may become eligible to receive any such benefit.

***Section 13.33 - Physician Or Surgeon***

The term “Physician” shall mean a doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as “practitioners.” The term physician or practitioner may also include other types of professional providers when they perform services they are licensed or legally qualified to perform in the state where the services are provided.

***Section 13.34 - Plan***

The term “Plan” shall mean the Sheet Metal Workers Local 7 Zone 3 Health Care Fund.

***Section 13.35 - Practitioner***

The term “Practitioner” shall mean a physician (a doctor of medicine, osteopathy, podiatry, or chiropractic) or a professional provider (a doctor of medicine, osteopathy, podiatrist, chiropractor, fully licensed psychologist, clinical licensed master’s social worker, licensed professional counselor or oral surgeon) or other professional provider who participates with BCBSM or who is in a BCBSM PPO network. Practitioner may also be referred to as “participating” or “in-network” provider.

***Section 13.36 - Preferred Provider Organization (PPO)***

The term “Preferred Provider Organization (PPO)” shall mean a limited group of health care providers or pharmacies who have agreed to provide covered drugs or services to BCBSM members enrolled in the PPO program. These providers or pharmacies accept the approved amount as payment in full for covered drugs or services.

***Section 13.37 - Professional Provider***

The term “Professional Provider” shall mean one of the following:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist
- Chiropractor
- Physician assistant (PA)
- Fully licensed psychologist
- Limited licensed psychologist (LLP)
- Clinical licensed master’s social worker (CLMSW)
- Licensed marriage and family therapist (LMFT)
- Licensed professional counselor (LPC)
- Oral surgeon
- Independent physical therapist (IPT)
- Independent speech therapist (IST)
- Independent occupational therapist (IOT)
- Certified nurse practitioner (CNP)
- Certified nurse midwife (CNM)
- Certified registered nurse anesthetist (CRNA)
- Other providers as identified by BCBSM

Professional providers may also be referred to as “practitioners.”

***Section 13.38 - Residential Substance Abuse Treatment Program***

The term “Residential Substance Abuse Treatment Program” shall mean a program that provides medical and other services on a residential basis specifically for those with substance use disorder in a facility that operates 24 hours a day, seven days a week. Treatment in a residential program is sometimes called “intermediate care.”

***Section 13.39 - Sickness***

The term “Sickness” shall mean any disease commencing after the effective date of coverage of the Eligible Person whose Sickness is the basis of the claim and resulting in a loss covered by the Plan. The term “Sickness” shall also include an illness not caused by an Accident.

***Section 13.40 - Skilled Care***

The term “Skilled Care” shall mean a level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be ordered by the attending physician; medically necessary according to generally accepted standards of medical practice; and provided by a registered nurse or a licensed practical nurse supervised by a registered nurse or physician.

***Section 13.41 - Skilled Nursing Facility***

The term “Skilled Nursing Facility” shall mean a facility that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

***Section 13.42 - Spouse***

The term “Spouse” shall mean the eligible Employee’s legal spouse. The term “Spouse” shall **NOT** include the divorced spouse of an eligible Employee.

***Section 13.43 - Substance Abuse Treatment Program Services***

The term “Substance Abuse Treatment Program Services” shall mean subacute services to restore a person’s mental and physical well-being when the person has a substance use disorder. Services must be provided and billed by an approved residential or outpatient substance abuse treatment program.

***Section 13.44 - Substance Use Disorder***

The term “Substance Use Disorder” shall mean taking alcohol or other drugs in amounts that can:

- Harm a person’s physical, mental, social and economic well-being
- Cause a person to lose self-control as reflected by alterations of thought, mood, cognition, or behavior

- Endanger the safety or welfare of self or others because of the substance's habitual influence on the person.

Substance use disorder is alcohol or drug abuse or dependence as classified in the most current edition of the "International Classification of Diseases."

***Section 13.45 - Trust Agreement***

The term "Trust Agreement" shall mean the Sheet Metal Workers Local No. 7 Zone 3 Welfare Fund Amended & Restated Agreement & Declaration of Trust.

***Section 13.46 - Trustees***

The term "Trustees" shall mean the Employer Trustees and Union Trustees, collectively, as appointed pursuant to the terms of the Trust Agreement, as amended.

***Section 13.47 - Union***

The term "Union" shall mean the Sheet Metal Workers Local 7 Zone 3 Union.

**SIGNATURE PAGE**

IN WITNESS WHEREOF, we have hereunto affixed our signatures and approved this restated Plan Document for the Sheet Metal Workers Local 7 Zone 3 Health Care Fund this 18th day of August, 2020.

APPROVED:

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## NOTES

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