

AGREEMENT BETWEEN

THE CITY OF NOVI

and

**COMMAND OFFICERS ASSOCIATION
OF MICHIGAN**



JULY 1, 2016 THROUGH JUNE 30, 2020

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**CITY OF NOVI
COMMAND OFFICERS ASSOCIATION OF MICHIGAN AGREEMENT**

The Agreement is made and entered into the 10th day of November, 2016 by and between the City of Novi in Oakland County, Michigan hereinafter referred to as "The City", and the Command Officers Association of Michigan, hereinafter referred to as "The Association", or "Union". It is the desire of both parties in this Agreement to continue to work harmoniously and to promote and maintain high standards between the City and its command officers, hereinafter referred to as "Officers", which will better serve the citizens of the City of Novi.

RECOGNITION

The City recognizes the Association as the exclusive representative of Sergeants and Lieutenants employed by the City of Novi Police Department, excluding the Police Chief and all other supervisory employees above the rank of Lieutenant for the purposes of collective bargaining with respect to rates of pay wages, hours of employment and other terms and conditions of employment, in the bargaining unit for which it has been certified, and in which the Association is recognized as sole and exclusive collective bargaining representative, subject to and in accordance with the provisions of Act 336 of the Public Acts of 1947, as amended.

1. ASSOCIATION DAYS

The City hereby grants to the Association forty hours (40) hours of paid time off during each year of this Agreement to be used by appropriate Association officers and representatives for the purpose of conducting Association business, including the attendance at conferences, workshops or seminars related to the bargaining or representation function of the Association. A schedule of any time off for such purposes shall be provided to the Chief and/or his/her designee 72 hours in advance.

2. ASSOCIATION SECURITY AND CHECK-OFF

The City agrees to deduct dues of the Association upon signed authorization of any member of the bargaining unit. The aggregate deductions of all officers shall be remitted together with an itemized statement, to the Treasurer of the Association by the 15th of the succeeding month after such deductions are made. Deduction authorization may be revoked upon sixty day's notice.

3. BASIS OF REPRESENTATION

- A.** There shall be one Association representative and an alternate to act in his absence.

- B. There shall be a grievance committee consisting of not more than two members of the Association.
- C. The names of officers selected as Association representatives and alternates, and the name of the President of the Association, shall be certified in writing to the City by the Association.
- D. The Association representatives may investigate and process grievances during working hours without loss of pay, if the case so warrants, and this privilege shall not be abused. Association representatives will be permitted to leave their work, after obtaining approval of their respective supervisors and recording their time. Permission for Association representatives to leave their work stations will not be unreasonably withheld. Association representatives will report their time to their respective supervisors upon returning from a grievance discussion.

4. BULLETIN BOARD

The City shall assign appropriate space on bulletin boards which may be used by the Association for posting notices, bearing the written approval of the President of the Association, which shall be restricted to:

- A. Notices of Association recreational and social affairs.
- B. Notices of Association elections.
- C. Notices of Association appointments and results of Association elections.
- D. Notices of Association meetings.
- E. Other notices of bona fide Association affairs which are not political in nature.

5. COPIES OF ORDERS AND REGULATIONS APPLICABLE TO OFFICERS

A copy of any order, general order, rule, regulations, training bulletin or document of a similar nature which applies to more than one officer shall be posted in an appropriate place and a copy made available to the Association.

6. DEFINITIONS

The use of the term "officer" or "command officer" or "employee" in this Agreement shall include all members of the bargaining unit as defined in Article I.

7. DISCIPLINARY LAYOFF AND DISCHARGES

- A.** The City may discharge or discipline any officer only for just cause. Any officer who has been disciplined by suspension or discharge may request the presence of an Association representative before he is required to leave the station, to discuss the matter with the officer and the City representative, as long as the circumstances permit prompt and orderly conversation on the matter. The Association representative will be called promptly, if available. In the case of a discharge, the officer and the Association will be given a written statement of the specific charges causing the discipline. In the case of a suspension, the officer and the Association will be given a written statement of the general nature of the charges causing the discipline.
- B.** It is important that complaints regarding discipline be handled promptly, and if a hearing is desired, the Association or the officer shall file an appeal with the Chief of Police or his designee, within two (2) working business day after such discharge or discipline is first imposed. The hearing will be held within two (2) working business days after the filing of the complaint. Association representation at the hearing will be the same as indicated in Step Two of the Grievance procedure. In addition, the disciplined officer has a right to be present.
- C.** If the Chief or his designee finds in his judgment that the discipline is to severe, he may reduce the discipline to a more appropriate penalty. The Chief will render a decision within five (5) working business days of the date of hearing. If his decision is not satisfactory to the Association, the grievance may be appealed under Step Three of the Grievance Procedure. If such appeal is not filed within five (5) working business days of the date of the Chief's decision, or the date on which it was due, the matter will be considered automatically settled on the basis of the last decision and not subject to further appeal.
- D.** The aggrieved officer shall have a right to be present and participate in the hearing before the City Manager or his/her designee. The City Manager or his/her designee shall, within five (5) working business days of the receipt of said complaint, hold a meeting thereon and within three (3) working business days of said meeting, render his written disposition of the complaint, copies of which shall be delivered to the Chief, the Association, and the disciplined officer. In the event there is no decision, the opinion rendered by the Chief shall continue in effect.

E. If the Association is not satisfied with the disposition of the complaint under paragraph "D", it may, within ten (10) working business days of the written disposition of the City Manager or his/her designee, appeal said grievance to binding arbitration in accordance with the procedures set forth in Step Four of the Grievance Procedure. In the event of such appeal, the decision of the arbitrator shall be final and binding upon the parties, including the disciplined officer.

F. All officers shall have the right to be represented by the Union at all disciplinary conferences or hearings under this procedure and to be represented by an attorney if he/she chooses.

G. **Employee Rights**

1) At no time shall any member of the Command Officers Association of Michigan be required to answer to any allegation(s) of misconduct unless said allegation(s) has been reduced to writing and the member shall be provided with a copy of the allegation(s) and an opportunity to read same before answering any questions or making any statements regarding the allegation(s). Further, at his/her request, the member shall have the right to representation from the Union or an attorney of his choice, present during the time any answers are given or statements made.

(a) If at any time, a member is answering to an allegation(s) which may result in criminal charges being filed against him/her, the Association member shall be advised of his/her rights (MIRANDA WARNING) prior to any questioning.

(b) At no time shall any member of the Command Officers Association of Michigan be required to take a polygraph test to prove or disprove any allegation(s) made against him, unless he/she so desires.

2) The private and personal life of any employee is not within the appropriate concern or attention of the City, as long as it is consistent with the high standards which the profession and the Association has set. No restriction, other than the approval of the Chief of Police, is placed upon the freedom of employees to use their own time for gainful employment, or other activities insofar as it does not interfere with the satisfactory performance of their police duties.

3) Within a two year period following the insertion of a letter of reprimand in the personnel file of the officer, he/she may ask that a review be made by the Personnel Director or designee,

and unless there is substantial reason otherwise, the letter will be removed and the record of it expunged.

8. DISCRIMINATION

The provisions of this Agreement shall be applied without regard to race, creed, religion, color, national origin, age, sex or marital status.

9. DURATION

This Agreement shall be effective as of the 1st day of July, 2016, and shall remain in full force and effect until the 30th day of June, 2020, except as otherwise provided in this Article of this Agreement. It shall be automatically renewed from year to year thereafter unless either party shall notify the other in writing sixty (60) days prior to the anniversary date that it desires to modify this Agreement. In the event that such notice is given, negotiations shall begin not later than forty-five (45) days prior to the anniversary date. This Agreement shall remain in full force and be effective during the period of negotiations and until notice of termination of this Agreement is provided to the other party in the manner set forth in the following paragraph.

In the event that either party desires to terminate this Agreement, written notice must be given to the other party no less than ten (10) days prior to the desired termination date which shall not be before the anniversary date set forth in the preceding paragraph.

10. GRIEVANCE PROCEDURE

- A.** Any grievance or dispute which may arise between the parties concerning the meaning, application or interpretation of this Agreement, and disputes as to wages, hours and working conditions, shall be settled in the following manner:

Step 1.

The parties recognize informal resolution of grievances at the lowest possible level of supervision as desirable and herein encouraged. In the event that an officer or the Association believes there is a basis for a grievance, the officer or Association representatives shall first discuss the alleged grievance with his immediate supervisor. If after an informal discussion with the immediate supervisor the grievance has not been settled, the officer or the Association may reduce the grievance to writing and the written grievance shall be presented by the Association representative to the Chief of Police within seven (7) calendar days of the alleged occurrence. It shall name the employee(s) involved, shall state the facts giving rise to the grievance, shall identify the alleged violation, shall state the contention of the employee and of the Association, shall indicate the relief requested.

Step 2.

Within seven (7) calendar days of receipt of the grievance, the Chief shall respond to the grievance in writing or resolve the grievance to the satisfaction of the Association.

Step 3.

If the Association is not satisfied with the disposition of the grievance or if no disposition has been made by the Chief of Police within seven (7) calendar days, the grievance may be appealed in writing to the Personnel Director. The Personnel Director shall within seven (7) calendar days of the receipt of said grievance, respond to the grievance and render his written disposition of said grievance.

Step 4.

If the Union is not satisfied with the disposition of the grievance at the Step 3 level, the Union may, within fifteen (15) calendar days of the date of the receipt of the written disposition, whichever is the earliest, invoke arbitration by sending to the other party written notice of the intention to arbitrate the grievance.

The arbitration proceedings shall be conducted by an arbitrator to be selected by the City and the Association. If the parties cannot agree as to the Arbitrator, he/she shall be selected in accordance with the recommended rules of the Federal Mediation and Conciliation Service. The decision of the arbitrator shall have no power to add to, subtract from or modify any of the terms of this Agreement or any supplement or amendment thereto or to go beyond the scope of the grievance as filed in writing.

Expenses for the arbitrator's services shall be borne equally by the parties. All other expenses shall be borne by the parties incurring them.

- B. Any grievance not appealed from a decision in one of the steps of the grievance procedure to the next step as hereinbefore described shall be considered dropped and the last decision final and binding, except that time limits may be extended by mutual written agreement of the parties.
- C. Notification within a reasonable time shall be given to the Association of any disciplinary action taken against any officer which may result in official entries being made in his personnel work file. All information forming the basis for disciplinary action shall be made available to the officer and the Association. All officers shall be entitled to review the contents of their Police Department personnel files at all reasonable times, except for those communications which are of a confidential nature. An officer shall be permitted to have inserted in his file his written response to any unfavorable communication from a citizen. For purposes of privacy, members shall be allowed to use department address as personal address on all reports and complaints and testimony.

- D. The City agrees that it will continue to regard all personnel files as confidential records to be kept under direct control of the Personnel Director, and no unauthorized person shall be allowed to see an officer's file without his prior written consent.
- E. The City agrees to furnish to the Association in response to reasonable requests, information which may be necessary for the Association to process any grievance.
- F. The Association shall have the right, through its Executive Board, to file a grievance if the Association believes that an alleged violation affects the members of the entire bargaining unit. In such a case, the Association shall be deemed to be the grievant.
- G. The Department shall make recordings of all disciplinary hearings available to the Union upon request.

11. HOLIDAYS

Uniform sergeants covered under this Agreement shall receive thirteen (13) paid holidays: New Year's Day, Lincoln's Birthday (Actual), Washington's Birthday (Actual), Easter Sunday, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving Day, Christmas Day, Christmas Eve Day, New Year's Eve Day, and Martin Luther King, Jr. Day (Observed). In the event an officer is not scheduled to work the holiday, he/she will receive his/her base rate of pay. Every effort will be made to allow the officer to be off duty for the holiday. In addition to his/her holiday pay, if the officer is scheduled to work on such holiday, he/she will be paid his/her base rate plus straight-time overtime for actual hours worked on the holiday, payable that pay period.

Payment for thirteen (13) of the foregoing holidays shall be made to each officer in a separate check on the last regular pay day in the month of November, each year.

Officers must meet the following conditions to receive the November Holiday Pay:

- A. During the payroll period in which an approved holiday occurs uniform sergeants must have worked a minimum of eighty four (84) hours (excluding briefing time). Non-uniform sergeants and lieutenants shall work a minimum of eighty (80) hours.
- B. Approved leave time including vacation days, personal business days, approved sick days, or other approved leave can be included in the eighty-four (84), or eighty (80) hours as outlined above, definition of working hours. However, a vacation day will be the only leave day which can be substituted as a Holiday.

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- C. If the combined work and approved leave time does not compute to eighty four (84) hours and ten (10) minutes, or eighty (80) hours as outlined above, during any payroll containing a holiday the pay for the specific holiday will be deducted from the November holiday check.
- D. **Members on an 80 hour pay period** (Non-Uniform officers) will be allowed to have holidays off that occur on a regular day off without loss of compensation. If the member is required to work a holiday, they will be paid double time for the hours worked. Only officers assigned to work a Holiday by the City will have the right to work the Holiday.

When an officer terminates his/her employment for any reason he/she shall be entitled to be paid at the time of termination for all holidays which he/she has worked and for which he/she has not yet been paid.

12. HOURS OF EMPLOYMENT

- A. Uniform Sergeants shall work the following 12-hour shifts:

Day shift 0700 a.m. – 0700 p.m.
Night shift 0700 p.m. – 0700 a.m.
- B. Uniform Sergeants will report to work 10 minutes prior to the start of their shift for briefing/training purposes.
- C. Uniform Sergeants will choose their shifts and days off based on seniority for six (6) months.
- D. All computations for leave time will be earned based on an 8 hour day and 2,080 hours a year.
- E. All non-uniform sergeants and lieutenants shall work an eight (8) hour day which includes a half hour paid lunch.
- F. For comp time refer to the letters of agreement with the last one dated September 11, 2002.

13. ILLNESS, DISABILITY AND PERSONAL BUSINESS

- A. Officers covered by this Agreement shall be allowed up to twelve (96 hours) illness days per calendar year at full base salary. When an officer uses five or more consecutive days for reasons of illness, the City may require a letter from the officer's physician prior to authorization of payment for such days. All of such twelve (12) days (96 hours) which are not used by an officer shall be carried over in his account from year to year on a

cumulative basis, to a maximum of one hundred thirty (130) days (1040 hours). An officer may use as many of his/her accumulated days as he/she has for purposes of illness at full pay. An officer whose employment is terminated by death, retirement, or other valid reasons, or his/her legal representative if he/she dies while employed by the City, shall be entitled to be paid for up to One Hundred Thirty (130) accumulated sick days (1040 hours) in his/her account at the rate of one-half (50%) of regular straight time pay at the time of termination for each such day, provided that sick leave days accumulated prior to July 1, 1979 will be paid for as provided above except at the rate of full pay at the time of termination for each such day.

- B. An unused sick day bank may be established and administered by the Association for the purpose of providing additional days to officers who have exhausted their normal and accumulated sick days. It is understood that administration of such bank shall not be the responsibility of the City and that the City shall not be required to grant any days in addition to the twelve (12) per officer provided in paragraph "A" above. It is understood that all donations to the bank shall be voluntary and accompanied by a letter of transfer signed by the transferring officer.
- C. All employees using less than forty eight (48) hours of sick time from January 1 through December 31, shall receive all unspent hours in excess of forty-eight (48) hours multiplied by .333 in straight time payment. Payment shall be made no later than first pay period in February. To be eligible for payment, an officer must have a minimum of 24 days in their sick leave bank on the last day of the previous calendar year. First payment to be February 1985.

Formula: $96 - 48 = 48 \text{ hours} - \text{hours used} \times .333$
 $\times \text{hourly rate} = \$ \underline{\hspace{2cm}}$

All unused sick time will continue to accumulate to the one hundred thirty (130) maximum accumulation.

- D. In addition to the twelve (96 hours) illness days, the officers covered by this agreement shall be allowed six (48 hours) personal business days with pay per year for personal business. Effective 1/1/92 officers will be allowed five (40 hours) days with pay per year for personal business. Personal business days will be authorized only by permission of the Bureau Commander with approval of the Chief of Police upon advance written request by the officer. It will be necessary, except in an emergency, that a twenty-four (24) hour notice be given the Bureau Commander when requesting a personal business day. If the Bureau Commander is not available to grant an immediate request, such time may be granted by the shift commander, in such event the oral request will be followed by a written one from the

officer. Any unused personal business days at the end of the fiscal year shall be added to the officer's sick day bank.

- E. Duty Disability - Duty Disability Leave: A "Duty Disability Leave" shall mean a leave required as a result of the employee incurring a compensable illness or injury covered by Michigan Worker's Compensation Act while in the employ of the City.

In order to be eligible for duty disability leave, an employee shall immediately report any illness or injury to his/her immediate supervisor, who shall note same in writing.

In the event an employee's illness or disability exceeds seven (7) calendar days, he/she shall cause any applicable insurance disability form to be completed and filed with the City.

If an employee suffers a duty disability and it is ascertained that the nature of the injury or illness is such that the employee will be unable to return to work, such employee will be retired if eligible under the City retirement system. Effective July 1, 2003, the City will adopt the MERS disability retirement benefit D-2 at the City's expense.

Eligibility for disability benefits shall depend upon a clear showing by competent medical evidence that such disability leave is necessary.

When absence results from a "Duty Disability", the benefits provided in this Article will terminate at the start of worker's compensation payments, thereafter, a seniority employee who is disabled and unable to work because of a duty disability, shall be entitled to receive 95% of the employee's regular take-home pay, including sums received by way of weekly benefits under the worker's compensation law, any other disability benefits provided by law, any disability insurance provided for by this Agreement, and any social security benefits. The City will pay the difference, if any, between all such payments and 95% of the employee's regular straight time pay for the period of the employee's disability, but not to exceed twelve (12) months from the date of injury or illness.

- F. Disability Insurance: The City shall provide disability insurance effective July 1, 1985, which will pay sixty percent (60%) of an employee's salary at time of disability for a period not to exceed five (5) years. Such coverage shall become effective after a period of six (6) months of continuous disability.
- G. Funeral Leave: Officers shall be granted a funeral leave of up to five (5) consecutive days (regardless of work schedule) with pay, in the event of a death in the officer's immediate family; spouse, father, mother, sister (including step or half), brother (including step or half), son (including step), daughter (including step), mother-in-law, father-in-law or step parent and three (3) consecutive days off (regardless of work schedule) pay, in the

event of a death of brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparents, grandchildren, aunt, uncle, niece or nephew.

- H. The Chief with the written consent of the City Manager or his/her designee may authorize additional leaves of absence, without pay, for any period or periods not to exceed one (1) year for the following purposes:
 - 1) Attendance at college, university or business school for the purpose of training in subjects related to the work of the officer and which will benefit the officer and the City.
 - 2) Urgent personal business requiring an officer's attention for an extended period such as settling estates, liquidating business, running for public or union elective positions or for purposes other than the above that are deemed justifiable.
- I. An officer who has been elected or appointed to a public or Association position will be granted a leave of absence without pay for a period not to exceed two (2) years to serve in such positions.

14. INSURANCE

- A. Hospitalization: The City shall provide a health care plan which coverage (to include co-pays, deductibles, prescription coverage and network) shall be on the whole substantially equal to or better than the level of coverage in effect as of June 30, 2016. Plan documents and summary of benefits attached hereto.
- B. Effective January 1, 2011 the office visit co-payment will be \$20.00
- C. Effective July 1, 2013, all bargaining unit members will contribute 20% of their monthly health care premium by way of once per month payroll deductions on a pre-tax basis. These deductions will be made the first pay period of each month. The cost sharing ensures compliance with PA 152.
- D. Effective January 1, 2009, employees who insure eligible dependents ages 19-25 by way of Family Continuation coverage shall contribute 50% of the premium for this coverage. This premium shall be made by way of monthly payroll deductions on a pre-tax basis. These deductions will be made the first pay of each month.
- E. Optical: The City shall provide group optical insurance coverage for each officer and his dependents, which is substantially equal to or better to the benefits in effect as of June 30, 2016. Plan documents and summary of benefits attached hereto.

- F. Life Insurance: The City shall provide life insurance in the face amount of \$50,000 for each officer in the bargaining unit, with triple indemnity provisions.
- G. The City shall provide each employee with a dental plan on the whole substantially equal to or better than the level of coverage in effect as of June 30, 2016. Plan documents and summary of benefits attached hereto. Orthodontic coverage for employee's dependents, up to age 19 with a \$1,500 lifetime cap.
- H. The City will continue to have the right to select the carrier, to change carriers, and to become self-insured, provided that there shall be no reduction or change in level of benefits. It is further agreed that the only liability assumed under this Article is to pay the premiums as provided herein. Any claim settlement between the employee and the insurance carrier shall not be subject to the grievance procedure. The City shall notify the Association prior to the implementation of a change of carriers.
- I. Effective December 2, 2016, couples who both work for the City of Novi shall receive a health care plan however shall not be eligible for an opt-out bonus payment. Couples already married and working for the City as of December 1, 2016 are grandfathered.

15. LAYOFFS AND RECALL

- A. Definition: A layoff is a reduction of the work force. A Lay Off Reduction is defined to be the reduction of an employee's rank within this bargaining unit, or the Command bargaining unit, when the employer has decided to lay off members of the Police Department because of lack of work, lack of funds, or reasons other than the acts or delinquencies of the employee. The employer will adhere to the principles of last hired, first laid off.
- B. Method: In such cases where the number of employees laid off necessitates a reduction of rank, it shall be done in the following manner: First, the City shall decide the number of Lieutenants to be reduced. That number of Lieutenants shall be reduced to the rank of Sergeant by inverse order of the length of service in the rank of Lieutenant and become members of this bargaining unit. After any Lieutenants have been reduced and if the City decides to reduce any member of the rank of Sergeant, it shall be done in the following manner: The Sergeant who has been a Sergeant the least amount of time shall be reduced to Detective. Should a reduction in total manpower be necessary, the least senior police officer will be laid off. The names of persons holding permanent positions in the rank effected, who have been reduced in rank under this article, shall be placed on an appropriate lay off reduction promotional list in the inverse order of their reduction. The City agrees that no promotion within or outside this unit shall take place until those persons who were laid off are first returned to work, and all members reduced in rank or re-promoted.

- C. Notice of Layoff: The Chief shall give written notice to the City Manger, to the employees, and to the Union on any proposed layoff. Such notice shall state the reasons therefor, and shall be submitted at least fourteen (14) calendar days, or earlier if possible, before the effective date thereof.
- D. Recall Procedure: When the working force is increased after a layoff, employees will be called in the inverse order of layoff. Notice of recall shall be sent to the employee at his/her last known address by telegram or certified mail. If an employee fails to report for work within ten (10) days from notice of recall, he/she shall be considered to have voluntarily terminated his/her employment.

16. LEGAL REPRESENTATION FOR OFFICERS AND POLICE PROFESSIONAL LIABILITY INSURANCE

The City shall provide at its expense such legal assistance as shall be required or needed by an officer as the result of acts occurring when and while said officer was in the good faith performance of his police duties and responsibilities. If for any reason such legal assistance is denied, then the City shall submit a written report to the affected officer and the Association setting forth the specific reasons for such denial, which denial and reasons may be the subject of a grievance.

The City shall further keep in effect and maintain a Police Professional Liability Policy insuring each employee in the amount of not less than one million (\$1,000,000) dollars for any claim, suits and/or judgements against the employee and occasioned by the officer's employment. In the event the City shall fail to maintain such a policy in effect, then the City shall agree to assume and pay any claims, suits and/or judgements rendered against the officer arising out of his employment.

17. LONGEVITY PAY

- A. Annually, on or before the first pay in December, the City will pay to eligible officers in addition to base rate of compensation, longevity payments of:
 - 1) Two percent (2%) of base compensation after five (5) years of service.
 - 2) Four percent (4%) of base compensation after ten (10) years of service.
 - 3) Six percent (6%) of base compensation after fifteen (15) years of service.
 - 4) Eight percent (8%) of base compensation after twenty (20) years of service.
- B. If an officer leaves the employment of the City he/she will receive longevity payments prorated on the months worked since December 1st of

the previous calendar year. An officer must work through the fifteenth of the month for that month to be included in the longevity calculation.

- C. Effective July 1, 2003, employees entering into this bargaining unit shall not receive longevity pay unless already receiving this benefit.

18. MAINTENANCE OF CONDITIONS

- A. Wages, hours, benefits, and working conditions of employment in effect as the execution of this Agreement shall be maintained during the term of this Agreement.
- B. The City will make no unilateral changes in wages, hours, benefits, and working conditions during the terms of this Agreement.
- C. This Agreement shall supersede any existing rules and regulations inconsistent herewith.

19. MANAGEMENT RESPONSIBILITY

The City Council on its own behalf and on behalf of its electors, hereby retains and reserves unto itself, all powers, rights, authority, duties, and responsibilities conferred upon and vested in it by the laws and the constitution of the State of Michigan and of the United States. Further, all rights which ordinarily vest in and are exercised by employers are reserved to and remain vested in the City Council,

- A. to manage its affairs efficiently and economically, including the determination of quantity and quality of services to be rendered to the public, the control of equipment to be used, and the discontinuance of any services or methods of operation;
- B. to introduce new equipment, methods, or processes, change or eliminate existing equipment and institute technological changes, decide on supplies and equipment to be purchased;
- C. to direct the work force, to assign the type and location of work assignments and determine the number of employees assigned to operation;
- D. to determine the number, location, and type of facilities and installations;
- E. to determine the size of the work force and increase or decrease its size;
- F. to hire new employees, to promote employees and to assign, transfer and layoff employees;
- G. to establish and change work schedules, work standards, and the methods, processes, and procedures by which such work is to be performed;
- H. to discipline, suspend, and discharge employees for cause;

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- I. to maintain the discipline and efficiency of officers;
- J. to establish the methods of departmental operation;
- K. to establish, change and enforce City rules and/or Departmental rules and regulations, not in conflict with the terms of this Agreement, governing discipline, health and safety, duties, rules of conduct and work rules.

The City reserves the foregoing rights except such as are specifically relinquished or modified by the terms of this Agreement.

20. MILEAGE REIMBURSEMENT FOR USE OF PERSONAL CAR ON CITY BUSINESS

Officers shall receive prompt reimbursement of the rate established by the Internal Revenue Service for all use of personal cars in connection with assigned duties. It is understood that if an adjustment is made in mileage payments to all City employees, the increase will apply to members of the bargaining unit. The City reserves the right to unilaterally cease the practice of City employees using City vehicles for commuting to and from work. Such action by the City will not be subject for the grievance procedure.

21. MISCELLANEOUS PROVISIONS

- A. The City hereby adopts by reference its Restricted Assignments Policy attached hereto.
- B. The City will afford each officer all necessary equipment to protect the health and safety of the officer.
- C. Medical Examinations: The City may, in its discretion, require that employees submit to medical examinations by City appointed doctors when such tests and examinations are considered to be of value to the City in maintaining a capable work force, employee health and safety, etc., provided, however, that the City will pay the cost of such tests and examinations. It will be the duty of every officer to maintain his stamina and physical condition sufficient to perform the responsibilities of a police officer.

22. NEGOTIATIONS WITHOUT LOSS OF COMPENSATION

Negotiations for successor Agreements shall be held during daytime working hours and Association negotiators shall suffer no loss of compensation for the time during which they participate in negotiations.

23. NO STRIKE PROVISION

The Association agrees that no strike, work stoppage, slow down or other intentional interference with the normal operation of the department, by officers, of any kind shall be caused or sanctioned by the Association at any time during the life of this Agreement. The occurrence of any such acts or actions, prohibited in this section, by the Association shall be deemed a violation of this Agreement.

24. OVERTIME, STANDBY AND CALL-BACK PAY

- A.** The current work schedule will remain in effect. The schedule will not be changed except by mutual agreement between the Union and Employer.
- B.** Officers shall receive time and one-half for all work scheduled or approved in excess of their regular shift (uniform sergeants 12-hours a in any one day, or in excess of eighty four (84) hours in any pay period, including time spent in court appearances. Non-uniform sergeants and lieutenants shall receive time and one-half for all work scheduled or approved in excess of their regular shift, 8-hours in any one day, or in excess of eighty (80) hours in any pay period, including time spent in court appearances. The overtime rate will be based on 2080 hours.
- C.** Trading of shifts shall be allowed, however no officer shall work or be scheduled more than eighteen (18) hours and ten (10) minutes. Any officer working more than eighteen (18) hours and ten (10) minutes may do so only at the request of the Chief of Police. Shift switches are limited to the pay period of the shift switch and the pay period following. This is not to prohibit the long term switching of shifts (i.e. midnight sergeant switching the remainder of their shift bid period with a day shift sergeant).

A sergeant will be called into work whenever there isn't a uniform patrol sergeant on duty. Uniform patrol sergeants will be called first by seniority to fill the vacancy. If there is no uniform patrol sergeant that is available or desires to work the vacancy or part of the vacancy, the work will be offered in the following manner: patrol lieutenant, detective sergeant, detective lieutenant, training and standards sergeant. In the event that no one accepts the assignment, the least senior uniform patrol sergeant will be ordered to work.

- D.** In the event of an absence that is going to exceed thirty (30) days, the City has the right to reschedule by seniority.
- E.** The term "two-week work period" shall be defined as a work period of 336 consecutive hours, i.e. 14 consecutive twenty-four hour days beginning at 11:01 PM every other Saturday.
- F.** An officer who is called back to work during his regularly scheduled time off, for any reason, including court time, shall receive compensation at the

rate of time and one-half for the actual hours worked for a minimum of three (3) hours.

- G. Officers who are placed on court stand-by after regular duty hours or on a day off by being served with a court issued subpoena will be paid at the rate of one-half of their normal base pay for all of such time during which they are required to stand-by, to a maximum of four (4) hours per day.
- H. Officers who are placed on a mobilization alert after regular duty or on a day off by the Chief or his authorized representative shall receive pay at the rate of one-half of their normal base pay for the entire period of such alert.
- I. Leave or vacation days shall not be changed, switched or rescheduled by the City for the purpose of avoiding payment of overtime or call-back pay.
- J. There shall be no pyramiding of overtime pay under any provisions of this Agreement.
- K. Any officer who is called back to work during a regularly scheduled vacation shall be reimbursed for all costs and expenses which he would not have incurred but for such call-back. Such officer shall not lose any vacation days by virtue of such call-back.
- L. Scheduling of work among officers will be done on an equitable basis and will not be arbitrary or capricious.

25. PROTECTION OF HEALTH AND SAFETY

- A. Physical Fitness Testing: All employees shall have the option of participating in the City's Physical Fitness Testing Program. (PFT) All participants must pass a medical examination to qualify for this program. The cost of this exam shall be the responsibility of the City. The PFT shall be scheduled by the City during the months of September or October (two (2) sessions per shift, plus one (1) make-up session, be scheduled so as to hold the testing, so far as possible, during on-duty time), participate in a physical fitness test as outlined below, unless excused from participation by a physician's certification. Employees who successfully complete the PFT by meeting the minimum level for their age/sex categories in all three (3) events shall receive a \$100 incentive bonus payment at the next pay period following completion of the test. Those employees who fail to successfully complete the test or who are excused from participation will receive no incentive bonus.

Participants shall be permitted to dress in comfortable, athletic-type clothing and wear running or athletic shoes.

Personnel on duty shall participate without loss of pay, personnel off duty shall not receive additional compensation.

The physical fitness test shall consist of three (3) events; pushups with a two (2) minute time limit, sit-ups with a two (2) minute time limit, and a two (2) mile run.

- 1) Push-ups: Push-ups shall be done with palms of the hands flat on the ground and toes on the ground, no other portion of the body will be permitted to touch the ground during the duration of the exercise period of two (2) minutes. Exercise will start with arms extended. The body will be lowered until the upper arms is horizontal or slightly below horizontal, it is not necessary to touch the chest, chin or any other portion of the body to the ground. The body will be raised back up until the arms are fully extended. The lowering of the body and raising back will constitute one (1) repetition.
- 2) Sit-ups: Sit-ups shall be done with knees bent, hands locked behind the head, and the feet held down. Exercise will start with the participant lying with the upper body on the ground until the upper body is past vertical, then lower the upper body back to the ground. Raising the upper body from the starting position and returning to the starting position shall constitute one (1) repetition. The exercise will have a two (2) minute duration.
- 3) Run: The run shall consist of traversing a measured two (2) mile distance within a time period.
- 4) Scoring: Minimum acceptable scores are as follows:

<u>Age</u>	<u>Push-ups</u> <u>Men/Women</u>	<u>Sit-ups</u> <u>Men/Women</u>	<u>Run</u> <u>Men/Women</u>
18-25	40/18	40/27	17:55/22:14
26-30	38/15	38/25	18:30/22:29
31-35	33/14	36/23	19:10/24:04
36-39	32/13	34/21	19:35/25:34
40-45	30/12	32/19	20:00/26:00
46-50	28/11	30/17	21:00/27:00
51-55	26/10	28/15	22:00/28:00
56-60	24/09	26/13	23:00/29:00

- B. The City will afford each officer all necessary equipment maintained in proper working order to protect the health and safety of the officers. The City agrees that no officer shall be required to use a marked car which has been driven in excess of 100,000 miles. City further agrees to replace

and/or repair the driver's seat if necessary prior to the 100,000 miles. All other vehicles are based upon the discretion of the City.

26. RESIDENCY

All employees shall, as a condition of continued employment, be residents and reside within that area which is within thirty (30) miles from any corporate City limit of the City of Novi.

27. RETIREMENT

A. The City shall continue to make monthly contributions on behalf of each officer to the Michigan Municipal Retirement System (MERS) to provide at a minimum all of the present and future benefits to which the officers are now entitled under the present arrangement between the City and MERS, as specified under benefit level B-2 including options F-50 with 25 years of service, and FAC-3. All contributions for the B-2 benefit level shall be fully paid by the City. Effective July 1, 2000, this unit shall begin participating under the benefit level B-4. The difference in cost between the B-2 and B-4 benefit shall be totally funded through employee contributions. For purposes of computing MERS final average compensation:

1. Any lump sum payment for personal business days paid to the employee upon termination will be excluded when computing the employee's final average compensation.
2. Any lump sum payment for "Comp Time" shall be excluded from MERS final average compensation.

Overtime shall be capped at 350 hours per fiscal year (based on payrolls from July 1 to June 30 each fiscal year). In July of each year the Finance Department will run a report of the overtime for the command officers. If the total hours of overtime exceeds 350 hours, the straight time overtime hours will be reduced first until gone, and then the cap will be applied to the regular overtime. For all hours exceeding the 350 cap, the employee will receive a reduction in eligible MERS wages for the amount in excess of the cap for purposes of the employee and employer contribution for eligible MERS earnings and the City will make an adjustment to the employee's first payroll in August. The City will also submit corrected ePASS reports to MERS for the months affected by the adjustment. In the event of termination of employment, the cap will be calculated and applied through that date and the MERS eligible wages will be adjusted in the final payment and reported to MERS thru corrected ePASS reports for each month affected by the adjustment.

B. Upon retirement or disability retirement as defined by MERS the City shall provide an eligible employee and spouse (as defined by law) or retiree's child up to their 26th birthday, with health care benefits that are on the whole substantially equal to or better than the level of coverage in effect as of June 30, 2016. Plan documents and summary of benefits attached

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- hereto. All employees who retire after January 1, 2009 shall make retiree health care premiums by way of Direct Payment Program offered by the City. The City maintains the same rights as contained in section 14, article H.
- C. Upon retirement or disability retirement as defined by MERS the City shall allow the eligible employee and one dependent, at the time of retirement, the option of obtaining dental insurance, based upon the current level of benefits at the time of retirement, with retiree paying 100% of the premium which shall be paid by way of auto payment to the City.
 - D. The sole obligation of the City shall be to provide the benefits upon retirement as defined by contract. Any funds established by the City shall be vested in the City, and no officer covered by this agreement shall be considered to have any proprietary interest in these funds. In the event that alternative funding sources become available, either by legislative action or at the option of the City, any funds established for the purpose of providing medical coverage upon retirement shall belong entirely to the City. Furthermore, the City reserves the right to change providers within the limitations as described by Article 14.
 - E. The City agrees to pay 80% of the retiree's medical coverage, and the retiree agrees to pay the remaining 20%. Failure to remit the retiree's share of the premium cost in a timely fashion shall be grounds for suspending the above coverage.
 - F. To qualify for this coverage an employee must possess a minimum of twenty (20) years of seniority upon retirement. Employees granted a disability retirement shall be excluded from this provision.
 - G. Effective the date of signing of this agreement, eligible Retirees who reach full Medicare eligibility (currently age 65) shall receive health care through Medicare, requiring the retiree (and spouse and/or one dependent) to be enrolled in and pay 100% of the premium for Medicare Parts A and B (current structure). Secondary coverage will be provided through a supplemental Plan. As set forth in sub-section (A) of the CBA, the City shall pay 80% of this supplemental plan and the retiree and spouse (and/or one dependent), if applicable, shall pay 20% of the premium for the supplemental plan.
 - H. The spouse of a retiree shall have survival rights to the medical coverage, as described above, subject to the following conditions:
 - 1) The City agrees to pay 80% of the spouse's medical coverage, and the spouse agrees to pay the remaining 20%.
 - 2) In the event that the spouse shall have comparable or better insurance available, the City shall have no obligation to continue coverage. In the event the spouse loses the comparable coverage the spouse will then become eligible for coverage from the employer.

- I. Upon the retirement or disability retirement the City shall provide to the officer his/her gun, badge and uniform silverware as a token of the City's appreciation for the officer's years of service.

28. SAVINGS CLAUSE

If any article or section of this Agreement or any appendixes or supplements thereto should be held invalid by operation of law or by any tribunal of competent jurisdiction, or if compliance with or enforcement of any article or section should be restrained by such tribunal, the remainder of this Agreement shall not be affected thereby, and the parties shall enter into immediate collective bargaining negotiations for the purpose of arriving at a mutually satisfactory replacement for such article or section.

29. SENIORITY

- A. Newly appointed command officers shall acquire bargaining unit seniority except in cases of extension, after working twelve (12) consecutive months in the command capacity in which event the officer's command seniority will date back to the date of his/her appointment. Such seniority shall not preclude any seniority rights preserved under the terms of the COAM contract. In the event that two or more officers have the same date of appointment, then seniority shall be determined among such officers by the date of the application for employment, the one with the earliest date of application having the greatest seniority.
- B. Any officer shall lose his seniority for the following reasons only:
 - 1) He/she quits.
 - 2) He/she is discharged. In the event the discharge is reversed through the grievance procedure, his/her seniority shall be reinstated to date of hire.
 - 3) He/she is absent for three (3) consecutive working days without notifying his/her supervisor or the Chief of Police. After such absence, the City will send written notification to the officer at his/her last known address that he/she has lost his/her seniority, and his/her employment has been terminated. If the disposition made of any case is not satisfactory, the matter may be referred to the grievance procedure.
 - 4) If he/she does not return to work from sick leave and leaves of absence within three (3) days of the end of the leave.
 - 5) Retirement or regular service retirement.
- C. An officer who at any time returns from leave granted by the City shall be entitled to return to his/her former position with no loss of rank or seniority.

- D. An officer who is promoted from the bargaining unit to a non-bargaining unit position with the City shall retain for a period of five (5) years all seniority accumulated by him/her as a member of the bargaining unit and shall be entitled to exercise the seniority at any time that he/she is either laid off or demoted from his/her position.
- E. An officer who is demoted from the bargaining unit to a non-command position within the Police Department shall lose all seniority accumulated by him/her as a member of the bargaining unit unless the decision is reversed through the grievance procedure.

30. TERMINATION

This Agreement shall be effective as of the 1st day of July, 2016 and shall remain in full force and effect until the 30th day of June, 2020. It shall be automatically renewed from year to year thereafter unless either party shall notify the other in writing sixty (60) days prior to the anniversary date that they desire to modify this Agreement. In the event that such notice is given, negotiations shall begin not later than forty-five (45) days prior to the anniversary date; this Agreement shall remain in full force and be effective during the period of negotiations and until notice of termination of this Agreement is provided to the other party in the manner set forth in the following paragraph.

In the event that either party desires to terminate this Agreement, written notice must be given to the other party no less than ten (10) days prior to the desired termination date which shall not be before the anniversary date set forth in the preceding paragraph.

31. TUITION REIMBURSEMENT

The reimbursement of tuition costs shall be governed by the City of Novi Tuition Reimbursement Policy which is herein adopted by reference. Effective January 1, 2009 tuition reimbursement shall be increased to \$3,500 per employee per year.

32. UNIFORMS AND CLEANING AND MAINTENANCE ALLOWANCE

Quartermaster Program: The City will assume the responsibility for cleaning and replacement of uniforms for the positions of Sergeant and Uniform Patrol Lieutenant. The City shall increase the annual shoe/boot allowance from \$50.00 to \$100.00 with proof of purchase.

Non-uniform positions in this bargaining unit shall continue to receive a uniform allowance. This allowance shall consist of a yearly maintenance of Four Hundred (\$400) dollars payable on April 15 and a yearly clothing allowance of Four Hundred (\$400) dollars payable on August 15.

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33. VACANCIES AND PROMOTIONS

- A.** In the event there is a vacancy in the Lieutenant rank the employer will establish an eligibility list for that position. The eligibility list will remain in effect for two (2) years. The employer will appoint an individual who is among the top three (3) on the eligibility list. After each appointment a new designation of the top three (3) on the eligibility list will be made.
- 1)** The preparation of an eligibility roster will be announced as follows:
 - a)** The Chief will announce the specific examination dates at least thirty (30) days in advance.
 - b)** To the extent possible, the Chief will furnish a bibliography and outline covering the contents of the written examination.
 - c)** Lieutenant's Competitive Examination: Those employees with a minimum of one (1) year of full-time service as a Sergeant or a Detective Sergeant in the Novi Police Department will be eligible to participate in the competitive examinations, provided that the employee must request to participate in the examinations by submitting an appropriate written request to the Chief no later than fourteen (14) days prior to the first examination date.
 - 2)** The competitive elements of the examination will consist of a written examination, oral examination and departmental evaluation. The City shall have the right to substitute an assessment center for the oral board.
 - 3)** Candidates will be ranked on the basis of a composite score computed as follows:
 - a)** The percentage attained on the written examination multiplied by fifty (50%) percent.
 - b)** The percentage attained on the oral examination multiplied by twenty-five (25%) percent.
 - c)** The average percentage attained on the departmental evaluations multiplied by twenty-five (25%) percent.
 - 4)** All individuals promoted to the rank of Lieutenant shall serve a one (1) year probationary period.
 - 5)** For new positions and assignments, other than uniform patrol, Sergeants must have one (1) year of uniform patrol experience before the employee can be eligible for reassignment.

- 6) The City maintains the exclusive right to determine the number of persons in each rank.
- B. In the event there is a vacancy to the rank of Captain, an assessment center will be used to test the candidates. The City will establish an eligibility list for the position of captain which will remain in effect for two (2) years.
- 1) The City will announce their intent to hold an assessment center at least 30 days in advance.
 - 2) All sergeants and lieutenants may test for the rank of captain. If no sergeants or lieutenants are deemed qualified by the assessment center, the City shall have the right to solicit outside candidates with the understanding that any sworn officers are also eligible to apply.
 - 3) Participants of the assessment center will be deemed either qualified or not qualified for the position of captain and be given a rank order. If two (2) or more lieutenants are deemed qualified, the Chief will chose one of them for the captain position. If fewer than two lieutenants are deemed qualified, the Chief may choose any one of the top three ranked candidates including sergeants.

C. Evaluations

1. Adopt the Current (2016) COAM semiannual Lieutenant Promotional Evaluation form and categories (documents attached).
 - a. Change scoring to a scale of 1 through 10.
 - b. Standards will be defined as; 1-2, Does not Meet Standards; 3-4, Below Standards; 5-6, Meets Standards; 7-8, More Than Meets Standards; 9-10, Exceeds Standards
2. Lieutenants complete evaluations of their subordinate sergeants. The evaluations are reviewed by the Assistant Chief for completeness. The Assistant Chief may add commentary, but may not change the scores. If the sergeant(s) are in a division with no assigned lieutenants, the Assistant Chief of the division will complete the evaluation.
3. An Assistant Chief completes evaluations for Lieutenants.
4. Evaluation scores may be appealed to the Chief by the employee.
5. Evaluations will be retained for two years only and then expunged.

6. The purposes of evaluations will be to provide a feedback mechanism for the Department to communicate with sergeants and lieutenants with information on their performance.
7. Evaluations will not be used in any disciplinary process against any employee.

D. Video Review

1. The purpose of random review of employee video footage is to provide quality assurance.
2. The random review may be conducted by the employee's direct supervisor. Approximately fifteen minutes of footage will be reviewed every quarter. A report will be generated documenting the results of the random review. The purpose of the report will only be to provide proof that the random review was completed. Documents and reports generated as a result of random video reviews shall be expunged after two years.
3. Substantial and/or Recurring violations or deficiencies identified as part of the review shall be handled in accordance with Directive 310. Lesser violations shall not be subject to discipline.

34. Vacation

- A. One (1) through four (4) years of service with the City ten (10) working days per year (80 hours).
- B. Five (5) through nine (9) years of service with the City fifteen (15) working days per year (120 hours).
- C. Ten (10) through fifteen (15) years of service with the City twenty (20) working days per year (160) hours.
- D. Beginning the sixteenth year of service an officer will be given one (1) additional day per year of service to a maximum of twenty-five (25) working days per year.
Eligibility for vacation time earned shall be administered in the following manner:

An officer will begin to earn vacation time immediately upon hire. At the end of the calendar year of hire an officer will be eligible for the vacation allotment as shown above in this agreement. Thereafter, vacation leave will be earned on a calendar year. Consistent with the requirements of the service, officers shall be entitled to take their vacation during the period which they request, except in cases of conflict which would create a staffing problem for the department. In the event of conflict, the officers with the most seniority shall be entitled to vacation preference. A carryover of vacation time, not to exceed ten (10) working days (80 hours) will be allowed.

As of September 26, 1994, it was agreed by and between the City of Novi and the Command Officers Association of Michigan that employees who are on vacation leave, but are available for overtime assignments shall be placed at the bottom of the overtime call-in list, and shall not be offered overtime unless all other Officers have either rejected the available time or are unavailable for work. Under these circumstances the employee will receive payment for the previously scheduled vacation and whatever overtime rate would be applicable per the union contract.

35. VETERANS LAW

The re-employment rights of officers and probationary officers who are veterans shall be as prescribed by applicable laws and regulations.

Officers who are in some branch of the armed forces, reserve or national guard, will be paid the difference between their reserve pay and their regular pay under this Agreement while they are on active duty in the reserve or national guard, provided proof of active duty and pay are submitted to the City. The obligation of the City under this provision is for a maximum of two weeks per year per officer.

36. WAGES

Officers shall be compensated in accordance with the wage schedule attached to this agreement and marked Appendix A. The attached wage schedule shall be considered a part of this Agreement. When any position not listed on the wage schedule is established, the City may designate a job classification and rate structure for the position. In the event the Association does not agree that the classification or rate is proper, the Association shall have the right to submit the issue as a grievance through the grievance procedure.

- A. Sergeants and uniform Lieutenants who work or are regularly scheduled to work between the hours of 7PM and 7AM shall be paid a shift premium of fifty cents (\$.50) per hour. This shift premium shall not include the hours of 6:50 A.M. to 7:00 A.M. All Sergeants and uniform Lieutenants who work after 7 P.M. and extends beyond 7 A.M. because of overtime will continue to receive the shift premium of fifty cents (\$.50) per hour to the end of their shift. Shift premiums shall be paid only for those hours actually worked between 7 P.M. and 7 A.M.
- B. Effective November 1, 2006, the 10-minute briefing period will be paid to each affected officer on a pro-rated basis, if necessary. This payment will be for 30.5 hours paid at the straight-time over-time rate (based upon 2,214 hours) on the second (2nd) pay in November.
- C. Effective the date of City Council adoption of this agreement, current

members of this bargaining unit will receive a 2% wage increase and a \$1,000 one-time stipend paid to each current member of the bargaining unit on the first pay in December, 2016.

- D. Effective July 1, 2017 current members of the bargaining group shall receive a 2.5% wage increase.
- E. Effective July 1, 2018, current members of the bargaining unit shall receive a 2.5% wage increase.
- F. Effective July 1, 2019, current members of the bargaining unit shall receive a 2% wage increase and a \$1,000 one-time stipend paid to each current member of the bargaining unit on the first pay in December 2019.

37. WAIVER CLAUSE

The parties acknowledge that during the negotiations which resulted in this Agreement, each had the unlimited right and opportunity to make demands and proposals with respect to any subject or matter not removed by law from the area of collective bargaining and that the understandings and agreements arrived at by the parties after the exercise of that right and opportunity are set forth in this Agreement, each voluntarily and unqualifiedly waive the right, and each agrees that the other shall not be obligated to, bargain collectively with respect to any subject or matter referred to or covered by this Agreement.

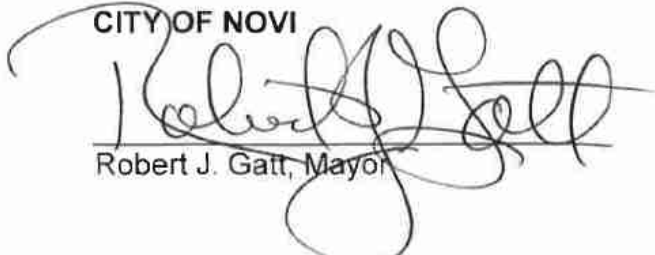
IN WITNESS WHEREOF, the parties hereto have set their hands and seals
this 14th day of March, 2017.

**COMMAND OFFICERS
ASSOCIATION OF MICHIGAN**

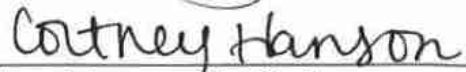


Mark Zacks, Business Agent

CITY OF NOVI




Robert J. Gatt, Mayor

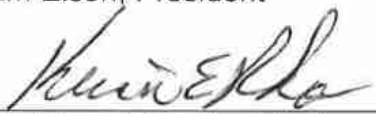


Cortney Hanson, City Clerk

**NOVI LIEUTENANTS AND
SERGEANTS ASSOCIATION**



Adam Elsen, President



Kevin Rhea, Vice President

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CLASSIFICATION			2% + \$1,000 Stipend 11/28/2016	2.5% 07/01/2017	2.5% 07/01/2018	2% + \$1,000 Stipend 07/01/2019
Sergeant	Salary Rate - 84 Hours	A	\$ 85,979	\$ 88,128	\$ 90,331	\$ 92,138
		H	\$ 39,368	\$ 40,352	\$ 41,360	\$ 42,188
		BW	\$ 3,306.88	\$ 3,389.54	\$ 3,474.27	\$ 3,543.77
	84 Hour Overtime Rate	H	\$ 62.004	\$ 63.554	\$ 65.143	\$ 66.446
	84 Hour Straight-Time Overtime Rate	H	\$ 38.834	\$ 39.805	\$ 40.800	\$ 41.616
Sergeant	Salary Rate - 80 Hours	A	\$ 85,979	\$ 88,128	\$ 90,331	\$ 92,138
		H	\$ 41,336	\$ 42,369	\$ 43,428	\$ 44,297
		BW	\$ 3,306.88	\$ 3,389.54	\$ 3,474.27	\$ 3,543.77
	80 Hour Overtime Rate	H	\$ 62.004	\$ 63.554	\$ 65.143	\$ 66.446
	80 Hours Straight-Time Overtime Rate	H	\$ 41.336	\$ 42.369	\$ 43.428	\$ 44.297
Lieutenant	Salary Rate - 80 Hours	A	\$ 92,624	\$ 94,940	\$ 97,314	\$ 99,260
		H	\$ 44,531	\$ 45,644	\$ 46,786	\$ 47,721
		BW	\$ 3,562.46	\$ 3,651.54	\$ 3,742.85	\$ 3,817.69
	80 Hour Overtime Rate	H	\$ 66.796	\$ 68.466	\$ 70.178	\$ 71.582
	80 Hours Straight-Time Overtime Rate	H	\$ 44.531	\$ 45.644	\$ 46.786	\$ 47.721

APPENDIX B

RESTRICTED ASSIGNMENTS

Section 1. A City of Novi full time employee who is unable to perform the essential functions of his/her regular job assignment as demonstrated by medical evidence due to a duty or non-duty related disability, may be eligible for a restricted assignment.

- A. **Non-Duty:** An employee may be eligible for a non-duty restricted assignment only after the employee has utilized one hundred sixty (160) hours of accrued sick leave benefits or after completing a thirty (30) day waiting period, whichever is less, during the six (6) month period following the date of the disability. After the employee has utilized the 160 hours of accrued sick leave benefits or has completed the 30 day waiting period, the employee may request a restricted assignment.

In the event of a progressive disability, verified through medical evidence in accordance with Section 6 and 7 below, the employee, at the employee's option, may request a non-duty restricted assignment without first exhausting one hundred sixty (160) hours of accrued sick leave or completing the thirty (30) day waiting period.

- B. **Duty:** An employee may be eligible for a duty restricted assignment at which time it is verified through medical evidence of the employer's physician.

Section 2. The request for restricted assignments will be considered upon the submission of the medical documentation set forth in Section 6 below. The City may require additional medical documentation as set forth in Section 7 below before considering the request.

Section 3. The number, if any, and the duration of restricted assignment positions available at any time shall be within the sole discretion of the Department. The functions, duties and scheduling of the restricted assignments shall be determined by the Department. The Department reserves the sole right to modify and/or eliminate restricted assignment positions.

Section 4. If a restricted assignment is available as determined by the Department and the employee is medically able to perform the functions of the restricted assignment, the employee may return to work at his/her regular base salary in the restricted assignment.

Section 5. Non-duty restricted assignments may be granted only during the six month period immediately following the date of disability. All restricted assignments are subject to the following conditions:

- A. The employee continues to be disabled as defined in Section 1
B. The restricted assignment continues to be available as determined by the Department
- TGF

- C. The employee performs satisfactorily in the restricted assignment as determined within the sole discretion of the City.
- D. The City receives all of the medical information it deems necessary pursuant to Sections 6 and 7.
- E. Each non-duty restricted assignment will continue for no more than six months following the date of the employee's disability. Each duty related assignment will continue for no more than one year following the date of the employee's disability.

Section 6. The City may require the employee to periodically submit detailed medical information from the employee's physician to determine whether the employee is disabled from performing the essential job functions, with or without accommodation, of his/her regular job assignment and/or to determine whether the employee can perform the duties and functions of the restricted assignment.

Section 7. The City may require the employee to submit to physical and/or mental tests and examinations by the City appointed physician to determine whether the employee is disabled from performing the essential job functions, with or without accommodation, of his/her regular job assignment and/or to determine whether the employee can perform the duties and functions of the restricted assignment. The City will pay the costs of such tests and examinations.

9/27/02

for
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LETTER OF AGREEMENT

Letter of agreement between the City of Novi and the Command Officers Association of Michigan (Novi Lieutenants and Sergeants Association) regarding the re-organization of the Novi Police Department, specifically the shift and duties of the Uniform Lieutenants and the duties of the Uniform Sergeants.

The job duties and job schedule for the Uniform Lieutenants with the City of Novi Police Department will change. The intent of the change is to provide a mechanism enabling the Uniform Lieutenants to be on-duty primarily when the departmental administration (Chief, Deputy Chief and Assistant Chief) are off-duty. The Uniform Lieutenants will be performing executive level tasks and responsible for managing their respective platoons, including the sergeants and police officers..

Throughout the Collective Bargaining Agreement (CBA) the words "Patrol Lieutenant", "Patrol Division Lieutenant", "Uniform Division Lieutenant" and "Uniform Lieutenant" shall be replaced or refer to the "Uniform Lieutenants"

Article 11, shall be modified to reflect the following:

"Uniform Sergeants and Uniform Lieutenants covered under this agreement shall receive thirteen (13) paid holidays"...

Section A; shall be modified to reflect the following:

"Non-Uniform Sergeants and both Uniform and Non-Uniform Lieutenants shall work a minimum of eighty (80) hours."

Article 12:

Section A, shall be modified to reflect the following:

The Uniform Lieutenants (2) will work an 80 hour work week; consisting of six (6) twelve-hour (12-hour) work days and one (1) eight (8-hour) hour work day.

The 12-hour work shifts of the Uniform Lieutenants will be 2:00 pm – 2:00 am and the 8-hour shift will be 12p-8p or 2p-10p on either a Monday or Tuesday. The specific day (Monday or Tuesday) will be decided at the beginning of the bid period. When establishing the shift, the start time may move up to two (2) hours in either direction. The start time for the shift will be established prior to the open bid period and shall remain in effect for the six-month (6 month) bid cycle

Section B, shall be modified to reflect the following:

The Uniform Lieutenants will choose their shift and days off based upon seniority for six months, i.e. A side or B side. The purpose of this will be to allow administrative meetings between the departmental command personnel.

Section E, shall be modified to reflect the following:

When the Uniform Lieutenants work an 8-hour shift, the shift will include a one-half hour paid lunch.

TGF

Article 24:

Section B, shall be modified to reflect the following:

The Uniform Lieutenants shall receive time and one-half for all hours worked in excess of 12-hours on their scheduled 12-hour work day and in excess of 8-hours on their scheduled 8-hour day or in excess of eighty (80) hours in any pay period, including time spent in court appearances.

Section D, shall be modified to reflect the following:

The words "Patrol Lieutenant" shall be deleted and "Uniform Division Lieutenants" shall be inserted.

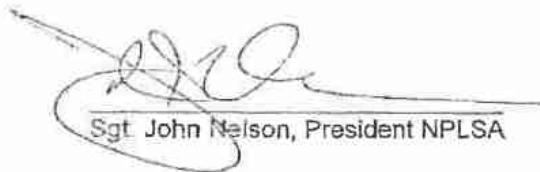
Article 36:

Section A, shall be modified to reflect the following:

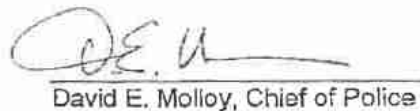
"Sergeants and Uniform Lieutenants who work or are regularly scheduled to work between the hours of 7pm and 7am shall be paid a shift premium of thirty cents (\$0.30) per hour."

IT IS AGREED:

Union:


Sgt. John Nelson, President NPLSA

City:


David E. Molloy, Chief of Police


Tia Gronlund-Fox, Human Resource Director

Dated; December 14, 2009

TGF



LETTER OF AGREEMENT

In settlement of the Grievance filed by the Command Officers regarding the Restricted Assignments Policy, it is hereby agreed by and between the City of Novi and the Command Officers Association of Michigan as follows:

The Police Department does maintain the right to order an employee back to work once that employee's treating physician has released them to return to work with/without restrictions.

The language in the above policy which was originally challenged, Section 1, A "the employee may request a restricted assignment." and Section 2, "The request..." refers to an employee injured in a non-duty incident who may request a restricted/light duty assignment.

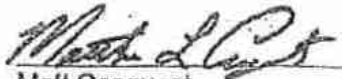
It has been agreed that the following language will replace existing language under Section 1., A. Non-Duty:

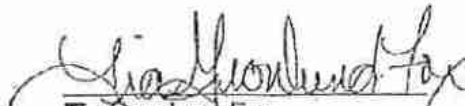
An employee may be eligible for a non-duty restricted assignment only after the employee has utilized one hundred sixty (160) hours of accrued sick leave benefits or after completing a thirty (30) day waiting period, whichever is less, during the six (6) month period following the date of the disability.

The remaining policy language will remain as is.

Union:

City:


Matt Conquest
President


Tia Gronlund-Fox
Director of Human Resources

9.27.02
Date

TGF



CITY OF NOVI

45175 West Ten Mile Road / Novi, Michigan 48375-3024 / (810) 347-0460 general information

CITY COUNCIL

Mayor
Stephen S. McLaughlin
Pro Tem
D. Crawford
A. Mason
J. Mitel
Tim Pope
Robert D. Schind
Joseph G. Toth
City Manager
Edward F. Kuenzli

LETTER OF AGREEMENT

It is hereby agreed by and between the City of Novi and the Command Officers Association of Michigan that employees who are on vacation leave, but are available for overtime assignments shall be placed at the bottom of the overtime call-in list, and shall not be offered overtime unless all other Officers have either rejected the available time or are unavailable for work. Under these circumstances the employee will receive payment for the previously scheduled vacation and whatever overtime time rate would be applicable per the union contract.

Union

A. M. McNamara
Tim McNamara

9-26-94
Date

City

Craig M. Klover
Craig Klover

9/26/94
Date

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**LETTER OF AGREEMENT
COMMAND OFFICERS ASSOCIATION OF MICHIGAN**

It is hereby agreed by and between the City of Novi and the Command Officers Association of Michigan as follows:


The City and the COAM have come to an agreement relating to the issue of Police Officers being dispatched to heart related medical runs and the use of defibrillators during such runs. The City has agreed to the following:

1. Increase officers' comp bank by 40 hours per year to an earned maximum of 120 hours per year. The carry over of hours from one year to the next will remain 40 hours.
2. The City has also agreed to allow each officer the choice between a City issued dickey/turtleneck to be worn under their uniform shirt, or a tie, as part of their winter uniform.

IT IS AGREED,

Union:

City:


Matt Conquest
President


Tia Gronlund-Fox
Director of Human Resources

Dated: September 11, 2002

TGF

Novi Police Department



Command Officer Performance Evaluation and Development Form

Name:

Rank:

Rater:

Date:

Rating Period From:

To:

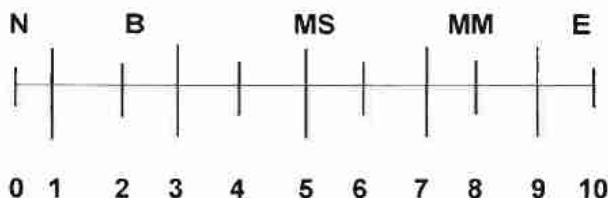
**NOVI POLICE DEPARTMENT COMMAND OFFICER
PERFORMANCE EVALUATION AND DEVELOPMENT FORM**

POSITION: _____

<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Name</p>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Badge</p>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Rank/Division</p>
<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Evaluation date</p>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Employment date</p>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Supervisor/Evaluator</p>

INSTRUCTIONS TO EVALUATORS

Using the numerical scale below, compare the performance of the employee being rated with the performance criteria listed for each category. Select the number which best indicates your perception of that individual's performance in each criterion, and enter it on the associated line. At the bottom of each category is a line on which you will enter a composite, or overall evaluation number for that category. The composite value is not necessarily a mathematical average of the criteria, as some may have greater weight than others. Following each category are lines provided for a narrative which supports or embellishes your number ratings. This narrative must be included and should cite examples of past performance or job behaviors which led to your number ranking. (See descriptive key, below)



"E" = Exceeds Standards: Exemplary performance far exceeding performance criteria and deserving special recognition (less than 5% of personnel). (scale range: 9.0 - 10.0)

"MM" = More than Meets Standards: Performance exceeds the supervisor's expectations in nearly all criteria. (scale range: 7.0 - 8.9)

"MS" = Meets Standards: Performance generally meeting the supervisor's expectations in most criteria. (scale range: 5.0 - 6.9)

"B" = Below Standards: Erratic performance falling short of the supervisor's expectations in most criteria (requires a plan for remedial action to improve employee's performance). (scale range: 2.1 - 4.9)

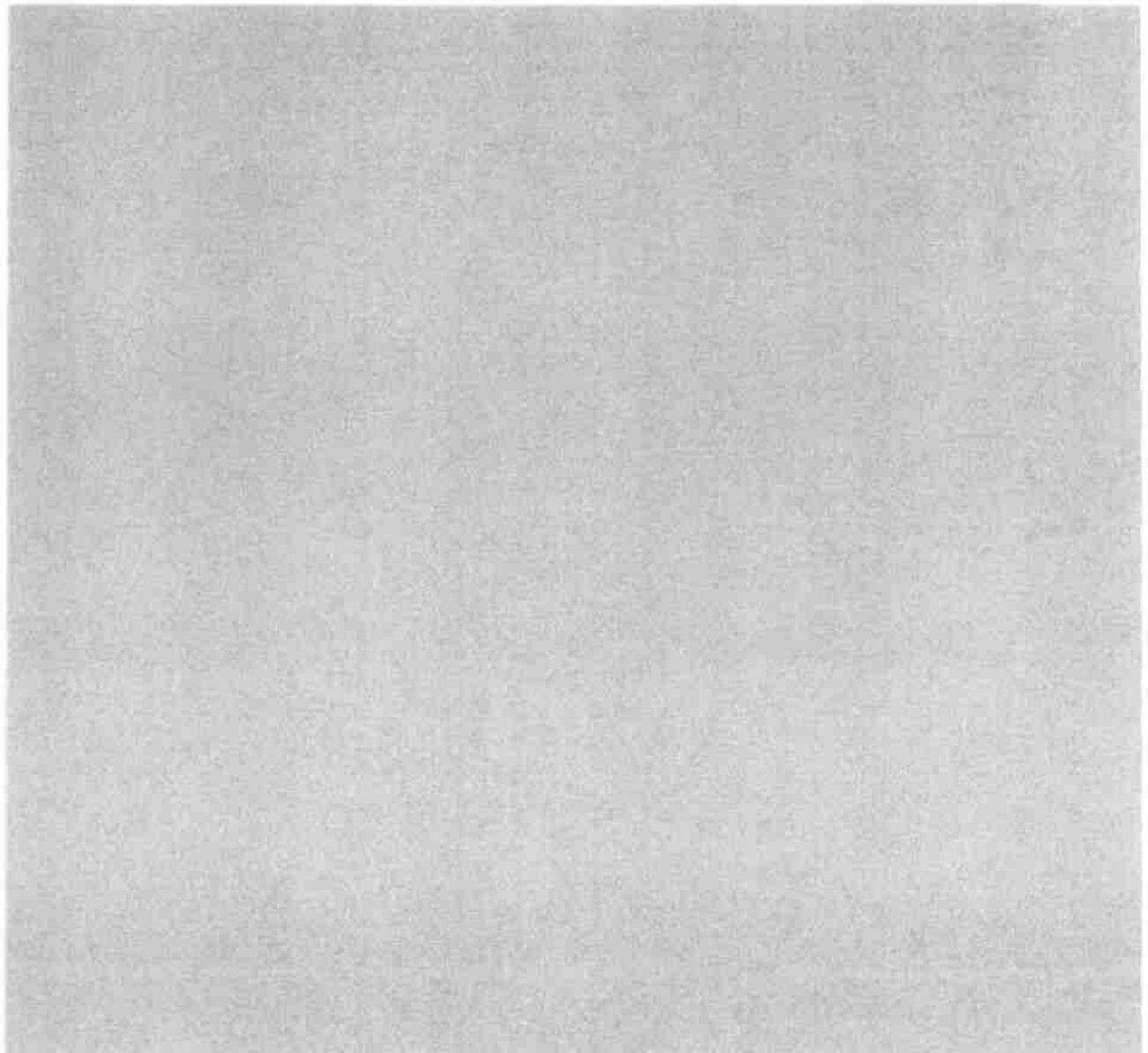
"N" = Does Not Meet Standards: Unacceptable performance in more than 50% of the criteria (requires remedial action plan and administrative review). (scale range 0 - 2.0)

GF

1. COMMITMENT TO DEPARTMENT MISSION/GOALS:

- ☐ a. Understands the mission & goals of the department.
- ☐ b. Properly communicates same to citizens and subordinates.
- ☐ c. Shows concern in his/her work for the entire department.
- ☐ d. Takes active role in developing policy and procedure.
- ☐ e. Is alert for, and assists with needed goal changes.
- ☐ f. Adheres to departmental directives and assures the compliance of his/her subordinates.

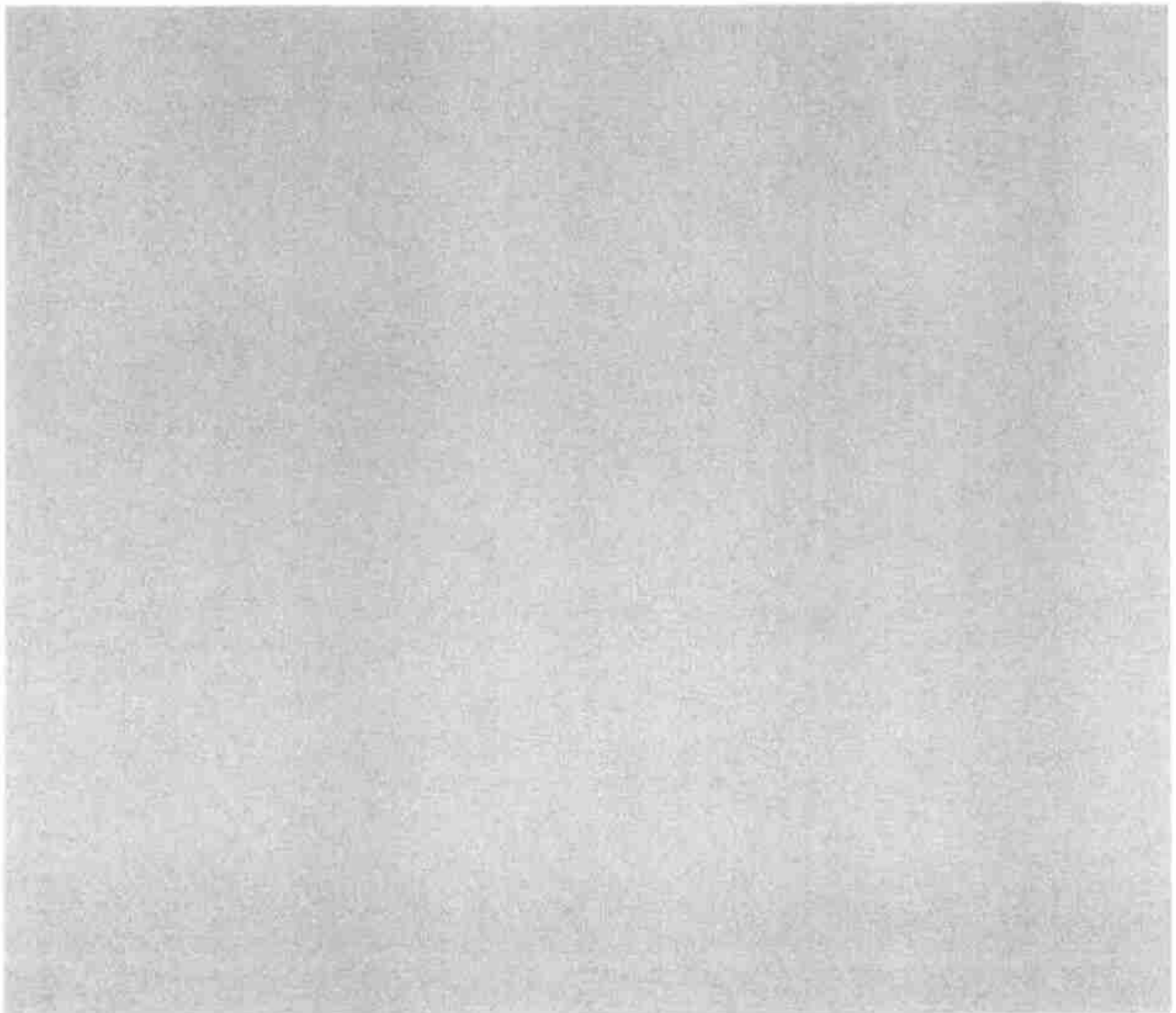
☐ Composite Score for this Category



2. SUPERVISORY KNOWLEDGE/SKILLS:

- ☐ a. Understands Problem-Oriented Policing and actively promotes same with his/her subordinates.
- ☐ b. Has working knowledge of state laws, city ordinance, and department directive/procedure.
- ☐ c. Knows and practices sound management principles.
- ☐ d. Has working knowledge of pertinent labor contracts.
- ☐ e. Displays good "people" skills.

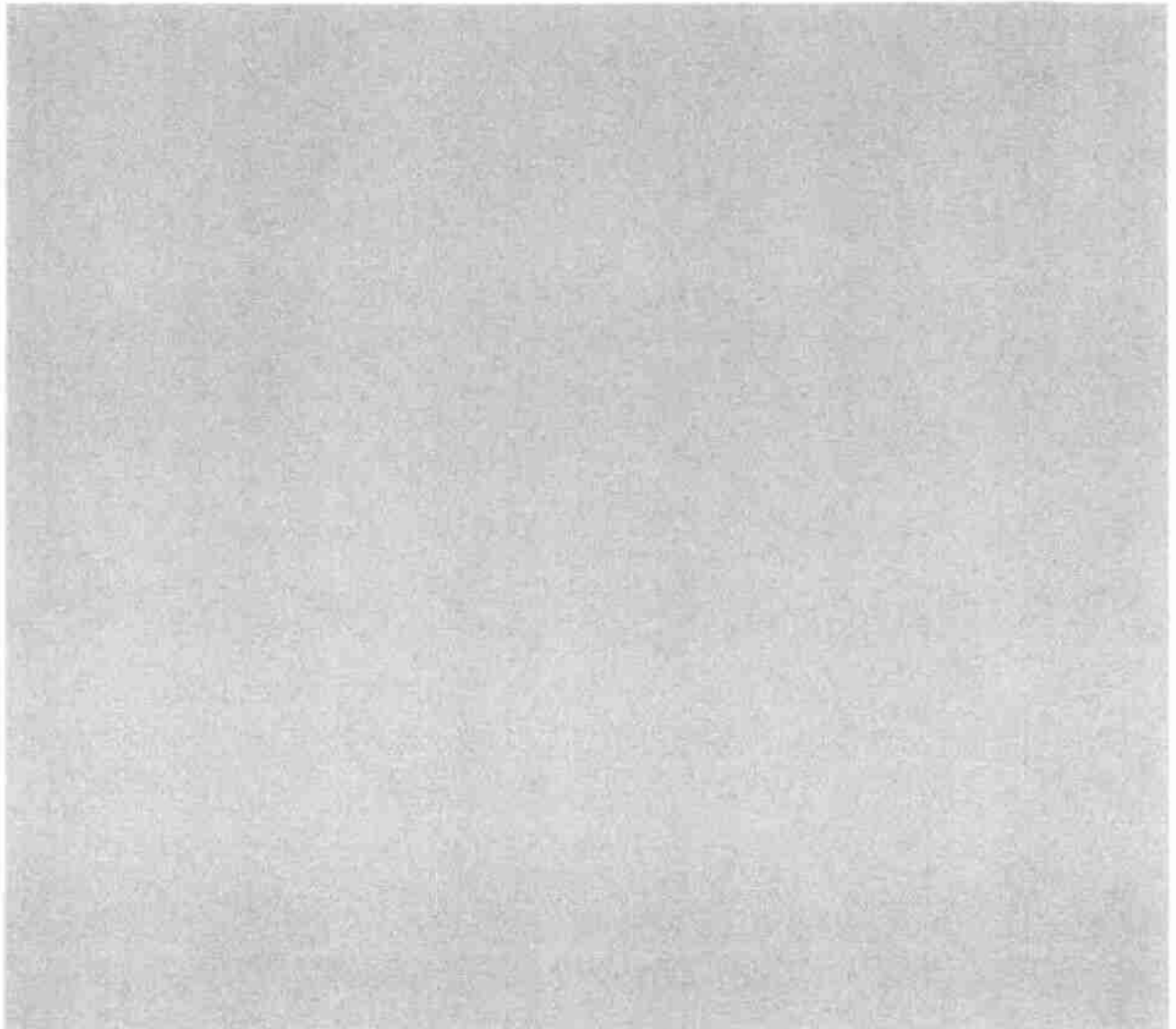
☐ Composite Score for this Category



3. ADMINISTRATIVE STAFF ASSIGNMENTS:

- ☐ a. Completes assigned administrative tasks with enthusiasm.
- ☐ b. Effectively analyzes tasks and finds creative solutions.
- ☐ c. Completed assignments are clearly written and free of major defects.
- ☐ d. Completed assignments are consistent with directives.
- ☐ e. Successfully combines projects with supervisor duties.
- ☐ f. Completes assignments in timely fashion.

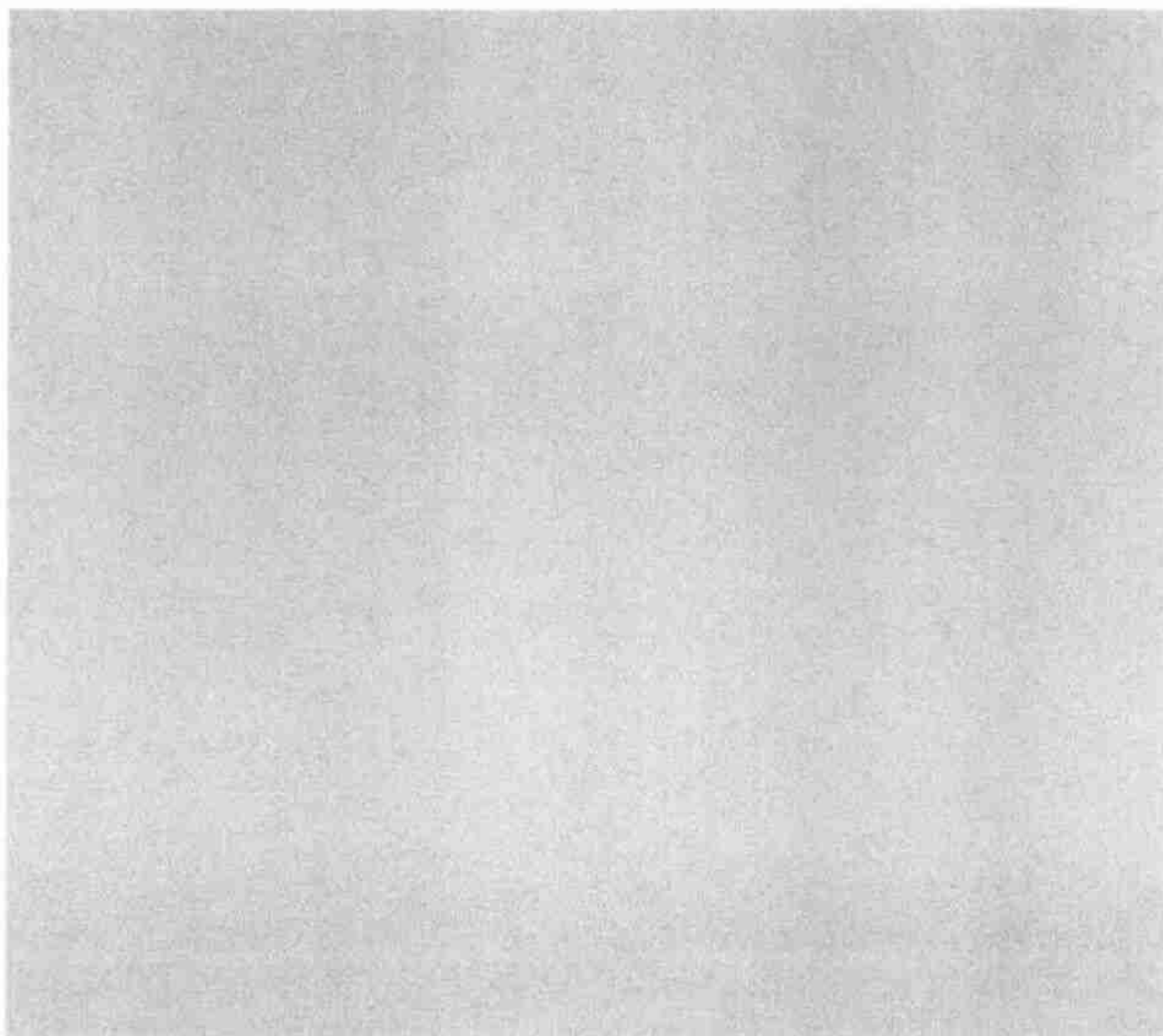
☐ Composite Score for this Category



4. SUPERIOR/SUBORDINATE RELATIONSHIPS:

- ☐ a. Readily accepts assignments and complies with orders.
- ☐ b. Serves as good professional example for subordinates.
- ☐ c. Treats superiors and subordinates with courtesy and respect.
- ☐ d. Deals with subordinates fairly and consistently.
- ☐ e. Serves as mentor and counselor to subordinates.
- ☐ f. Is respectful advisor and assistant to his/her superior.

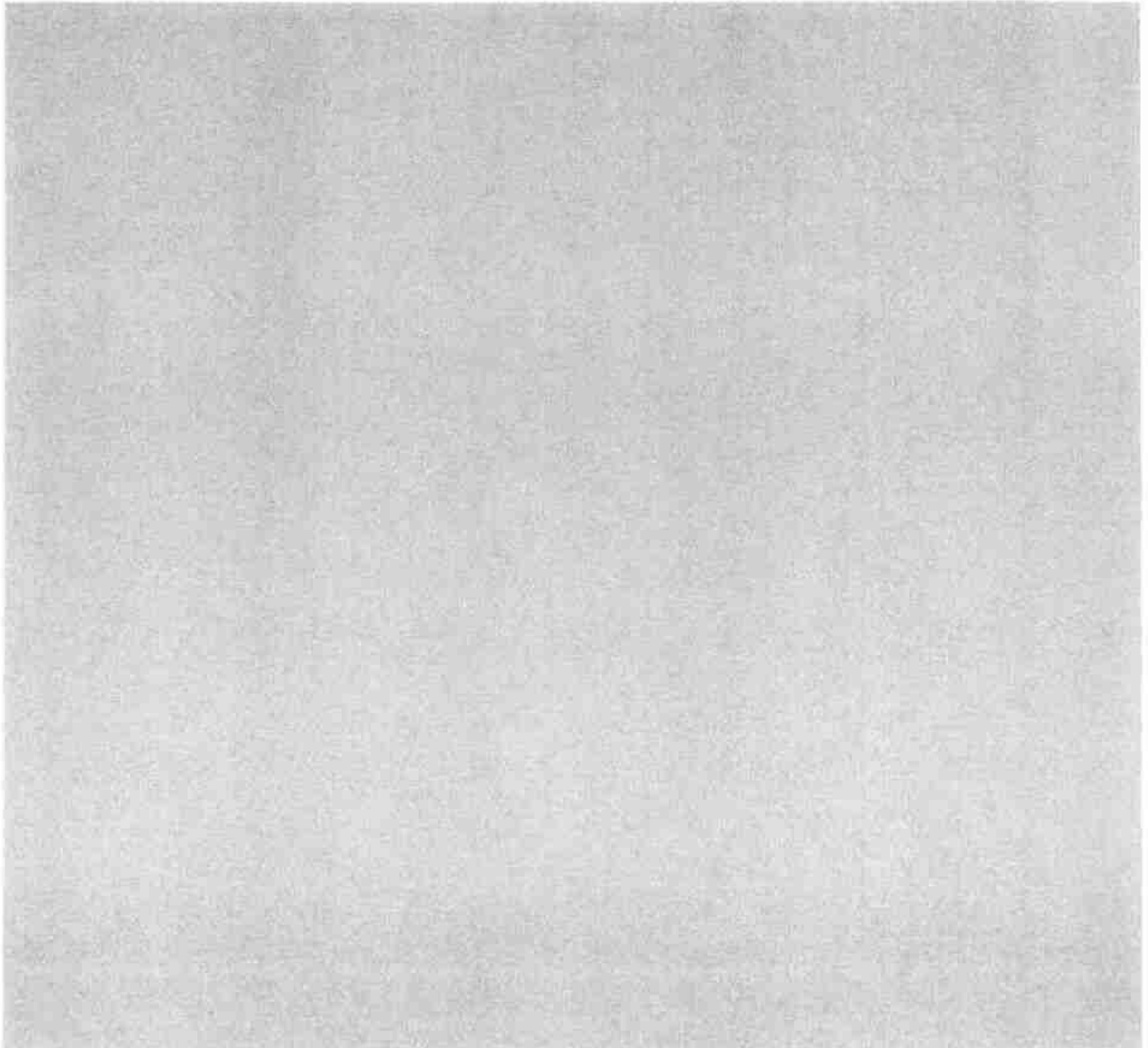
☐ Composite Score for this Category



5. STATION ADMINISTRATION/SUPERVISION:

- ☐ a. Completes required forms accurately and completely.
- ☐ b. Schedules and delegates to subordinates effectively.
- ☐ c. Handles station assignments effectively and efficiently.
- ☐ d. Represents administration well in their absence.
- ☐ e. Spontaneous and flexible in problem-solving.

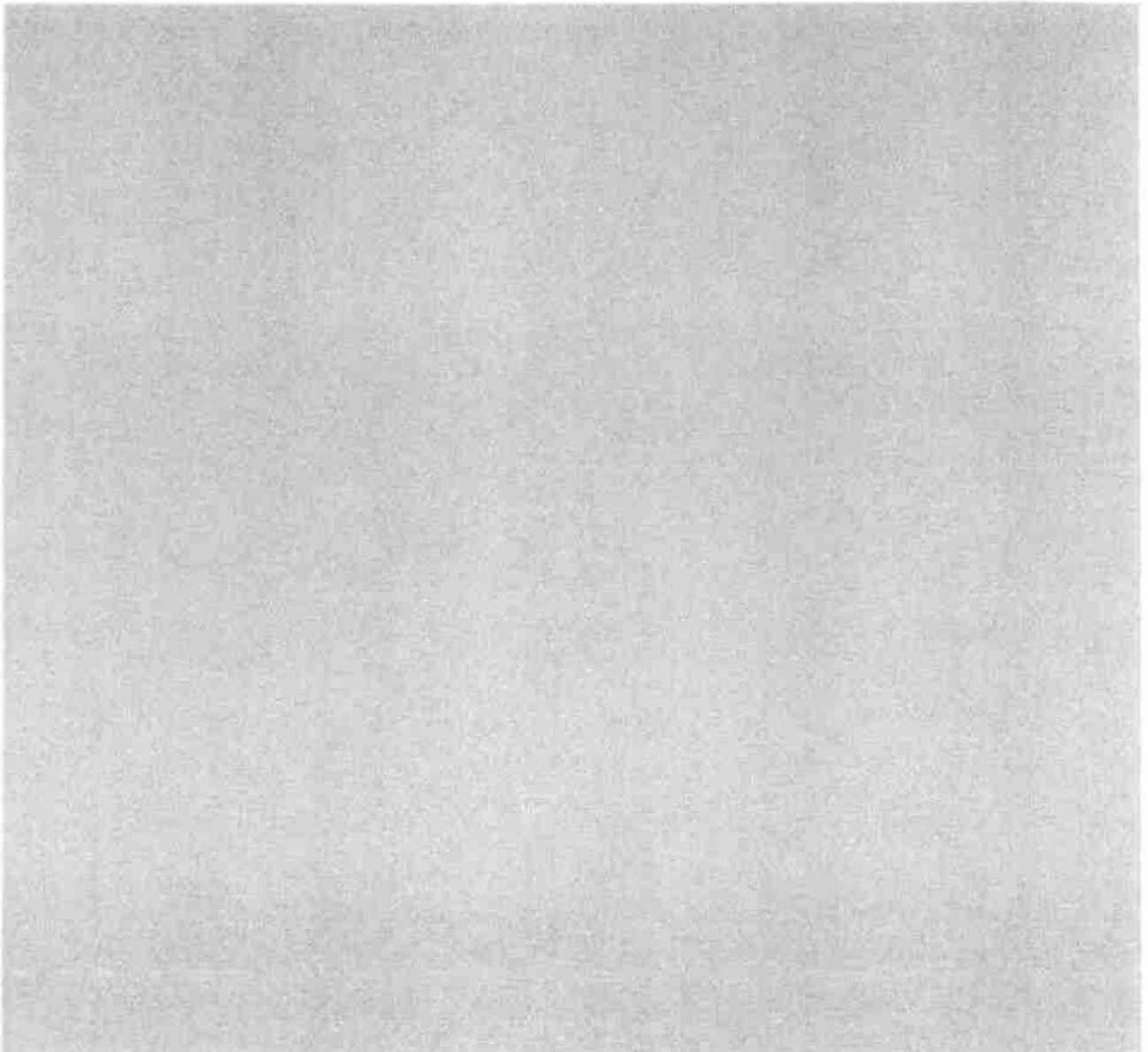
☐ Composite Score for this Category



6. FIELD SUPERVISION:

- ☐ a. Makes effective command decisions when required.
- ☐ b. Guides subordinates in making effective decisions.
- ☐ c. Monitors field activity, even while at the station.
- ☐ d. Displays flexibility and "common sense" in solving field problems.
- ☐ e. Properly deploys department resources.

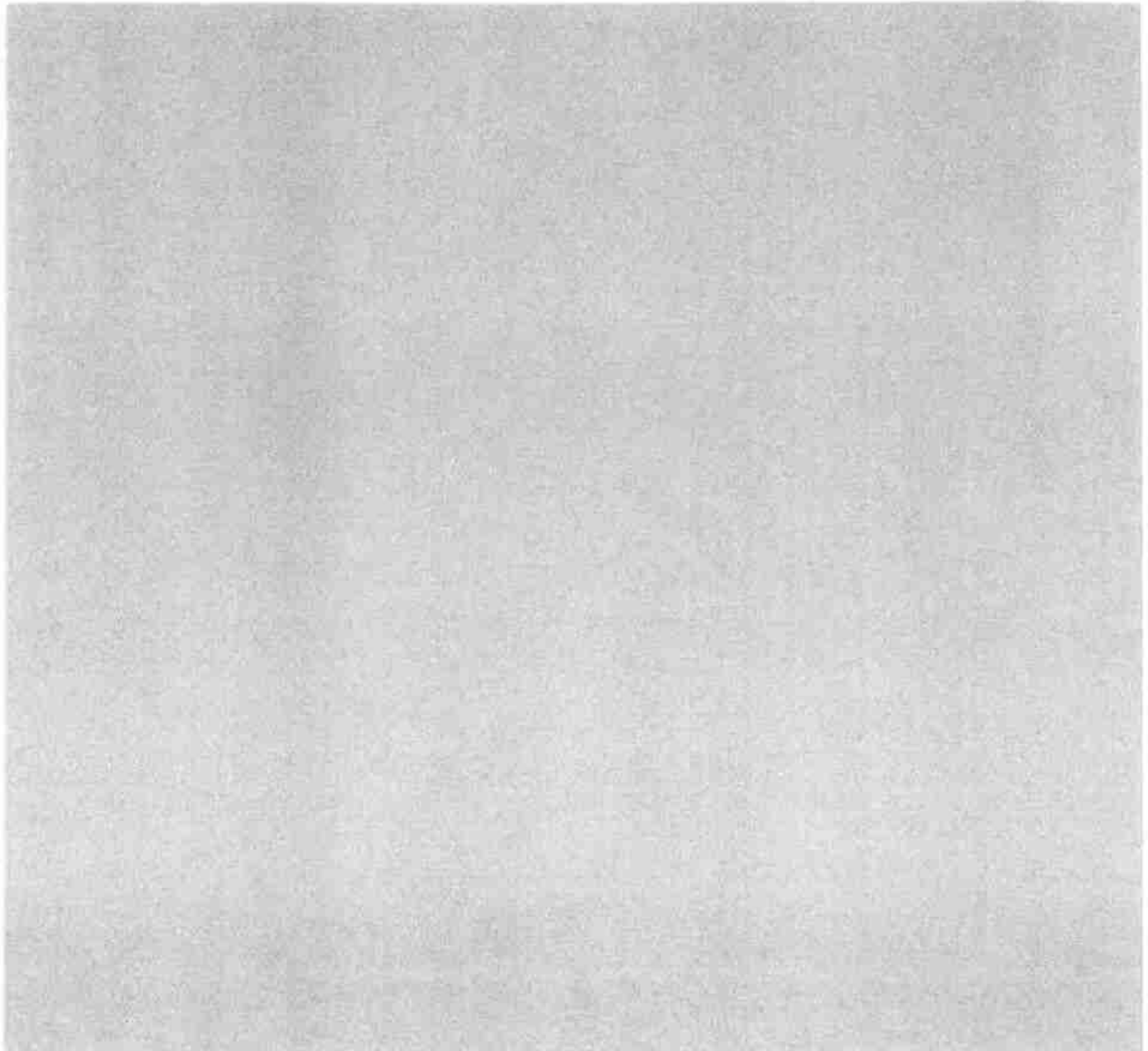
☐ Composite Score for this Category



7. PERSONNEL DEVELOPMENT/TRAINING:

- a. Effectively recognizes and deals with strength/weakness of subordinates.
- b. Provides or facilitates proper subordinate training.
- c. Assists subordinates in reaching their career goals.
- d. Corrective action is rapid, objective, and fair.
- e. Facilitates subordinates' P.O.P projects.

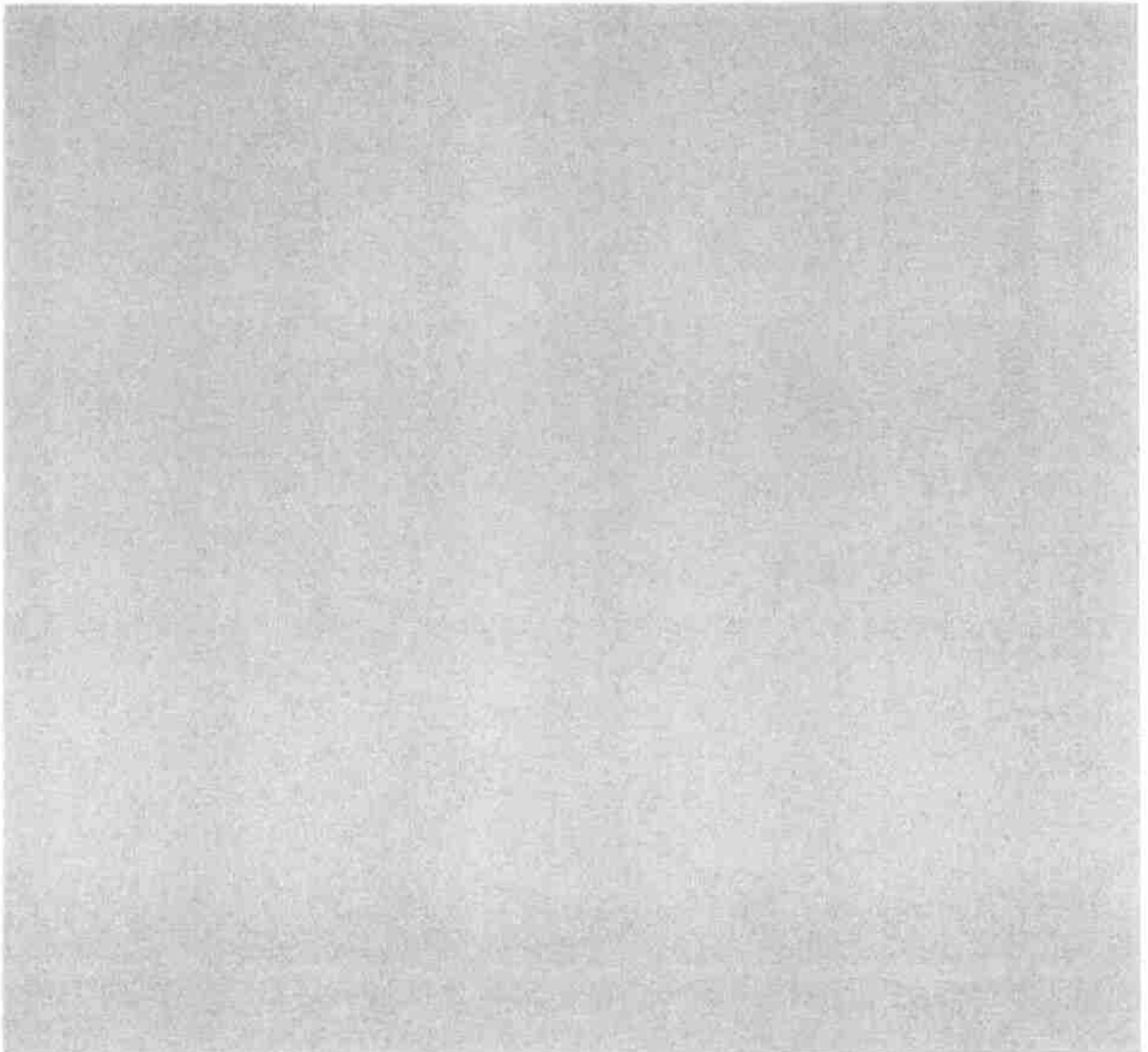
 Composite Score for this Category



8. PUBLIC/INTER-AGENCY RELATIONS:

- a. Treats citizens with courtesy and respect.
- b. Effectively communicates with individuals or groups.
- c. Presents a professional command image to citizens.
- d. Properly represents the department when dealing with other agencies.
- e. Properly handles complaints from citizens in conflict with officers.
- f. Maintains professionalism with hostile citizens.

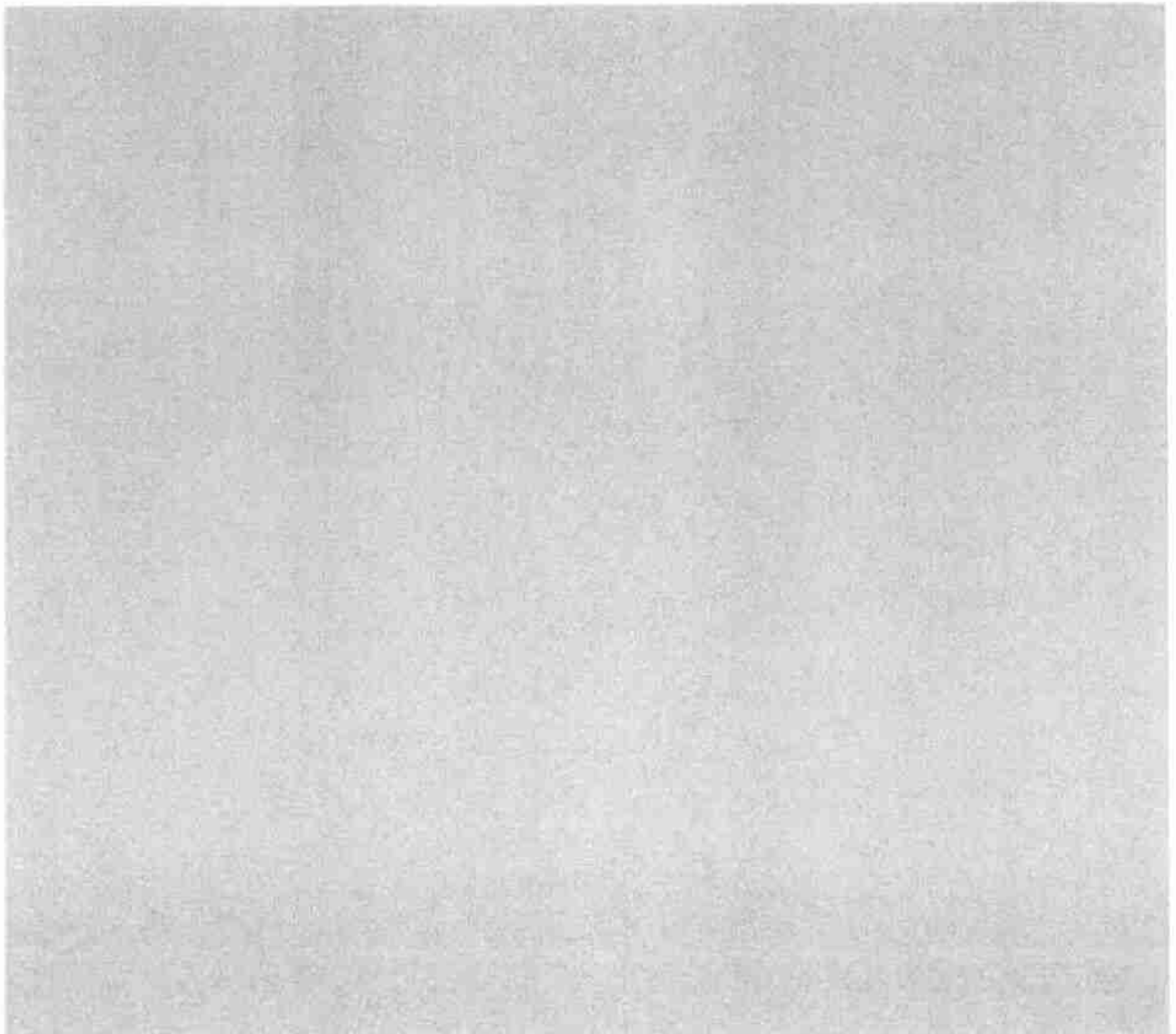
Composite Score for this Category



9. PERSONAL APPEARANCE/PROMPTNESS:

- ☐ a. Sets a good example for subordinates in dress and grooming.
- ☐ b. Consistently ready for work on schedule.
- ☐ c. Properly uses sick time.
- ☐ d. Administers personal schedule effectively (work).
- ☐ e. Consistently keeps professional commitments.
- ☐ f. Develops similar traits in subordinates.

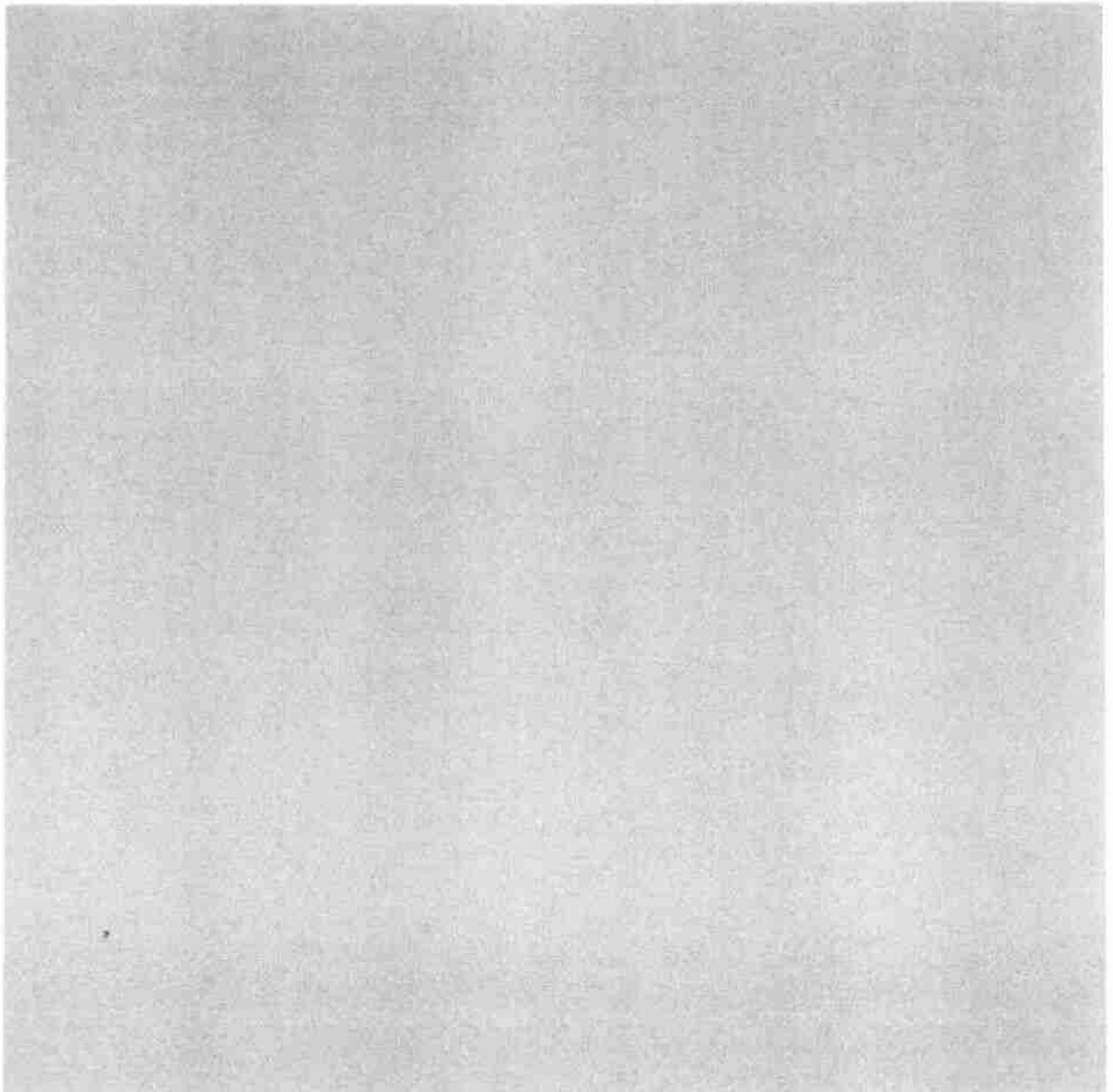
☐ Composite Score for this Category



10. JOB-RELATED SELF-IMPROVEMENT:

- ☐ a. Advanced education.
- ☐ b. Reads current literature.
- ☐ c. Seeks additional involvement in department activities.
- ☐ d. Maintains relationship with other agencies and departments.

☐ Composite Score for this Category



OVERALL PERFORMANCE RATING

Numerical overall value (see instructions below)

(overall performance descriptor from key, pg. 1)

Based upon the ten performance categories and the composite percentage values assigned to them, calculate an overall performance value, using the method illustrated below, and enter it in the space above. Then carefully read the criteria listed on page 1, which define the various performance level ranges and, in the space above, list the word that best describes the employee's overall performance for the evaluation period. This is not necessarily based on the numerical value alone, and may be modified to some degree by the supervisor's narrative, above and/or in "summary" on page 6. The narrative should cite specific examples of the employee's job performance/behavior.

I have read and received a copy of this evaluation

Date

Employee Signature

Date

Rater Signature



COAM



2016 EMPLOYEE BENEFITS OPEN ENROLLMENT GUIDE

January 1, 2016—
December 31, 2016



TGP

WELCOME TO OPEN ENROLLMENT

The City of Novi is committed to offering you a variety of healthcare options to protect you and your eligible family members. For 2016, we will continue to offer the Community Blue PPOs, Health Alliance Plan HMO and Priority Health High Deductible HSA HMO plans you are already familiar with. Details about each of these options are provided in this benefit guide.

The benefits you select during this open enrollment period will remain in place throughout 2016 (unless you have a qualified change in family status).

The information provided in this newsletter is meant to help you and your family choose the health care options best suited to your needs. Please be sure to read the open enrollment newsletter in its entirety and review each option carefully. It contains important information that will help you make informed decisions regarding your health care participation for the 2016 plan year. If you have questions, contact the Human Resources Department at ext. 452.

During this open enrollment period you will have the opportunity to:

- Change your medical coverage selection.
- Enroll in the medical plan of your choice if you have previously waived coverage.
- Enroll eligible dependents previously not enrolled.
- Waive medical coverage if you have coverage available through another source (Note: if you waive coverage you will be eligible for an opt-out bonus).

Note that you and your eligible dependents must each enroll in the same plan.

Summary of Benefits and Coverage (SBC) - under healthcare reform, all plans must distribute a new summary of benefits including coverage examples and a glossary of terms. We are working with our carriers to complete this requirement. Once this information is ready, we will make it available to all employees.



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GP

MEMO FROM HR



It's that time of year again – Open Enrollment. Please take some time to look through the Benefit Guide that has been created for you in order to provide a detailed look into your City of Novi health care and Wellness options for 2016. This Guide not only defines what health care options are available for you and your family, but also breaks down the costs associated with each plan.

Also contained within your Benefit Guide are instructions on what you need to do in order to change your health care election for the upcoming year. Open Enrollment is the only time during the year that you can change your health care selection; unless you have a qualifying event (change in family status due to a marriage, divorce, loss of spousal coverage, etc.). If you have any questions please call Human Resources and we will be happy to assist you.

In 2016, when you file your federal tax return, you will have to provide proof that you were enrolled in a qualifying health plan during 2015. The City of Novi will provide the needed documents for you to submit with your tax return. This information will be mailed to you on or before January 31, 2016. Please keep these documents!

So, look inside the guide and see all the City of Novi has to offer!

From all of us in Human Resources – we wish You and Your Family a safe, happy and healthy 2016!



cityofnovi.org

well-being

Novi - VI dimensions of employee wellness



SOCIAL



OCCUPATIONAL



ENVIRONMENTAL



INTELLECTUAL



EMOTIONAL



PHYSICAL

The City of Novi Employee Wellness Program:



Offering a variety of events, activities, challenges, incentives and information to help you

BE Well

Events listing is always on the Eweb under : HR/Wellness!



well-being

2015- 2016 programs to look for:

- Healthy Eating Workshops and Lunch and Learns
- Interactive Cooking Classes
- Heart Health programs and Blood Drives
- Stress Reduction and Sleep Management Classes
- Chair Massages
- Fitness Challenges and Walking Incentive Programs
- Social Wellness: Food Drives and Service Days
- Fitness Class/ Membership Reimbursement Programs
- Financial Wellness Sessions
 - Retirement Planning
 - Tax Season Preparation
 - Budgeting and Debt Management
- Health Fairs and Health Screenings
 - One on One Health Assessments
 - Flu Shots
 - Local Health and Wellness Vendors
 - BMI, Blood Pressure, Glucose and Cholesterol Screenings



SOCIAL



OCCUPATIONAL



ENVIRONMENTAL



INTELLECTUAL



EMOTIONAL



PHYSICAL



well-being

2015- 2016 TRAINING to look for:
Learn and Share your knowledge!

- Communication, Conflict Resolution, and Leadership Training
- Work Place Safety, CPR, AED, Fire Safety, & Emergency Procedure Training
- Application/Software Training
 - BS&A Modules
 - OnBase
 - City Works
- Microsoft Training
 - Word
 - Excel
 - Outlook
 - Publisher/ Access/ OneNote



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ENROLLMENT STEPS

Open Enrollment Process—What Do I Need To Do?

- 1 Read this newsletter carefully. Familiarize yourself with each benefit plan option.
- 2 Review your current benefit elections.
- 3 Consider your health care needs. Think about the health care needs that you can anticipate for yourself and your covered family members in the coming year.
- 4 Determine how much to contribute to your Flexible Spending Account. Please note that the annual limit for healthcare flexible spending accounts will be \$2,550 in 2016 (this limit is required as part of federal healthcare reform).
- 5 Ask Questions. If you have questions about your benefit plan options, contact your HR Team at ext. 452.
- 6 Submit your completed enrollment form by December 7, 2015 to Human Resources.

Do I need to complete an enrollment form?

Yes, all employees must complete an enrollment form.

Once your enrollment form has been submitted, you will not be permitted to change your benefit elections unless you experience a qualified change in family status. To modify your elections after a qualified change in family status, you must contact Human Resources within 30 days of the event and complete a new benefits enrollment form.



Forms

Important Dates to Remember

November 23 to December 7 — Open Enrollment

December 7 — Enrollment forms due

January 1, 2016 — Benefit effective date



ELIGIBILITY

Eligibility / Waiving Coverage

Eligible dependents include your spouse, children and step children until they reach age 26. You may be required to provide proof of dependent status (e.g., birth certificates, marriage licenses, etc.).

Children over 26 who are physically or mentally handicapped may also be eligible for coverage. Contact HR if you have a special situation.

If you have new dependents, keep in mind that you must enroll them within 30 days of their eligibility. If you fail to do so, they will not be eligible until the City's next open enrollment period.

If you are covered under another group health plan, you may waive medical coverage. Keep in mind that if you choose to waive coverage, you may not be able to enroll in the City's plan until the next open enrollment unless you have a qualified change in family status.



Dependent Eligibility

It is your responsibility to notify the Human Resources Department within 30 days if a dependent becomes ineligible under the terms of the plan (for instance, a child who reaches 26 years of age or if you become divorced). These dependents may have continuation rights for health coverage under the law known as COBRA. If you do not notify the Human Resources Department within the required timeframe, the dependent may be left without coverage under our plan and you will be responsible for back premiums paid for that ineligible dependent.



Important Note: If you waive the medical coverage because you are covered under your spouse's plan and you lose that coverage involuntarily (e.g., spouse's loss of employment, divorce, etc.), you may enroll in this plan within 30 days from the date of coverage loss with proper documentation. Your coverage will become effective on the day of the qualifying event/change.

Handwritten initials and signature in the bottom right corner, including 'TGF'.

MEDICAL PLAN OPTIONS

BCBSM Community Blue PPO Plans

With a Preferred Provider Organization (PPO) plan, you have complete freedom to see any medical provider of your choice. If you choose doctors and hospitals within the BCBSM PPO network, your out-of-pocket costs are lower than if you use other providers. BCBSM maintains a proprietary network of providers. This is the largest statewide network of hospitals and primary and specialty care physicians, with a national network of providers also available to you.

The PPO2 plan requires an annual deductible of \$100 per person/ \$200 per family in-network and \$250 per person/ \$500 per family out-of-network. The plan provides coverage at 90% for most in-network services and 70% for most out-of-network services, after deductibles.

The PPO4 plan requires an annual deductible of \$500 per person/\$1,000 per family in-network and \$1,000 per person/\$2,000 per family out-of-network. The plan provides coverage at 80% for most in-network services and 60% for most out-of-network services, after deductibles.



These are some of the highlights of the plan when you use a participating provider in the PPO network:

BCBSM — Community Blue 2 PPO

- \$20 office visit copay
- \$20 urgent care facility copay
- \$50 emergency room copay
- Retail Rx — \$10 generic / \$20 brand name / \$40 non-formulary brand

BCBSM — Community Blue 4 PPO

- \$20 office visit copay
- \$20 urgent care facility copay
- \$150 emergency room copay
- Retail Rx — \$15 generic / \$30 brand name / \$60 non-formulary brand

Preventive care benefits include (but are not limited to):

- Routine physical exams
- Gynecological exams
- Well baby/child care
- Immunizations
- Routine pap smear
- Prostate-specific antigen (PSA) test

Preventive services are covered at 100% without any cost sharing or annual limits.

MEDICAL PLAN OPTIONS

Health Alliance Plan (HAP) HMO Plan

Health Maintenance Organization (HMO) benefits are provided with minimal copayments and no annual deductible. No claim forms are necessary for treatment furnished by a network provider. However, in order to receive these benefits, you must select, enroll with and receive all services from a Primary Care Physician (PCP) from the list of health care providers in the network.

At enrollment, you and your family members each select a PCP in the network who will perform, arrange or authorize all medical treatment. This includes tests and referrals to specialists when necessary.

Most services are covered in full (subject to applicable copayments) as long as your PCP authorizes that medical care. Any services that have not been authorized by your PCP will not be covered. If you elect to change your PCP, simply contact HAP Member Services at 1-800-422-4641 for directions.



HAP HMO Plan Highlights:

- \$20 office visit copay
- \$20 urgent care facility copay
- \$50 emergency room copay
- Retail Rx — \$10 generic / \$20 brand name / \$40 non-formulary brand
- Full coverage for preventive care services without copayments or dollar limits

A SPECIAL NOTE FOR WOMEN:

Under HAP, you may visit any participating OB/GYN without a referral. You may see your OB/GYN without a referral for the following services:

- Breast physical exams, pap smears, maternity ultrasound, mammograms;
- Diagnosis and treatment of cystitis and other minor infections during pregnancy;
- Gynecological exams and non-surgical treatment of gynecological disorders; and
- Hospital admission for delivery.



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MEDICAL PLAN OPTIONS

Priority Health HMO Plan with Health Savings Account

This innovative plan combines the comprehensive benefits of an HMO plan with a special tax-preferred savings account. This account, known as a Health Savings Account (HSA), can be used to help you pay for out of pocket medical expenses for yourself and your eligible dependents, now and in the future. To open a health savings account, you must be enrolled in a qualified high deductible health plan, such as the new Priority HMO plan.

Here's how the plan works: Once you enroll in the Priority Health HMO plan, you must open an HSA account at a banking institution of your choice and provide HR your account and routing numbers for direct deposit of City contributions to your HSA. The City will contribute \$975 to your account if you have single coverage or \$1,950 if you have two-person or family coverage. The City will make an initial contribution of \$487.50 (single coverage) and \$975 (two-person or family coverage) in January. The remaining contributions will be paid out in 6 equal installments (the first pay period of each month) from July to December. You can also make pre-tax contributions to the account, up to the following annual limits:

	Single Coverage	2-Person or Family Coverage
Maximum Allowable Contribution per Year	\$3,350.00	\$6,650.00
City's Annual Contribution	\$975.00	\$1,950.00
Your Maximum Annual Contribution	\$2,375.00	\$4,700.00
Catch Up Contribution for Employees over Age 55	\$1,000 per year	\$1,000 per year

As you incur medical expenses throughout the year, you can use your HSA funds for payment or to reimburse yourself. Any funds you do not use during the year will remain in your account and roll over into the new year. Your account is owned and managed by you so you can keep the account, even if you leave employment with the City.

TRIPLE TAX ADVANTAGE

- Contributions to the account are made on a tax-free basis.
- Investment earnings on account balances are not subject to taxation.
- Account withdrawals for qualifying healthcare expenses are not subject to taxation.



MEDICAL

Important Features to Note About Priority Health HMO Plan

- The plan is an HMO. You and each covered family member must select a PCP and that PCP will coordinate all of your care
- Each family member may select a different PCP
- Care must be provided within the network of physicians, hospitals and other medical providers. There is no coverage when using non-network providers, except in emergency situations
- The full calendar year deductible must be satisfied before any benefits will be paid (except for preventive benefits, which are paid in full and are not subject to the deductible). This means that you pay for all services, including office visits and prescriptions, until you have met your deductible
- If you have two-person or family coverage, the full family deductible must be satisfied before any member can receive plan benefits (except for preventive care)
- Prescription drug copayments will apply after the deductible has been satisfied. The copayments are \$10 for generic drugs and \$40 for brand name drugs
- Please refer to the Priority Health benefits summary for details about other plan features

Important Features to Note About Health Savings Accounts

- You must be enrolled in a qualifying high deductible health plan to establish a HSA. You cannot also be enrolled in any other non-high deductible plan at the same time (such as a spouse's plan, Medicare, Medicaid or even a flexible spending account)
- If you use your HSA funds for non-qualifying healthcare expenses, you will be subject to normal income taxes on the amount of the withdrawal plus a 20% excise penalty
- You cannot use your HSA to reimburse yourself for over-the-counter medications (except insulin) unless they are prescribed by a physician
- Each year, you will receive forms from your banking institution indicating the total of deposits made into your account and withdrawals made from your account. These amounts must be included on your annual tax return
- If you have funds remaining in your HSA upon your death, those funds may pass to your spouse or dependent children on a tax-free basis



MEDICAL BENEFITS COMPARISON



ITEM	BCBSM COMMUNITY BLUE 2 PPO		BCBSM COMMUNITY BLUE 4 PPO		HEALTH ALLIANCE PLAN	PRIORITY HEALTH HMO
	In-Network	Out-of- Network	In-Network	Out-of- Network	In-Network Only	In-Network Only
Calendar Year Deductible						
Individual	\$100	\$250	\$500	\$1,000	None	\$1,300
Family	\$200	\$500	\$1,000	\$2,000		\$2,600
Coinurance						
Individual	90%	70%	80%	60%	100% for most services	100% for most services
Family						
Calendar Year Coinurance Maximum (Does not include copays)						
Individual	\$500	\$1,500	\$1,500	\$3,000	Minimal	\$800
Family	\$1,000	\$3,000	\$3,000	\$6,000		\$1,600
Calendar Year Out of Pocket Maximum (Includes deductible, coinsurance and copays)						
Individual	\$6,350	\$12,700	\$6,350	\$17,700	\$6,350	\$6,350
Family	\$12,700	\$25,400	\$12,700	\$25,400	\$12,700	\$12,700
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
HOSPITAL SERVICES						
Hospital Room & Board	90% after deductible	70% after deductible	80% after deductible	60% after deductible	100%	100% after deductible
In-Patient Surgery	90% after deductible	70% after deductible	80% after deductible	60% after deductible	100%	100% after deductible
Emergency Room	\$50 copay	\$50 copay	\$150 copay	\$150 copay	\$50 copay	100% after deductible
Diagnostic X-Ray & Lab	90% after deductible	70% after deductible	80% after deductible	60% after deductible	100%	100% after deductible
PHYSICIAN SERVICES						
Doctor Office Visits (medically necessary)	\$20 copay	70% after deductible	\$20 copay	60% after deductible	\$20 copay	100% after deductible
Outpatient and Home Visits	90% after deductible	70% after deductible	80% after deductible	60% after deductible	\$20 copay	100% after deductible
Pre & Post Natal Care	100%	70% after deductible	100%	60% after deductible	\$20 copay	100% after deductible
Allergy Testing & Therapy	100%	70% after deductible	100%	60% after deductible	\$20 copay	100% after deductible
Chiropractic Care	\$20 copay	70% after deductible	\$20 copay	60% after deductible	Not covered	100% after deductible
Out-Patient Surgery	90% after deductible	70% after deductible	80% after deductible	60% after deductible	100%	100% after deductible
PREVENTIVE SERVICES						
Routine Physical Exams	100%	Not covered	100%	Not covered	100%	100%
GYN Exams	100%	Not covered	100%	Not covered	100%	100%
Well Child Care	100%	Not covered	100%	Not covered	100%	100%
Immunizations	100%	Not covered	100%	Not covered	100%	100%
Routine Pap Smear	100%	Not covered	100%	Not covered	100%	100%
Routine Mammogram	100%	70% after deductible	100%	60% after deductible	100%	100%

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MEDICAL BENEFITS COMPARISON



CITY OF NOVI PLANS AT A GLANCE						
ITEM	BCBSM Community Blue 2 PPO		BCBSM Community Blue 4 PPO		HEALTH ALLIANCE PLAN	PRIORITY HEALTH HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
MENTAL & NERVOUS						
Inpatient	90% after deductible	70% after deductible	80% after deductible	60% after deductible	100%	100% after deductible
Outpatient	\$20 copay	70% after deductible	\$20 copay	60% after deductible	\$20 copay	100% after deductible
SUBSTANCE ABUSE						
Inpatient	90% after deductible	70% after deductible	80% after deductible	60% after deductible	100%	100% after deductible
Outpatient	\$20 copay	70% after deductible	\$20 copay	60% after deductible	\$20 copay	100% after deductible
OTHER SERVICES						
Prescription Drugs	\$10/\$20/\$40 copay Non-Network pharmacies are reimbursed 75% less the copayment (includes contraceptives) 90-day supply available through mail order for one copay		\$15/\$30/\$60 copay Non-Network pharmacies are reimbursed 75% less the copayment (includes contraceptives) 90-day supply available through mail order for one copay		\$10/\$20/\$40 copay (includes contraceptives) 90-day supply available through mail order for one copay	\$10/\$40 copay (includes contraceptives) after deductible 90-day supply available through mail order for two copays
Ambulance Services	90% after deductible	90% after deductible	80% after deductible	80% after deductible	100%	100% after deductible
Durable Medical Equipment	90% after deductible	90% after deductible	80% after deductible	80% after deductible	100%	100% after deductible
Prosthetics and Orthotics	90% after deductible	90% after deductible	80% after deductible	80% after deductible	100%	100% after deductible
Home Health Care	90% after deductible	90% after deductible	80% after deductible	80% after deductible	100%	100% after deductible

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COORDINATION OF BENEFITS



- ✓ Please be aware that all two person and family participants of the Community Blue plan will receive a "Coordination of Benefits Subscriber Questionnaire".
- ✓ The purpose of this questionnaire is to determine if any member on your medical contract is covered under another group health plan.
- ✓ If this questionnaire is not returned to BCBSM and a claim is received, the claim will not be paid. The claim will be pended (held by BCBSM).
- ✓ BCBSM will then send another questionnaire to you with a request to return it within 15 days, or claims will be rejected.
- ✓ If the second questionnaire is not returned to BCBSM within 45 days from the day the claim is received, the claim will be rejected.
- ✓ You and/or your provider will be advised that the rejection is due to your failure to return the completed questionnaire.
- ✓ If the questionnaire is then returned completed, you must resubmit any claims that have been rejected for manual processing.
- ✓ You will receive this questionnaire annually from BCBSM.
- ✓ Please complete the questionnaire and return it promptly to BCBSM to avoid any claim problems.

If you have any questions regarding the questionnaire or coordination of benefits procedure, please contact BCBSM customer service at 1-888-800-7580.

PRESCRIPTION DRUG COVERAGE

BCBSM and HAP

Most pharmacies participate with BCBSM and HAP and you can fill a 30-day prescription for the following:

Type of Prescription	BCBSM B2 Copay per Prescription	BCBSM CB4 Copay per Prescription	HAP Copay per Prescription
Generic Drug	\$10	\$15	\$10
Brand Name Drug	\$20	\$30	\$20
Non-Formulary Brand Name Drug	\$40	\$60	\$40

As prescription drug costs continue to rise, all carriers regularly monitor the use of certain medications to ensure members receive the most appropriate and cost-effective drug therapy available. Some high cost drugs may require prior authorization before being dispensed; and, depending upon the drug, you may be required to first try a lower cost drug before being prescribed the higher cost alternative. The lower cost drug might be an over-the-counter medication.

Keep in mind that drug formularies change from time to time as new drugs come to market. If you are refilling a script and you see that the copayment has increased from \$20 to \$40 or \$30 to \$60, it is because your medication has become non-formulary. If this happens, you should ask your physician if an alternative formulary drug is available to you. Also, please note that the formularies at BCBSM and HAP are different.



MAIL ORDER PROGRAM

Both BCBSM and HAP offer a mail-order prescription plan so that you can obtain up to a 90-day supply of maintenance medications for only one copayment. Your prescription order will be mailed directly to your home via UPS or first class mail. You may want to consider this convenient and money-saving option.

Maintenance medications are those taken on a regular or long-term basis. For example, the following conditions may be treated with maintenance medication: high blood pressure, ulcers, arthritis, heart or thyroid conditions, emphysema and diabetes. To participate, have your doctor write you a 90-day prescription, request a mail order form from Human Resources and complete and mail it with your copayment and original prescription.

PRESCRIPTION DRUG COVERAGE



Priority Health

Under Priority Health, your copay for a 30-day supply is \$10 for generic drugs or \$40 for all brand name drugs. These copayments apply *after* you have met your full calendar year deductible.

A home delivery service for maintenance medications is also available through Priority Health. Your copayments for a 90-day supply of medications will be \$20 for generic drugs and \$80 for brand name drugs. You can obtain the mail service forms from the Human Resources Department.

Generic Drugs

Understanding the advantages of generic medications as compared with more expensive brand name medications can help you effectively lower your prescription drug costs.

Generic medications contain the same active ingredients and deliver the same therapeutic effects as their brand name counterparts. The big difference between generics and brand name drugs is the price. Generic drug costs are between 40% to 60% less than brand name drug prices.

Plus, with generic medication there is no compromise on quality. The Food and Drug Administration holds generic drug manufacturers to the same stringent standards as brand name drug manufacturers.

Under each pharmacy benefit plan, you will automatically receive the generic equivalent unless:

- There is no generic equivalent available.
- The doctor writes "dispense as written" on your prescription, and the drug is approved by the health plan.
- You specifically request the brand name drug and are willing to pay the difference between the brand name drug and the generic drug, in addition to the copayment.



DENTAL/VISION BENEFITS

Dental Benefits

Your dental benefits are covered through Delta Dental. Eligible benefits under the plan include:



- Type 1: Diagnostic and Preventive Services**, such as oral examinations, cleanings, fluoride treatment, space maintainers and x-rays
- Type 2: Basic Restorative Services**, such as fillings, periodontics, endodontics, oral surgery, root canal therapy, extractions and crowns
- Type 3: Major Restorative Services**, such as bridges and dentures
- Type 4: Orthodontic Services**

The benefits are paid as follows:

- Type 1 at 75%
- Type 2 at 75%
- Type 3 at 50%
- Type 4 at 50%, \$1,500 lifetime maximum

The annual maximum benefit per insured is \$1,000 on Type 1-3.

Note: Newborn dependents will not be added until the month of their first scheduled dental appointment. Please contact Human Resources to enroll.

You can use the **Subscriber Tool Kit** at www.deltadentalmi.com to verify eligibility, review benefits, check on claim status, and print new ID cards. Or you can call Customer Service at 800-524-0149.

Vision Benefits

Following is your vision coverage depending on what medical plan you choose:

BCBSM and Priority Health

- Eye exams -- 80% of approved amount
- Lenses/Frames -- 80% of approved amount
- Contacts in lieu of glasses -- 80% up to \$45.00
- Benefit frequency -- Every 24 months

HAP

- Eye exams -- Covered at 100%
- Lenses/Frames -- One pair every 12 months with prescription changes; otherwise, one pair every 24 months up to \$40 for frames and 100% for basic lenses only (medically necessary only)
- Contacts in lieu of glasses -- Covers up to \$80
- Benefit frequency -- Eye exams every 12 months, see above for lenses/frames/contacts



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EMPLOYEE CONTRIBUTIONS

2016 Monthly Healthcare Premium Contributions

The following monthly contributions are required and will be split over the first two pays of each month. The total monthly cost is also shown below.



Monthly Employee Cost

	BCBSM CB2	BCBSM CB4	HAP	Priority
Single	\$222.54	\$185.62	\$129.42	\$107.32
Two-Person	\$534.10	\$445.48	\$297.64	\$242.02
Family	\$667.62	\$556.84	\$336.46	\$269.60

City of Novi Total 2016 Cost

	BCBSM CB2	BCBSM CB4	HAP	Priority
Single	\$1,112.69	\$928.10	\$647.08	\$536.59
Two-Person	\$2,670.50	\$2,227.38	\$1,488.20	\$1,210.11
Family	\$3,338.11	\$2,784.21	\$1,682.30	\$1,348.02

Premium Conversion

To help minimize your employee contribution for your medical plan, The City of Novi will continue to offer an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows you to pay for your medical, dental and vision coverage on a pre-tax (before tax) basis. As a result, your net take home pay will be higher than if contributions were deducted on a post tax (after tax) basis.

Contributions taken on a pre-tax basis are not subject to federal or state income taxes or FICA taxes. The amount of savings depends on your individual contribution and tax bracket.

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FLEXIBLE SPENDING ACCOUNTS

The Health Care and Dependent Care Flexible Spending Accounts (FSA) allow you to set aside pre-tax dollars from your paycheck to pay for eligible health care and/or dependent care expenses.

Plan Year January 1, 2016 – December 31, 2016

Plan Highlights

- Reimburse yourself with tax free dollars and save money
- Dependent care account maximum: \$5,000 per household
- Healthcare flexible spending account maximum: \$2,550
- Guaranteed reimbursement turnaround time: 48 hours
- Minimum reimbursement check amount: \$20
- You must be an eligible employee to participate
- You cannot change your election during the plan year without a qualified change in status
- You can have direct deposit
- The BCI mySourcecard debit card is available for your use to pay for eligible medical expenses. Please visit the eWeb for additional information.



Eligible Healthcare Expenses

- Deductibles, copays, doctor's office and clinic visits
- Routine physical exams
- Mental health / substance abuse services
- Vision care (glasses and contacts)
- Dental expenses
- Prescriptions

Eligible Dependent Healthcare Expenses

- Child care (daycare / preschool)
- Before / after school care
- Day camps
- In-service days (no school)
- School holidays / vacation
- Transportation

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ADDITIONAL BENEFITS

The life and disability carrier will continue to be Lincoln Financial. The benefits are not changing. Please review your current beneficiary designation information and let HR know if have any changes.

Life/AD&D Benefits

The City of Novi provides Life insurance and Accidental Death and Dismemberment (AD&D) for City of Novi employees. Each full time employee is eligible for a life benefit of \$50,000 and AD&D benefit of \$100,000.

Long Term Disability Benefits



Long term disability (LTD) provides a portion of your income when you are unable to work due to injury or illness, to help meet ongoing expenses. If you qualify, benefits become payable after 180 days of disability. Your LTD coverage will insure 60% of basic monthly earnings up to \$4,000 per month.

For the purposes of this insurance, you will be considered disabled if you are unable to perform the substantial and material duties of your job due to injury or illness. Partial disability benefits are also available in some circumstances. Long term disability benefits are payable for up to five years. Please refer to your Certificate of Coverage for details about this important benefit.

Other Benefits

MESP – Michigan Education Savings Program – Section 529 plan is available for college savings. You may start with as little as \$15. Payroll deduction is available.

ICMA – Optional 457 plan – The limit is \$18,000 (2016). A variety of investment funds is available. It is possible to manage your account on-line or over the phone.

AFLAC – Supplemental Insurance – Available plans includes short term disability, cancer protection, accident protection and hospital indemnity. Contact Human Resources to review a brochure or contact Mary Thomas at (517) 416-7728 or m8_thomas@us.aflac.com.

BENEFITS



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EMPLOYEE ASSISTANCE PROGRAM (EAP)

EmployeeConnect– Employee Assistance Program (EAP)

Lincoln Financial's Employee Assistance Program, offered by Compsych, helps you and your family cope with life, from the everyday to the unexpected. Whether managing everyday issues such as job pressures, relationships, retirement planning, finding child care, grief, loss, or the impact of a disability, EmployeeConnect is your resource for professional support.



Ability Assist helps you cope with life by providing the following services:

- In-person help with short-term issues; up to
- Four sessions per person, per issue, per year
- Toll-free phone and web access 24/7
- Unlimited phone access to legal, financial and
- Work-life services
- A 25% discount on in-person consultations with network lawyers
- Financial consultations and referrals
- Work/life services for assistance with childcare, finding movers, kennels and pet care, vacation planning, and more.

Help is only a phone call away. We encourage you to take advantage of the resources available through Lincoln Financial's Employee Assistance Program program.

1-888-628-4824

www.guidanceresources.com

(user name = LFGsupport; password =LFGsupport1)



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FEDERAL LAWS

Women's Health and Cancer Rights Act of 1998

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and physical complications for all stages of a mastectomy, including lymph edemas (swelling associated with the removal of the lymph nodes).



The group health plan must determine the coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Newborns' and Mothers' Health Protection Act

This 1998 Federal law states: "Group plans and health insurers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth".



The law provides that neither you nor your newborn baby may be sent home less than 48 hours following a natural childbirth. If you have a Caesarean section, you may remain at the hospital for 96 hours. A longer stay is based on medical necessity, which is determined by your physician. However, the law does not prohibit either of you from going home in less than 48 hours, or 96 hours following a Caesarean section, provided that you or your physician agrees that is safe to do so.

Children's Health Insurance Program

If you or a dependent is covered under a Medicaid or Children's Health Insurance Program Reauthorization Act (the "Act") of 2009 plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s) in the City's plan. However, you must request enrollment within 60 days after the date eligibility is lost.

Finally, if you or a dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, you may be able to enroll yourself and/or your dependent(s). However, you must request enrollment within 60 days after you or your dependent is determined to be eligible for state premium assistance. Please note that premium assistance is not available in all states.



NEED HELP? IMPORTANT CONTACT INFORMATION



Human Resources Department
City of Novi
248-347-0452

Gallagher Benefit Services, Inc.
248-203-0626
800-201-7070

Medical
Health Alliance Plan (HAP)
Customer Service: 800-422-4641
www.hap.org

Medical
Blue Cross Blue Shield of MI (BCBSM)
Customer Service: 800-637-2227
www.bcbsm.com

Medical
Priority Health
Customer Service: 1-800-446-5674
www.priorityhealth.com

Dental
Delta Dental
Customer Service Number: 1-800-524-0149
www.deltadental.com

Life, AD&D & Long Term Disability
Lincoln Financial
Customer Service Number: 1-800-487-1485
www.lfg.com



Gallagher Benefit Services, Inc.



City of Novi
Human Resources..... 248-347-0452
humanresources@cityofnovi.org

Tia Gronlund-Fox 248-347-3272
tgronlundfox@cityofnovi.org

Glenn Caldwell 248-735-5629
gcaldwell@cityofnovi.org

Jackie Smale 248-347-0591
jsmale@cityofnovi.org

Robin Kummer 248-735-5610
rkummer@cityofnovi.org

Gallagher Benefit Services 800-201-7070
Fax..... 248-540-6015

Kelley A. Demiryan, Account Director 248-502-1102
kelley_demiryan@ajg.com

Nicole H. Lee, Account Manager 248-502-1129
nicole_lee-mi@ajg.com

Julie James, Claim Issues 248-683-3310
julie_james@ajg.com

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WAIVER FORM



Name: _____ Social Security: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ I acknowledge that I have been notified by my employer that I am eligible to enroll in the medical coverage offered to me under the employee benefits plan; however, I hereby waive coverage for the medical benefits under my employer's plan with respect to myself and my present and/or future dependents.

☐ I understand that I must provide proof of coverage under another group medical plan in order to decline coverage under the City of Novi medical plan. I will also be eligible to receive an Opt-Out Bonus of \$175 per month which will be dispersed on the first check of the month. I understand that I must be an active employee at the time of pay-out.

☐ I understand that if coverage is declined at this time, my dependents and I may not be able to get back into this plan until the next open enrollment, unless I experience a "family status" event as defined by the IRS and the plan.

Employee Signature _____ Date _____

Company Representative _____ Date _____

(Please attach proof of other insurance)

REQUIRED FORM



ENROLLMENT FORM Deadline is December 7, 2015
Benefit Plan Year Effective January 1, 2016 – December 31, 2016

REQUIRED FORM

Last Name:		First Name & Middle Initial:	
Date of Birth:			Home Phone No.:
Home Address:		City/State/Zip Code	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married		<input type="checkbox"/> Check box if any <u>personal information</u> has changed from previous year.	
Dependents to be Covered Below Including Spouse: Indicate coverage requested.			
Spouse:		<input type="checkbox"/> Check box if dependent information has changed from previous year	
Date of Birth:		<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent 2:		<input type="checkbox"/> Check box if dependent information has changed from previous year	
Date of Birth: Age:		<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent 3:		<input type="checkbox"/> Check box if dependent information has changed from previous year	
Date of Birth: Age:		<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent 4:		<input type="checkbox"/> Check box if dependent information has changed from previous year	
Date of Birth: Age:		<input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Emergency Contact:			
Name		Contact Phone Number	
Other Coverage Affidavit: (Required Information)			
1) Is your spouse employed? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> N/A Spouse's Employer & Phone No. _____			
2) Are any of the following benefits offered by your Spouse's employer?		Are any family members:	
<input type="checkbox"/> Medical - Insurance Carrier		enrolled in Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Dental - Insurance Carrier		enrolled in Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Vision - Insurance Carrier		enrolled in Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please mark one of the choices under each benefit.			
Any required contributions for plans in which you participate will be deducted from your pay on a before-tax basis.			
MEDICAL PLAN - BCBSM, HAP or Priority Health			
<input type="checkbox"/> I wish to keep my current election the same.			
<input type="checkbox"/> I wish to enroll and/or make changes to my dependent's coverage (adding or deleting). I will complete the Appropriate Carrier Form (BCBSM, HAP or Priority Health). Please visit the eWeb for forms.			
<input type="checkbox"/> I am choosing to waive coverage. (For eligible groups, in lieu of Medical Insurance, you will receive the dollar sum designated in the collective bargaining agreement).			

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REQUIRED FORM

DENTAL through DELTA DENTAL:

- ☐ I wish to keep my current election the same.
- ☐ I wish to enroll and/or make changes to my dependent's coverage (adding or deleting). I will complete the **Appropriate Carrier Form (Delta Dental)**. Please visit the eWeb for forms.
- ☐ I am choosing to waive coverage.

FLEXIBLE SPENDING ACCOUNT through BCI Administrators:

(You must re-enroll in plan each year)

Health Flexible Spending Account

- ☐ I elect to participate and will complete the BCI form.
- ☐ I do not elect to participate.

Dependent Care Flexible Spending Account

- ☐ I elect to participate will complete the BCI enrollment form.
- ☐ I do not elect to participate.

Authorization

I understand that:

- ☒ This election is effective 1/1/2016 and will continue unless changed by a subsequent election as may be permitted by the Plan.
- ☒ I cannot change or revoke this election during the plan year unless I have a change in "family status" (this includes marriage, divorce, death of a spouse, birth or adoption of a child, termination of employment of a spouse) or other such qualifying events as allowed by the Plan.
- ☒ This election will automatically terminate if the plan is terminated or discontinued, or if I cease to receive compensation from the "City" which is less than equal to the amount of my elected deduction.
- ☒ Required Contribution means the amount I must pay for coverage (for myself and my dependents) under any of the employer-sponsored health plans. I will be notified of any subsequent change in the Required Contribution.
- ☒ By reducing my compensation on a PRE-TAX basis, my social security benefits may be reduced.

I enroll or decline coverage in the plans as noted above. I understand that by waiving my right to elect coverage I may not be eligible for coverage or able to cancel coverage until the next Plan Year unless I experience a family status change which is authorized under the plan as a Special Enrollment Event. It is my responsibility to notify the Human Resources Department within 30 days of a Special Enrollment Event taking place.

I affirm that the information provided is correct. I understand that if I submit false information intended to provide coverage for alleged dependents not eligible for such coverage, I may be subject to corrective action up to including discharge. Also, I may be held financially responsible for all claims filed and be required to reimburse the City for any Payments made on behalf of or for the benefit of an ineligible person claimed as a dependent. I authorize payroll deductions, if applicable, for my benefit choices based on the current rate and any future rate changes (increases or decreases).

Signature _____

Date _____

Please sign and email this Mandatory Enrollment Form to Human Resources at:
humanresources@cityofnovi.org

Deadline for 2016 Enrollment Forms is Monday, December 7th!



Every effort has been made to ensure the accuracy and completeness of the benefit descriptions contained within this notice. However, this notice is not meant to be a detailed description of your benefits. Your official plan documents cover your benefits in more detail. Whenever there is a question of interpretation or discrepancy between this notice and the official plan documents, the official plan documents will govern. This notice is not intended to create nor to be construed as a contract between the City and its employees for any matter, including for the provisions of benefits described.

A handwritten signature in black ink, appearing to be a stylized "J" or "K" followed by a flourish.

Handwritten initials "TGF" in black ink.



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

CITY OF NOVI
17674012
0070034690018 - 03TJY
Effective Date: 01/01/2016

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at bcbsm.com/importantinfo. Select **Approving covered services**.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Services from a provider for which there is no Michigan PPO network and 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 are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

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Eligibility information

Member

Dependents

Sponsored dependents

Eligibility Criteria

- Subscriber's legal spouse
- **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26
- Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits

Deductibles

In-network

\$100 for one member,
\$200 for the family (when two or more members are covered under your contract) each calendar year

Out-of-network

\$250 for one member,
\$500 for the family (when two or more members are covered under your contract) each calendar year

Note: Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance abuse services that are equivalent to an office visit and performed in an in-network physician's office.

Note: Out-of-network deductible amounts also count toward the in-network deductible

Flat-dollar copays

- \$20 copay for office visits and office consultations
- \$20 copay for online visits
- \$20 copay for chiropractic and osteopathic manipulative therapy
- \$50 copay for emergency room visits
- \$20 copay for urgent care visits

- \$50 copay for emergency room visits

Coinsurance amounts (percent copays)

- 50% of approved amount for private duty nursing care
- 10% of approved amount for mental health care and substance abuse treatment
- 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)

- 50% of approved amount for private duty nursing care
- 30% of approved amount for mental health care and substance abuse treatment
- 30% of approved amount for most other covered services

Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts

\$500 for one member,
\$1,000 for the family (when two or more members are covered under your contract) each calendar year

\$1,000 for one member,
\$2,000 for the family (when two or more members are covered under your contract) each calendar year

Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable

\$6,350 for one member,
\$12,700 for the family (when two or more members are covered under your contract) each calendar year

Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.

\$12,700 for one member,
\$25,400 for the family (when two or more members are covered under your contract) each calendar year

Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.

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Benefits	In-network	Out-of-network
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> 8 visits, birth through 12 months 6 visits, 13 months through 23 months 6 visits, 24 months through 35 months 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

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Benefits

Routine mammogram and related reading

In-network

100% (no deductible or copay/coinsurance)

Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance

One per member per calendar year

Out-of-network

70% after out-of-network deductible

Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.

Colonoscopy - routine or medically necessary

100% (no deductible or copay/coinsurance), for the first billed colonoscopy

Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.

One per member per calendar year

70% after out-of-network deductible

Physician office services**Benefits**

Office visits - must be medically necessary

Online visits - must be medically necessary

Outpatient and home medical care visits - must be medically necessary

Office consultations - must be medically necessary

Urgent care visits - must be medically necessary

In-network

\$20 copay per office visit

\$20 copay per online visit

90% after in-network deductible

\$20 copay per office consultation

\$20 copay per urgent care visit

Out-of-network

70% after out-of-network deductible

70% after out-of-network deductible

70% after out-of-network deductible

70% after out-of-network deductible

70% after out-of-network deductible

Emergency medical care**Benefits**

Hospital emergency room

Ambulance services - must be medically necessary

In-network

\$50 copay per visit (copay waived if admitted or for an accidental injury)

90% after in-network deductible

Out-of-network

\$50 copay per visit (copay waived if admitted or for an accidental injury)

90% after in-network deductible

Diagnostic services**Benefits**

Laboratory and pathology services

Diagnostic tests and x-rays

Therapeutic radiology

In-network

90% after in-network deductible

90% after in-network deductible

90% after in-network deductible

Out-of-network

70% after out-of-network deductible

70% after out-of-network deductible

70% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife**Benefits**

Prenatal care visits

Postnatal care visits

Delivery and nursery care

In-network

100% (no deductible or copay/coinsurance)

100% (no deductible or copay/coinsurance)

90% after in-network deductible

Out-of-network

70% after out-of-network deductible

70% after out-of-network deductible

70% after out-of-network deductible

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Hospital care

Benefits

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies

In-network

90% after in-network deductible

Out-of-network

70% after out-of-network deductible
Unlimited days

Note: Nonemergency services must be rendered in a **participating** hospital

Inpatient consultations

90% after in-network deductible

70% after out-of-network deductible

Chemotherapy

90% after in-network deductible

70% after out-of-network deductible

Alternatives to hospital care

Benefits

Skilled nursing care - must be in a **participating** skilled nursing facility

In-network

90% after in-network deductible

Out-of-network

90% after in-network deductible

Limited to a maximum of 120 days per member per calendar year

Hospice care

100% (no deductible or copay/coinsurance)

100% (no deductible or copay/coinsurance)

Up to 28 pre-hospice counseling visits before electing hospice services, when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)

Home health care:

- must be medically necessary
- must be provided by a **participating** home health care agency

90% after in-network deductible

90% after in-network deductible

Infusion therapy:

- must be medically necessary
- must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC)
- may use drugs that require preauthorization - consult with your doctor

90% after in-network deductible

90% after in-network deductible

Surgical services

Benefits

Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility

In-network

90% after in-network deductible

Out-of-network

70% after out-of-network deductible

Presurgical consultations

100% (no deductible or copay/coinsurance)

70% after out-of-network deductible

Voluntary sterilization for males

90% after in-network deductible

70% after out-of-network deductible

Note: For voluntary sterilizations for females, see "Preventive care services."

Elective Abortions

Not covered

Not covered

Human organ transplants

Benefits

Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)

In-network

100% (no deductible or copay/coinsurance)

Out-of-network

100% (no deductible or copay/coinsurance) - in designated facilities **only**

Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)

90% after in-network deductible

70% after out-of-network deductible

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Benefits	In-network	Out-of-network
Specified oncology clinical trials	90% after in-network deductible	70% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	90% after in-network deductible	70% after out-of-network deductible

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health or substance abuse service is considered by BCBSM to be comparable to an office visit, we will process the claim under your office visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance abuse treatment	90% after in-network deductible	70% after out-of-network deductible Unlimited days
Residential psychiatric treatment facility:	90% after in-network deductible	70% after out-of-network deductible
<ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility treatment must be preauthorized subject to medical criteria 		
Outpatient mental health care:		
<ul style="list-style-type: none"> Facility and clinic 	90% after in-network deductible	90% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Physician's office 	90% after in-network deductible	70% after out-of-network deductible
Outpatient substance abuse treatment - in approved facilities only	90% after in-network deductible	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	90% after in-network deductible	90% after in-network deductible
Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	90% after in-network deductible	70% after out-of-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited
Other covered services, including mental health services, for autism spectrum disorder	90% after in-network deductible	70% after out-of-network deductible

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Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	<ul style="list-style-type: none"> 90% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training 	70% after out-of-network deductible
Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider.		
Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.		
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit Limited to a combined 24-visit maximum per member per calendar year	70% after out-of-network deductible
Outpatient physical, speech and occupational therapy - when provided for rehabilitation	90% after in-network deductible	70% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a combined 60-visit maximum per member per calendar year
Durable medical equipment	90% after in-network deductible	90% after in-network deductible
Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.		
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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BCBSM Preferred RX Program

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs - The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits	In-network pharmacy	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
Tier 2 - Preferred brand-name drugs	You pay \$20 copay	You pay \$20 copay plus an additional 25% of BCBSM approved amount for the drug
Tier 3 - Nonpreferred brand-name drugs	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Copay for up to a 90 day supply: <ul style="list-style-type: none">• You pay \$10 copay for Tier 1 (generic) drugs• You pay \$20 copay for Tier 2 (formulary brand) drugs• You pay \$40 copay for Tier 3 (nonformulary brand) drugs	Not covered

Note: An in-network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

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Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	75% of approved amount
FDA-approved generic and select brand name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved brand name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/ coinsurance	75% of approved amount less plan copay/ coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

Note: Needles and syringes have no copay/ coinsurance.

Note: An in-network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs

Features of your prescription drug plan

Custom Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> • Tier 1 (generic) - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • Tier 2 (preferred brand) - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • Tier 3 (nonpreferred brand) - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Drug interchange and generic copay/ coinsurance waiver	<p>BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Features of your prescription drug plan

Prior authorization/step therapy

A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy.

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Vision Coverage

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Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

Member's responsibility (copays)

Benefits	Participating provider	Nonparticipating provider
Eye exam	20% of approved amount	25% of approved amount after it has been reduced by member's 20% copay
Prescription glasses (lenses and/or frames)	20% of approved amount	50% of approved amount
Medically necessary contact lenses	20% of approved amount	50% of approved amount

Eye exam

Benefits	Participating provider	Nonparticipating provider
Eye exam by a physician or optometrist	80% of approved amount	75% of approved amount after 20% copay (member responsible for difference)

One eye exam in any period of 24 **consecutive** months

Lenses and Frames

Benefits	Participating provider	Nonparticipating provider
Standard lenses, not to exceed 65 mm in diameter, when prescribed or dispensed by a physician, optometrist or optician. Lenses may be molded or ground, glass or plastic.	80% of approved amount, up to program specifications	The lesser of 50% of approved amount or 75% of the average covered vision expense benefit paid to participating providers for comparable lenses (member responsible for difference)
		One pair of lenses, with or without frames, in any period of 24 consecutive months
Standard frames	80% of approved amount, up to program specifications	The lesser of 50% of approved amount or 75% of the average covered vision expense benefit paid to participating providers for comparable frames (member responsible for difference)

One frame in any period of 24 **consecutive** months

Contact Lenses

Benefits	Participating provider	Nonparticipating provider
Medically necessary contact lenses (must meet criteria of medically necessary)	80% of approved amount, up to program specifications	Individual consideration
		One pair of contact lenses in any period of 24 consecutive months
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	80% of approved amount, up to a maximum payment of \$35 (member responsible for difference)	80% of approved amount, up to a maximum payment of \$35 (member responsible for difference)
		One pair of contact lenses in any period of 24 consecutive months

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: Beginning 01-01-2016
Coverage for: Individual/Family Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$100 Individual/ \$200 Family	\$250 Individual/ \$500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> limit for this plan? (May include a <u>coinsurance</u> maximum)	\$6,350 Individual/ \$12,700 Family	\$12,700 Individual/ \$25,400 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket</u> limit?	Premiums, <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of <u>network providers</u> .		This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .

Group Number 007003469-0018

SBC000003034248

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All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /office visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	May require <u>preauthorization</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	\$10 <u>copay</u> for retail 30-day supply; \$10 <u>copay</u> for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	<u>Preauthorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. 90-day supply not covered out of network.
	Preferred brand-name drugs	\$20 <u>copay</u> for retail 30-day supply; \$20 <u>copay</u> for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
	Non preferred brand-name drugs	\$40 <u>copay</u> for retail 30-day supply; \$40 <u>copay</u> for retail or mail order 90-day supply.	In-Network <u>copay</u> plus an additional 25% of the approved amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted or for an accidental injury
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Mileage limits apply
	<u>Urgent care</u>	\$20 <u>copay/visit</u> ; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	10% <u>coinsurance</u> ; <u>deductible</u> does not apply	10% <u>coinsurance</u> ; <u>deductible</u> does not apply	Your cost share may be different for services performed in an office setting
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	No Charge; <u>deductible</u> does not apply;	30% <u>coinsurance</u>	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. <u>Cost sharing</u> does not apply to certain maternity services considered to be <u>preventive</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	10% <u>coinsurance</u> for Applied Behavioral Analysis; 10% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	10% <u>coinsurance</u> for Applied Behavioral Analysis; 30% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to <u>preauthorization</u> .
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	<u>Preauthorization</u> is required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-------------------------|-------------------------|------------------------|
| • Acupuncture treatment | • Hearing aids | • Routine foot care |
| • Cosmetic surgery | • Infertility treatment | • Weight loss programs |
| • Dental care (Adult) | • Long term care | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|--|---|----------------------------|
| • Bariatric surgery | • If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses - like the deductible, co-payments, or co-insurance, or benefits not otherwise covered | • Routine eye care (Adult) |
| • Chiropractic care | | |
| • Coverage provided outside the United States. See http://provider.bcbs.com | • Non-emergency care when traveling outside the U.S. | |
| | • Private duty nursing | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$100
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing

Deductibles	\$100
Copayments	\$70
Coinsurance	\$1,000

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$1,230

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$100
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$100
Copayments	\$700
Coinsurance	\$200

What isn't covered

Limits or exclusions	\$60
The total Joe would pay is	\$1,060

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$100
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing

Deductibles	\$100
Copayments	\$200
Coinsurance	\$100

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$400

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
 Summary of Benefits for

AA000752 / XR001047

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:		
Benefit Period	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Annual Out-of-Pocket Maximum	\$6,500 Individual, \$13,200 Family	These values do not accumulate. Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
Preventive Services:		
Preventive Office Visit / Physical Exam	Covered	
Well Baby Office Visit	Covered	
Routine Hearing Exam	Covered	
Routine Eye Exam	Covered	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	\$20 Copay	
Specialty Physician Office Visit	\$20 Copay	
Gynecology Office Visit	\$20 Copay	
Audiology Office Visit	\$20 Copay	
Eye Exam Office Visit	\$20 Copay	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Office Visit and Related Services	Not Covered	
Emergency/Urgent Care:		
Emergency Room Services	\$50 Copay	Copay will be waived if admitted
Urgent Care Facility Services	\$20 Copay	
Emergency Ambulance Services	Covered	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	
Bariatric Surgery & Related Services	\$1,000 Copay	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	Covered	Covered under Preventive Services
Subsequent Prenatal Office Visits	Covered	Covered under Preventive Services
Postnatal Office Visits	\$20 Copay	
Labor, Delivery and Newborn Care	Covered	
Mental/Behavioral Health:		
Inpatient Services	Covered	
Outpatient Services	\$20 Copay	
Substance Use Disorder:		
Inpatient Services	Covered	
Outpatient Services	\$20 Copay	
Other Services:		
Home Health Care	Covered	Unlimited
Hospice Care	Covered	Up to 210 days per lifetime
Skilled Nursing Care	Covered	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment, Prosthetic & Orthotics	Covered	Coverage provided for approved equipment based on HAP's guidelines
Hearing Aid Hardware	Not Covered	
Vision Hardware	Covered	Coverage for one pair of eye glasses each year. Detailed information regarding coverage of lenses and Collections Frames can be found in your policy or plan documents.
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 100%	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. Women: Covered as Preventive Services
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Covered	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Covered	One attempt of artificial insemination per lifetime
Pharmacy:		
Generic / Preferred Brand / Non-Preferred Brand	\$10 / \$20 / \$40 Copay	Retail: 35 day supply for non-maintenance drugs at one Copay, 35 day supply or 100 doses, whichever is greater, for eligible maintenance drugs at 1 Copay Mail Order: 90 day supply of non-maintenance drugs at 3 Copays less \$5.00, 90 day supply of eligible maintenance drugs at 1 Copay

Rev 08/2012

Benefit Riders: 599,573,126,124,118,034,016,014,012,096,K60,MHE

* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.

* Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.

* In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.

* Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.

Handwritten signature/initials



Member Handbook

Effective April 2016

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Welcome

Thank you for choosing Blue Cross Blue Shield of Michigan. This *Member Handbook* will help you and your family get the most from your health plan. By being well-informed, you will have the confidence and security of knowing that health care coverage is available when you need it.

This handbook gives you an overview of your health care coverage. For more details about your coverage:

- Visit **bcbsm.com** and click *Login*.
- Register to create an account.

If you have technical difficulties, please call Web Support at 1-888-417-3479.

To request a hard copy of this handbook, please call the Customer Service number on the back of your ID card.

The information in this handbook is a summary of your group's health care benefits. It is not a contract. This summary may not reflect additional limitations or exclusions that apply to covered services or the most recent updates to Blue Cross certificates, riders, plan modifications and/or changes that your group may be making to your coverage. Please contact your health care administrator or call the Customer Service phone number printed on the back of your ID card if you have additional questions about your health care benefits.

Your Blue Cross ID card

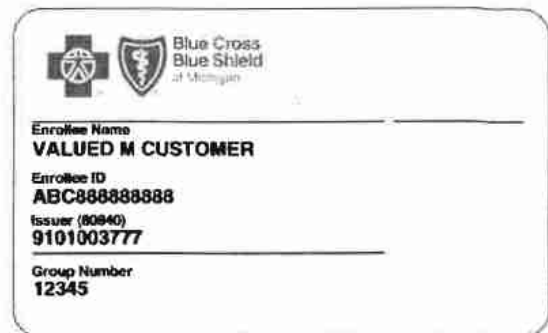
Once enrolled, you'll receive an ID card. All cards will show the contract holder's name, even those issued to dependents.

Enrollee name: The contract holder's name,

Enrollee ID: The contract holder's assigned contract number with Blue Cross.

Issuer: Identifies you as a Michigan Blue Cross Blue Shield member to out-of-state providers.

Group number: Refers to your employer group.



About your ID card

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

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

If you need additional ID cards:

- Visit **bcbsm.com** and log in.
- Click *Get an ID card*

You can also call the Customer Service number that is online.

Discounts for members

With our exclusive Healthy Blue Xtras program, members can score big savings and special offers on a variety of healthy products and services from companies across Michigan, as well as from nationwide businesses through our Blue 365 savings program.

Visit **bcbsm.com/xtras**. Then just show your Blue Cross ID card to save.

Choosing your provider

Looking for a doctor, hospital or other health care professional?

You can choose any health care provider in your network for routine or general care. You don't need a referral for specialty or behavioral health care, and hospital services. To help narrow your options, visit **bcbsm.com** and click *Find a Doctor* to choose a health care provider who best matches your needs and maximize the value of your benefit plan. With this application you can:

- Enter your preferred location
- Easily compare providers
- Review specialty, board certification and education information
- Find contact information
- Read a review of a doctor
- Print your search results
- Find out-of-state doctors
- Get cost estimates to help you research and compare for certain procedures

You can also find a network provider for the following services on our site:

- Primary care services (routine exams or general health issues)
- Specialty care
- Behavioral care and substance abuse services
- Evening or weekend services
- Services from a doctor who speaks another language
- Services located near you

Approving covered services

Depending on the health care services you need, your provider might have to get approval before providing that service. For more information and a list of services that need approvals, visit **bcbsm.com/importantinfo** and click on *approving covered services*.

What is a network provider?

A network provider is a physician, hospital or other health care specialist who provides services through our PPO network. PPO stands for preferred provider organization. PPO network providers have signed agreements with us to accept our approved amount as payment in full for services covered under your health care plan. Using PPO

network providers limits your out-of-pocket costs for covered services to any deductible and copayments that may be required by your plan.

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

Limited network

Certain types of providers – including speech pathologists, nursing facilities and others – are not in our PPO network, but the services are paid at the in-network level. If you are unsure whether or not a health provider is considered in-network under your plan, please call the Customer Service number on the back of your Blue Cross ID card.

What is an out-of-network provider?

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

Important: Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our approved amount plus your out-of-network deductible and copayment as payment-in-full for covered services.

Nonparticipating providers have not signed an agreement and can bill you for any differences between their charges and our approved amount.

How providers are paid

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

Under your health care program, the payment allowed for covered services is called our approved amount. This amount is the lower of the provider's billed charge or our maximum payment level for the covered service. Any deductible or copays required by your health care plan are subtracted from the approved amount before we make our payment.

PPO network providers — Blue Cross pays network providers directly. Because of their signed agreement with us, network providers accept this payment as payment in full for covered services. You are only responsible for any in-network deductible or copays that may be required by your health care plan.

Out-of-network providers — If you choose to go to a provider who is not in our network, it is important to verify if the service is covered. Not all services outside the

network are covered. Please call the Customer Service phone number on the back of your ID card to verify if a service is covered.

When using out-of-network providers, you also need to find out whether or not the provider participates with Blue Cross. Here's why this is important:

Participating providers — We pay participating providers directly. Because they have signed agreements with us, participating providers accept our payment as payment in full for covered services. You are responsible only for any out-of-network deductible or copays required by your health plan.

Nonparticipating providers — We send the payment directly to you, and it is your responsibility to pay the provider. Because our payment to you may be less than the provider's charge, you may also have to pay the difference between our payment and the provider's charge. This would be in addition to any out-of-network deductible or copays required by your health plan.

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

Preventing fraud

If your provider asks for another form of identification, don't worry. This is just one way our providers help us protect you against unauthorized use of your card.

You can also help prevent fraud by checking your Explanation of Benefit Payments form, or EOB. If you see a discrepancy on your EOB, contact your provider first to see if it is an error. If it's not and you believe it is fraudulent billing or use of your card, let us know by calling our anti-fraud hot line at 1-800-482-3787. You can also fill out our online Anti-Fraud form or write to:

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

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

Keeping your health information secure

Expect confidentiality regarding your care and that Blue Cross will adhere to strict internal and external guidelines concerning your personal health information. This includes the use, access and disclosure of that information or any other information that is of a confidential nature.

- Visit **bcbsm.com/importantinfo**.
- Click on *Keeping your health information secure*.

What you pay out of pocket

For details of the amount of out-of-pocket expenses you pay for covered services:

- Visit **bcbsm.com** and log in.
- Click *My Coverage* and select either *Medical*, *Dental* or *Vision*.
- Click *What's Covered*.

If you have to pay for covered services, we will reimburse you for our share of the cost. For more information and for a copy of the form:

- Visit **bcbsm.com** and log in.
- Click *Forms*.

Health resources

Blue Cross[®] Health & Wellness

Your health and well-being are important to your employer, not only while you're at work but also while you are at home spending time with friends and family. That's one of the main reasons your health care plan includes Blue Cross Health & Wellness, which helps you get healthy, stay healthy or improve your quality of life if you are living with an illness. This resource offers a 24-Hour Nurse Line that you can call with questions about your health. It also offers an effective disease management program to help you better manage your condition. In addition, if you have a specific health condition, a nurse health coach may contact you by phone or send information to you.

The Blue Cross Health & Wellness website, powered by WebMD[®], offers you a variety of helpful tools and resources that can help you learn about your health risks and ways to stay healthy or improve your health. The Blue Cross Health & Wellness site includes:

- An easy-to-use online health assessment that provides you with an analysis of your personal health risks and what you can do to improve your health
- Digital Health Assistant programs for exercise, nutrition, weight loss, tobacco cessation, stress relief and mental health that help you set goals and make small positive changes
- Health trackers so you can chart your healthy measures over time
- A Device and App Connection Center where you can sync your favorite fitness and medical devices and apps
- Message Board Exchanges that are professionally monitored
- Interactive programs such as calculators, guides, quizzes, slide show and more
- Videos, recipes, articles, health encyclopedias and more

To access the Blue Cross Health & Wellness website:

1. Log in or register for **bcbsm.com**.
2. Click on the *Health & Wellness* tab to enter the Blue Cross Health & Wellness website. You'll need to register for the website on your first visit.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan by providing health and wellness services.

BlueCard® program

When traveling outside of Michigan, your coverage travels with you. Through the BlueCard program, you can find network and participating providers throughout the U.S. and around the world.

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

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

1. In an emergency, go directly to the nearest hospital.
2. Call 1-800-810-BLUE (2583) or bluecardworldwide.com
3. When you arrive at the network or participating provider's office or hospital, present your ID card. The doctor or hospital will recognize the suitcase logo and know that you are receiving services under the BlueCard program. This means they will submit any claim forms and only bill you for any deductible or copay that may be required by your health care plan.

Care out of the U.S.

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

1. Check your certificate to make sure your international benefits are the same outside of the U.S.
2. If you need to find a provider, call the BlueCard Worldwide Service Center at 1-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.
3. In an emergency, go directly to the nearest doctor or hospital, then call the BlueCard Worldwide Service Center if you are hospitalized. For nonemergency inpatient medical care, you must call the BlueCard Worldwide Service Center to arrange access to a BlueCard Worldwide hospital, to locate a doctor or hospital, or if you need medical assistance.
4. If you need to be hospitalized, call your Blue plan for precertification or preauthorization. You can find the phone number on your Blue ID card. Note: This number is different from the phone number listed above.
5. If the BlueCard Worldwide Service Center arranged your hospitalization, the hospital will file the claim for you. You will need to pay the hospital for the deductible or copay expenses you normally pay.
6. For outpatient and doctor care or inpatient care not arranged through the BlueCard Worldwide Service Center, you will need to pay the provider and submit a claim form with original bills to Blue Cross Blue Shield of Michigan. Try to get all itemized receipts, preferably in English. We will pay the approved amount for covered services at the rate of exchange in effect on the date of service, minus any deductible or copay that may be required by your plan.

Eligibility, enrollment and membership

You can also verify your Blue Cross membership records on our website in when you log in to your account and click *Account Settings*.

Dependent coverage

Coverage for your dependents is based on the certificates and riders included in your health care plan. For dependent eligibility criteria, refer to your certificates and riders, which are available online. If you don't have online access, call the Customer Service phone number on the back of your ID card.

Special enrollment periods

If you decline enrollment for yourself and your dependents (including your spouse) because of other health coverage, you may enroll later in this plan if:

- Your other coverage is terminated because of loss of eligibility, or if employer contributions for the other coverage are terminated — provided that you request enrollment within 30 days after your other coverage or the contribution toward that coverage ends.
- You have a new dependent because of marriage, birth, adoption or placement for adoption — provided you request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

Note: Loss of eligibility includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It does not include loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim. If you decline enrollment because you had COBRA, or Consolidated Omnibus Budget Reconciliation Act continuation coverage under another plan, you must exhaust your COBRA coverage before you may enroll in this plan because of a loss of eligibility.

To request a special enrollment or obtain more information, please see your Human Resources department.

Making membership changes

Promptly report the following changes to your employer. Your employer will notify Blue Cross Blue Shield of Michigan.

- Change of name or address — immediately
- Weddings — within 31 days of marriage
- New babies — within 31 days of birth
- Adoptions — within 31 days of the date of petition or the date of adoption
- Military service — within 30 days of induction or discharge
- 65th birthday — when you or your dependent become eligible for Medicare
- Children — contact your employer to verify eligibility for your children

Continuing coverage on your own

Your coverage will end for you and your dependents when you are no longer eligible through your employer group. However, you may continue temporary coverage through COBRA.

Please contact your Human Resources department for your coverage options and to find out eligibility dates.

Certificate of creditable coverage

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

Claims information

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

Filing a claim

If you receive services from a nonparticipating or non-network provider, ask the provider if he or she will bill us for the services. Most providers will submit claims to their patients' insurance companies when asked.

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

- Ask the provider for an itemized statement or receipt with the following information:
 - Name and address of provider
 - Full name of patient
 - Date of service
 - Provider's charge
 - Diagnosis and type of service

- Make a copy of all items for your files, and send the originals to us with the claim form. It is important that you file claims promptly because most services have claims filing limitations. To find the form:
 - Visit **bcbsm.com** and log in.
 - Click *Forms*.

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

Payments for services will be made directly to the health care contract holder.

Your explanation of benefits

After we process claims for services you receive, we send you an explanation of benefits, which we refer to as an EOB. The EOB is not a bill. It helps you understand how your benefits were paid. At the top of the EOB you'll find Blue Cross Blue Shield Customer Service numbers and an address to use for questions.

Receive your explanation of benefits electronically

Instead of receiving your EOBs in the mail, you can sign up to get them online. Blue Cross will send you an email to notify you when a new EOB has been posted. You can view, save or print your EOB statements.

- Visit **bcbsm.com** and log in.
- Click *Account Settings*.
- Click *Paperless Options*.

Reading your EOB

Briefly, your explanation of benefits tells you:

- The person who received the services and the date services were provided
- "Claim Summary" includes the provider(s) of the services, and payments, including the amount saved by using network providers.
- "Summary of Deductibles and Out-of-Pocket Mximums" shows your deductible and copayment requirements and a total of all deductibles and copayments paid to date.
- "Claim Details" summarizes the Blue Cross payment and shows your balance.

If you see an error, contact your provider first. If your provider cannot correct the error, call the Customer Service number on your EOB.

What if my claim is rejected or denied?

Our goal is to process your claims correctly every time. If we deny your claim for benefits, you can appeal the denial of payment. For more information on the appeals process:

- Visit bcbsm.com/importantinfo.
- Click *Appealing a claims decision*.

Getting the care you need

Access to our staff

Blue Cross works with our network providers to make sure you're getting the highest quality care and service, and that you receive it promptly. This is called utilization management. If you have questions or want more information about this process, please call the Customer Service number on the back of your ID card. TDD/TTY users start by dialing 711 or call 1-800-696-8350. You must have a TTY/TDD device to use the TTY/TDD number.

Evaluating medical technology

Blue Cross Blue Shield of Michigan Blue Care Network of Michigan evaluate new technologies and the new applications of existing technologies develop medical policies related to these technologies and make coverage recommendations. This process includes, but is not limited to, medical procedures and services, medical devices, surgical procedures, behavioral health procedures and pharmaceuticals.

Emergency care

If you're not sure whether your condition (such as high fever, sharp or unusual pain or minor injury) requires emergency care, but you think it needs prompt attention, it's best to call your doctor or your doctor's after-hours phone number.

You can also visit a network urgent care center for nonemergency conditions, such as earaches, colds, flu, minor burns, fever, sprains, sore throats and headaches. Visit **bcbsm.com** for a list of urgent care centers.

If you have an emergency and taking the time to call your doctor may mean permanent damage to your health, seek treatment first. Go to the nearest emergency room or call 911.

After the emergency has passed, your doctor can arrange appropriate follow-up care.

Some services aren't covered

Experimental treatment: We do not pay for experimental treatment. Facility services and physician services, including diagnostic tests related to experimental procedures are also not payable. Please refer to your certificate for an explanation on how we determine experimental services. For a list of services not covered by your health plan:

- Log in at **bcbsm.com**
- Click *My Coverage*
- Click *Medical*
- Click *What's Covered* and scroll down to see what's not covered

Prescription drug coverage

If you have prescription drug coverage, visit **bcbsm.com/pharmacy** for detailed information about what your plan covers and the best way to use your prescription benefits. You can also find information about:

- If your drug is covered under our pharmacy plans
- Mail order drug forms
- How to get approval for your medications (some drugs need approval, or prior authorization, or step therapy before your plan will cover them)
- Generic drug substitutions
- Quantity limits
- Preferred alternatives
- How to find a pharmacy
- Saving money on prescriptions
- How to request a review for coverage (if a drug isn't covered in your plan)
- Out-of-pocket expenses you pay for prescription drugs:
 - Visit **bcbsm.com** and log in.
 - Click *My Coverage* and select Prescription Drugs.
 - Click *What's covered* — prescription benefits
- Do you need to speak to someone? Visit **bcbsm.com** and click on *Contact Us* at the top of the page and follow the instructions.

Coordination of benefits

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

If Blue Cross is not your primary care provider, ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier's payment statement to Blue Cross.

Updating COB information is your responsibility

You can avoid claims-processing delays if you keep your COB information up to date. You can view your current COB information online.

If you need to change the information we have on record, notify your employer immediately. We may also periodically ask you to update your COB information.

For more information, visit [bcbsm.com/cob](https://www.bcbsm.com/cob).

Subrogation

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

- Visit bcbsm.com.
- Click *Help*.
- Click *Popular Health Topics*.
- Click *Other Topics*.

Send us the completed form.

Mailing:

Blue Cross Blue Shield of Michigan
Subrogation Department
232 S. Capitol Ave., L09A
Lansing, MI 48933-1504

Email: SubrogationUnit@bcbsm.com

Phone: 1-866-296-3975

Fax: 1-877-257-2012

If you hire an attorney to represent you in such a situation, have your attorney call Blue Cross at 1-866-296-3975.

Customer service

To call us, please use the phone number printed on the back of your ID card. You can also find this number on your Explanation of Benefit Payments, or EOB.

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

You can visit **bcbsm.com** to see if there's a walk-in customer service center near you for personal, face-to-face service.

Our goal is to provide excellent service. When you call, please be ready to tell us your contract number. If you're inquiring about a claim, we'll also need the following information:

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

Please remember, Blue Cross Blue Shield of Michigan follows strict privacy policies in accordance with state and federal law. You'll find our Notice of Privacy Practices at **bcbsm.com/importantinfo**.

Language translation services

When you call the Customer Service number, you can request language assistance.

If you have a complaint

Blue Cross Blue Shield of Michigan and your primary care physician want you to be satisfied with the health services you receive. If you have a problem or concern about your care, we encourage you to discuss this with your primary care physician first. Often your primary care physician can correct the problem to your satisfaction. You are always welcome to call our Customer Service department with any questions or problems you may have.

At any point during the complaint process, you may submit any information or evidence concerning the complaint to assist us in our investigation. You may file a complaint or appeal verbally or in writing. Complaints will not be accepted through email. There are no fees or costs associated with filing a complaint. All complaints can be submitted by calling Customer Service or via mail to the address listed below.

Customer Service: Use the phone number on the back of your Blue Cross Blue Shield of Michigan ID card.

Mailing address:

BCBSM Complaints — Mail Code 2004
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

Fax: 1-877-348-2210

Dear Subscriber:

We are pleased you have selected Blue Cross Blue Shield of Michigan for your prescription drug coverage. Your coverage provides many benefits for you and your eligible dependents. These benefits are described in this book, which is your **certificate**.

Your certificate, your signed application and your BCBSM identification card are your **contract** with us.

You may also have **riders**. Riders make changes to your certificate and are an important part of your coverage. When you receive riders, keep them with this book.

This certificate will help you understand your prescription drug coverage and each of our responsibilities **before** you require services. Please read it carefully. If you have any questions about your coverage, call us at one of the BCBSM Customer Service telephone numbers listed in the "How to Reach Us" section of this book.

Thank you for choosing Blue Cross Blue Shield of Michigan. We are dedicated to giving you the finest service and look forward to serving you for many years.

Sincerely,



Daniel J. Loepp
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan

About Your Certificate

This certificate is arranged to help you locate information easily. You will find:

- **A Table of Contents** - for quick reference
- **Information About Your Contract**
- **Prescription Drug Coverage**
- **Prescription Drugs Not Covered**
- **General Conditions of Your Contract**
- **The Language of Health Care** - explanations of the terms used in your certificate
- **How to Reach Us**

This certificate provides you with the information you need to get the most from your BCBSM prescription drug coverage. Please call us if you have any questions.

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Section 1: Information About Your Contract

- **ELIGIBILITY**
 - Who is Eligible to Receive Benefits
- **CANCELLATION**
 - How to Cancel Coverage
 - Automatic Cancellation
 - Rescission
- **CONTINUATION OF BENEFITS**
 - Consolidated Omnibus Budget Reconciliation Act

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ELIGIBILITY

Who is Eligible to Receive Benefits

You, your spouse (this does not include a person who marries a member who has coverage as a surviving spouse) and your children listed on your contract are eligible. You will need to complete an application for coverage.

BCBSM will review your application for coverage to determine if you, your spouse and your dependents are eligible for coverage. This determination is based upon the terms of your benefit plan, which include this certificate and any underwriting policies that are in effect at the time of your application.

NOTE: If you, your group or someone applying for coverage on your behalf commits fraud or makes an intentional misrepresentation of material fact in completing the application, your coverage may be rescinded as described on Page 1.5, under Rescission.

Children are covered through the end of the calendar year in which they turn 26 years of age if, and as long as, the subscriber continues to be covered under this certificate and the children are related to you by birth, marriage, legal adoption or legal guardianship.

NOTE: Your child's spouse and your grandchildren are not covered under this certificate.

Disabled unmarried children may remain on your contract beyond the end of the calendar year in which they turn age 26 if all of the following apply:

- They are diagnosed as totally and permanently disabled due to a physical condition or mental retardation and are incapable of self-sustaining employment.
- They receive more than half of their support from you.

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ELIGIBILITY

Who is Eligible to Receive Benefits (continued)

- The disability began before their 19th birthday.

NOTE: Physician certification, verifying the child's disability and that it occurred prior to the child's 19th birthday, must be submitted to us by the end of the calendar year in which the child turns age 26.

You may also request group coverage for yourself or your dependents within 60 days of either of the following events:

- Your Medicaid coverage or your dependents' CHIP coverage (Children's Health Insurance Program) is terminated due to loss of eligibility.
- You or your dependent becomes eligible for premium subsidies.

You must notify your employer or group if there is a change in your family such as birth, divorce, death, etc. We must receive notice from your employer or group within 30 days of the change so that any contract changes take effect as of the date of the event. Any change in rates resulting from contract changes will take effect as of the effective date of the contract change.

If a dependent becomes ineligible for coverage under your contract, as in the case of a divorce, that dependent may be eligible for his or her own contract. However, we must be notified within 30 days of the change in order to provide continuous coverage.

CANCELLATION

How to Cancel Coverage

Send your written request to cancel coverage to your employer or group. We must receive it from your employer or group within 30 days of the requested cancellation date. Your coverage will then be canceled on the requested date and all benefits under this certificate will end.

CANCELLATION

Automatic Cancellation

We will automatically cancel your coverage if:

- Your group does not qualify for coverage under this certificate
- Your group does not pay its bill on time

NOTE: If you are responsible for paying all or a portion of the bill, then you must pay it on time or your coverage will be automatically cancelled. For example, if you are a retiree or enrolled under COBRA and you pay all or part of your bill directly to BCBSM, we must receive your payment on time.

- You are serving a criminal sentence for defrauding BCBSM
 - You no longer qualify to be a member of your group
 - Your group changes to a non-BCBSM health plan
 - We no longer offer this coverage
 - You **misuse** your coverage
- Misuse** includes any illegal or improper use of your coverage such as:
- Allowing an ineligible person to use your coverage
 - Requesting payment for services you did not receive
- You fail to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to your rights under the appeal process
 - You are satisfying a civil judgment in a case involving BCBSM
 - You are repaying BCBSM funds you received illegally
 - You no longer qualify as a dependent

Your coverage will end on the last day covered by the last payment made by your group, employer, or remitting agent.

CANCELLATION

Rescission

We will rescind your coverage if you, your group or someone seeking coverage on your behalf has:

- Performed an act, practice, or omission that constitutes fraud, or
- Made an intentional misrepresentation of material fact to BCBSM or another party, which results in you or a dependent obtaining or retaining coverage with BCBSM or the payment of claims under this or another BCBSM certificate.

NOTE: Your coverage may be rescinded back to the effective date of your contract after we have provided you with prior notice, if required under the law. You will be required to repay BCBSM for its payment for any services you received during this period.

CONTINUATION OF BENEFITS

Consolidated Omnibus Budget Reconciliation Act

COBRA is a federal law that affects all employers with 20 or more employees. It extends the opportunity for continued group coverage when such coverage is lost due to a qualifying event. This group continuation option must be selected within 60 days of the qualifying event. It provides the following coverage at the covered member's expense:

- 18 months of coverage for an employee who is terminated, other than for gross misconduct, or whose hours are reduced
- 29 months of coverage for all qualified beneficiaries if one member is determined by the Social Security Administration to be disabled at the time of the qualifying event or within 60 days thereafter
- 36 months of coverage for qualified beneficiaries in case of the death of the employee, divorce, legal separation, loss of dependency status or employee entitlement to Medicare

CONTINUATION OF BENEFITS

**Consolidated
Omnibus
Budget
Reconciliation
Act (continued)**

COBRA coverage can be terminated because:

- The 18, 29 or 36 months of COBRA coverage end
- The required premium is not paid on time
- The employer terminates its group health plan
- The qualified beneficiary becomes entitled to Medicare coverage
- The qualified beneficiary obtains coverage under a group health plan, unless that new health plan has preexisting condition limitations that apply to the qualified beneficiary

Please contact your employer for more details about COBRA.

Section 2: Prescription Drug Coverage

Your annual out-of-pocket maximum for covered services are determined by your hospital, medical, surgical certificate and/or related riders. Most copayments/coinsurance for covered drugs are included in the annual out-of-pocket maximum. Once the out-of-pocket maximum is satisfied, covered drugs will be reimbursed at 100% of the approved amount for the remainder of the calendar year.

After the cost-sharing requirements have been met, we will pay for each covered drug and each refill of a covered drug as follows:

Covered Drugs Obtained from an In-Network Pharmacy

When an in-network pharmacy fills a prescription for a covered drug or for a covered compounded drug that contains bulk chemical powders that BCBSM has approved for payment, we will pay the pharmacy the approved amount for the drug after deduction of your copayment.

NOTE: Your copayment will not be more than BCBSM's approved amount for covered drugs.

Certain drugs may not be covered for a second prescription if a suitable alternate drug is identified by BCBSM (either a comparable brand, generic or over-the-counter drug), unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at the BCBSM website at bcbsm.com.

NOTE: We reserve the right to limit the initial quantity of select specialty drugs. Your copayment will be reduced by one-half (1/2) for this initial fill (15 days) once applicable deductibles have been met.

For all covered drugs, if your physician rewrites your prescription for a comparable brand, generic or OTC drug, your copayment may be waived for an initial period of time. After this period, if you are prescribed a generic or OTC drug, you will only be responsible for the generic copayment.

**Covered Drugs
Obtained from
an In-Network
Pharmacy**
(continued)

• **For MAC Drugs**

When an in-network pharmacy fills a prescription with a MAC drug, we will pay the pharmacy the maximum allowable cost of the drug after deduction of your copayment.

However, if you request a brand name drug and

- The prescriber did not write “Dispense as Written” or “DAW” on the prescription,

You must pay:

- The difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug, PLUS
- Your copayment.

If the prescriber wrote “Dispense as Written” or “DAW” on the prescription, we will pay the pharmacy the approved amount for the brand name drug, after deduction of your copayment.

**How to File a
Claim**

If an in-network pharmacy required you to pay for a prescription, or if you disagree with the amount you had to pay for a prescription, you may submit to us a claim form and proof of payment, including the National Drug Code (NDC) of the drug dispensed. To obtain a claim form, please refer to the “How to Reach Us” section at the back of this book for the phone number or address of the customer service center nearest you. Or check our website at bcbsm.com.

**Covered Drugs
Obtained from
an Out-of-
Network
Pharmacy**

When an out-of-network pharmacy fills a prescription for a covered drug, you must pay the pharmacist the full cost of the drug and submit to us a claim form and proof of payment, including the National Drug Code (NDC) of the drug dispensed. To obtain a claim form, please refer to the “How to Reach Us” section at the back of this book for the phone number or address of the customer service center nearest you. Or check our website at bcbsm.com.

Section 2: Prescription Drug Coverage

Covered Drugs Obtained from an Out-of- Network Pharmacy (continued)

For covered drugs obtained in the United States, we will reimburse you 75 percent (100 percent for emergency pharmacy services) of the BCBSM approved amount for the drug minus your copayment.

For covered drugs obtained outside of the United States, we will reimburse you 100 percent of the approved amount, minus your copayment.

Certain drugs may not be covered for a second prescription if a suitable alternate drug is identified by BCBSM (either a comparable brand, generic or over-the-counter drug), unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at the BCBSM website at bcbsm.com.

For all covered drugs, if your physician rewrites your prescription for a comparable brand, generic or OTC drug, your copayment may be reimbursed. Afterward, if you are prescribed a generic or OTC drug, you will only be responsible for the generic copayment.

Contraceptive Medication

~~We pay the approved amount (minus any applicable member deductible, copayment and/or coinsurance) for FDA-approved generic contraceptive medication, as required by the FDA-approved Protection of Affordable Care Act (ACA).~~

When a covered **generic** contraceptive drug is dispensed by an in-network pharmacy, we will pay 100% of our approved amount. You have no out-of-pocket cost in these instances.

We pay the approved amount (minus any applicable member deductible, copayment and/or coinsurance) for FDA-approved **brand name** contraceptive medication.

NOTE: When a brand-name contraceptive drug is dispensed by an in-network pharmacy, we will pay the pharmacy 100% of the approved amount, **but only if** your physician receives prior authorization from BCBSM.

Prior authorization will depend on medical necessity and/or other criteria as determined by BCBSM.

When a covered generic **or** brand-name contraceptive drug is dispensed by an out-of-network pharmacy, you are responsible for:

- the member cost-sharing amounts for generic drugs as described in this certificate and/or related riders;
- 25% of the approved amount (if the drug is obtained in the United States); and
- any amount in excess of our approved amount.

**Chemotherapy
Specialty
Pharmaceuticals**

Preauthorization is required for select chemotherapy specialty pharmaceuticals used in chemotherapy treatment. These drugs are only covered when dispensed by an in-network pharmacy, as designated by BCBSM.

The preauthorization requirement affects all in-state and out-of-state prescription drug claims. The prescribing physician should contact BCBSM and follow BCBSM's prior authorization processes in order to obtain preauthorization of the chemotherapy specialty pharmaceuticals. Only FDA-approved medications can be preauthorized, and of those drugs, only the specialty pharmaceuticals that meet BCBSM's clinical criteria for treatment of the member's condition will be preauthorized.

- If preauthorization is requested, but is not approved by BCBSM, you have the right to appeal under applicable law. If the preauthorization is not approved via the appeal, you will be responsible for the full cost of the specialty pharmaceuticals.
- If preauthorization is not sought, BCBSM will deny the claim and you will be responsible for the full cost of the specialty pharmaceuticals.

**Preventative
Drugs,
Supplements
and Vitamins**

Your coverage includes benefits for preventive drugs, supplements and vitamins as required by the Patient Protection and Affordable Care Act. This may include coverage for folic acid, iron supplements, fluoride supplements, aspirin and smoking cessation drugs. However, we reserve the right to cover only over-the-counter versions of folic acid, iron supplements, aspirin, and nicotine patches, gums and lozenges or any other drug required to be covered under this Act.

To be covered, preventive drugs, supplements and vitamins must be prescribed by a physician, dispensed by a participating or in-network pharmacy, approved by the FDA, when FDA approval is available, and meet coverage criteria required under the Patient Protection and Affordable Care Act.

When a covered generic preventive drug, supplement or vitamin is dispensed by a participating or in-network pharmacy, we will pay 100 percent of our approved amount. You have no out-of-pocket cost in these instances.

- When a BCBSM participating or in-network pharmacy fills a prescription for a prescribed brand-name drug required under the Patient Protection and Affordable Care Act, we will pay the pharmacy 100 percent of the approved amount but only if your physician receives prior authorization for BCBSM. Prior authorization will depend on medical necessity and/or other criteria, as determined by BCBSM.

You can call the Pharmacy Help Desk toll-free number on the back of your BCBSM ID card to get more information about preauthorization.

When a covered generic preventative drug, supplement or vitamin is dispensed by an out-of-network pharmacy, you are responsible for:

- the member cost-sharing amounts for generics, as described in this certificate and/or related riders;
- 25% of the approved amount (if the drug is obtained



Section 2: Prescription Drug Coverage

in the United States); and

- any amount in excess of our approved amount.

PREFERRED RX LG

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Section 3: Prescription Drugs Not Covered

We will not pay for the following:

- Contraceptive medications and devices that are not required to be covered under the Patient Protection and Affordable Care Act. Therapeutic devices or appliances including, but not limited to, hypodermic or disposable needles and syringes when not dispensed with a covered injectable drug, insulin or self-administered chemotherapeutic drugs
- Drugs prescribed for cosmetic purposes
- The charge for any prescription refill in excess of the number specified by the prescriber or any refill dispensed one year after the prescriber's prescription order
- Any vaccine given solely to resist infectious diseases
- More than a 30-day supply of a covered drug. We may make exceptions for certain maintenance drugs or for drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g., inhalers)

NOTE: The 30-day supply limitation also applies to prescription drugs that BCBSM defines as "specialty pharmaceuticals." We will not pay for more than a 30-day supply of a covered specialty pharmaceutical. We may make exceptions if a member requires more than a 30-day supply.

- More than 12 doses of an impotence drug in a 30-day period. If you have a BCBSM mail order drug program, no more than 36 doses in a 90-day period
- More than the quantities and doses allowed per prescription of select drugs by BCBSM, unless the prescribing physician obtains preauthorization from BCBSM. A list of drugs that may have quantity and/or dose limits is available at the BCBSM website at bcbsm.com.
- Any drug we determine to be experimental or



Section 3: Prescription Drugs Not Covered

investigational

- Any covered drug entirely consumed at the time and place of the prescription
- Administration of covered drugs (e.g., injections)
- Non-self-administered injectable drugs
- Non-self-administered contraceptive drugs or devices
- Anything other than covered drugs and services
- Diagnostic agents
- Any drug or device prescribed for uses or in dosages other than those specifically approved by the Federal Food and Drug Administration. This is often referred to as the off-label use of a drug or device. (However, we will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescribing M.D. or D.O. can substantiate that the drug is recognized for treatment of the condition for which it was prescribed. See criteria under "Covered Drug" in "The Language of Health Care" section.) Some chemotherapeutic drugs may be subject to prior authorization review.
- Chemotherapy specialty pharmaceuticals that are not preauthorized
- Drugs that are not labeled "FDA approved," except for state-controlled drugs and insulin, or such drugs that BCBSM designates as covered
- Covered drugs or services dispensed to a member when such services are benefits under other Blue Cross and Blue Shield certificates
- Drugs or services obtained before the effective date of this contract, or after the contract ends
- Claims for covered drugs or services submitted after the applicable time limit for filing claims (see Page 4.7)
- Support garments or other nonmedical items
- Compounded drugs that contain any bulk chemical

Section 3: Prescription Drugs Not Covered

powders that are not approved by BCBSM

PREFERRED RX LG

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Section 4: General Conditions of Your Contract

Certain general conditions apply to your contract. These conditions may make a difference in how, where and when benefits are available to you. This section lists and explains these conditions.

Assignment

The services provided under this certificate are for your personal benefit and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all your rights under it. No right to payment from us, claim, or cause of action against us may be assigned by you to any provider. We will not pay any provider except under the terms of this contract.

Care and Services That are Not Payable

We do not pay for the following care and services:

- Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under this certificate
- Those available in a hospital maintained by the state or federal government, unless payment is required by law
- Those payable by government sponsored health care programs such as Medicare for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal law requires the government sponsored program to be secondary to this coverage.
- Any services not listed in this certificate as being payable

Changes in Your Family

We must be notified by your employer or group within 30 days of any changes in your family. This requires you to complete an enrollment/change of status form with your employer or group. Any coverage changes will then take effect as of the date of the event. Changes include marriage, divorce, birth, death, adoption, or the start of military service. An enrollment/change of status form should be completed when you have a change of address.

Changes to Your Certificate	<p>BCBSM employees, agents or representatives cannot agree to change or add to the benefits described in this certificate.</p> <ul style="list-style-type: none">• Any changes must be in writing and approved by BCBSM and the Michigan Commissioner of Financial and Insurance Regulation.• We may add, limit, delete or clarify benefits by issuing a rider. Keep any riders you receive with this certificate.
Coordination of Benefits	<p>We will coordinate the benefits payable under this certificate pursuant to the Coordination of Benefits Act, Public Act No. 64 of 1984 (starting at MCLA 550.251). To the extent that the services covered under this certificate are also covered and payable under another group health care plan, we will combine our payment with that of the other plan to pay up to the maximum amount we would routinely pay for covered services.</p> <p>NOTE: We do not pay for sanctions imposed by other health care plans, such as additional or increased costs you must pay for obtaining services from out-of-network providers.</p>
Deductibles and Copayments Paid Under Other Certificates	<p>We do not pay deductibles or copayments that you were required to pay under any other certificate.</p>
Experimental or Investigational Services	<p>We do not pay for experimental or investigational treatment or for services that are related to experimental or investigational treatment.</p> <p>We do not pay for experimental or investigational drugs or for administrative costs related to health care services and/or research management.</p>

**Experimental or
Investigational
Services**
(continued)

NOTE: This does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

However, we do pay for conventional (non-experimental) services related to experimental or investigational treatment when:

- Provided during a BCBSM-approved oncology clinical trial (check with your provider to determine whether a clinical trial is approved by BCBSM) and
- Covered under your certificate and riders when provided during conventional (non-experimental) treatment

NOTE:

- We do not provide coverage for conventional (non-experimental) services not otherwise covered under your certificate(s) and riders.
- We do not provide coverage for experimental or investigational treatment rendered during a BCBSM-approved oncology clinical trial unless specifically provided for in this certificate.
- We do not provide coverage for experimental or investigational drugs that are normally covered by other funding sources (e.g., experimental or investigational drugs funded by a drug company).
- We do not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

The BCBSM medical director is responsible for determining whether the use of any service is experimental or investigational. For example, the service may be determined to be experimental or investigational when there is:

Section 4: General Conditions of Your Contract

**Experimental or
Investigational
Services**

(continued)

- A written experimental or investigational plan by the attending provider or another provider studying the same service or
- A written informed consent used by the treating provider in which the service is referred to as experimental or investigational, or other than conventional or standard therapy or
- An ongoing clinical trial

Or, the BCBSM medical director may rely on other information to determine whether a service is experimental or investigational, including but not limited to:

- Scientific data such as controlled studies in peer reviewed journals or medical literature
- Information from the Blue Cross and Blue Shield Association or other local or national bodies
- Information from local and national medical societies, other appropriate professional societies, organizations, committees or governmental bodies
- Approval, when applicable, by the Food and Drug Administration (FDA), the Office of Health Technology Assessment (OHTA) and other governmental agencies
- Accepted national standards of practice in the medical profession
- Approval by the institutional review board of the hospital or medical center

**Illness or
Injuries
Resulting from
War**

Services are not payable for the treatment of illness or injuries resulting from declared or undeclared military acts of war.

Section 4: General Conditions of Your Contract

- Improper Use of Contract** If you allow any ineligible person to receive benefits (or try to receive benefits) under your contract, we may:
- Refuse to pay benefits
 - Cancel your contract
 - Begin legal action against you
 - Refuse to cover your health care services at a later date
- Notification** When we need to notify you, we mail the notice to your employer, your remitting agent or your most recent address we have in our records, as applicable. This fulfills our obligation to notify you.
- Other Coverage** In certain cases, we may have paid for health care services for you or your covered dependents that should have been paid by another person, insurance company or organization. In these cases:
- You grant us a lien or right of reimbursement on any money or other valuable consideration you or your covered dependents or representatives receive through a judgment, settlement, or otherwise. You grant us the lien or right of reimbursement regardless of 1) whether the money or other valuable consideration is designated as economic or non-economic damages, 2) whether the recovery is partial or complete, and 3) who holds the money or other valuable consideration or where it is held.
 - You agree to inform us when you hire an attorney to represent you, and to inform your attorney of our rights under this certificate.
 - You must do whatever is necessary to help us recover the money we paid to treat the injury that caused you to claim damages for personal injury.
 - You must not settle a personal injury claim without first obtaining our written consent if we paid for the treatment you received for that injury.



Section 4: General Conditions of Your Contract

Other Coverage
(continued)

- You agree to cooperate with us in our efforts to recover money we paid on behalf of you or your dependents.
- You acknowledge and agree that this certificate supercedes any made whole doctrine, collateral source rule, common fund doctrine or other equitable distribution principles.

Personal Costs

We will not pay for care, services, supplies or devices that are personal or convenience items. BCBSM is not responsible for any claims for injury or damage due to the manufacturing, compounding, dispensing or use of any prescription drug or injectable insulin whether or not covered under this certificate.

Refunds of Premium

If we determine that we owe a refund of premium, we will repay up to a maximum of two years of payments.

Release of Information

You agree to permit providers to release information to us. This can include medical records and claims information related to services you may receive or have received.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized or required by law.

Reliance on Verbal Communications

Verbal verification of a member's eligibility for coverage or availability of benefits is not a guarantee of payment of claims. All claims are subject to a review of the diagnosis reported, medical necessity verification, the availability of benefits at the time the claim is processed as well as to the conditions, limitations, exclusions, maximums, deductibles and copayments under your coverage.

Right to Interpret Contract

During claims processing and internal grievances, BCBSM reserves the right to interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances are subject to your right to appeal under applicable law.

Section 4: General Conditions of Your Contract

Services Before Coverage Begins and After Coverage Ends	<ul style="list-style-type: none">• Unless otherwise stated in this certificate, we will not pay for any services, treatment, care or supplies provided <u>before</u> the effective date of this certificate.• Unless otherwise stated in this certificate, we will not pay for any services, treatment, care or supplies provided <u>after</u> the date on which coverage under this certificate ends.
Time Limit for Filing Claims	<p>We will not pay for claims that are not filed within the following time limits from the date of service:</p> <ul style="list-style-type: none">• 60 days for pay-provider claims• One year for pay-subscriber claims
Time Limit for Legal Action	<p>Legal action against us may not begin later than two years after we have received a complete claim for services.</p>
Unlicensed Provider	<p>Benefits are not payable for services provided by persons who are not legally qualified or licensed to provide them.</p>
What Laws Apply	<p>This certificate will be interpreted under the laws of the state of Michigan.</p>
Workers Compensation	<p>We do not pay for the treatment of work-related injuries covered by workers compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by an employer.</p>

AK

Section 5: The Language Of Health Care

This section explains the terms used in your certificate. The terms are listed in alphabetical order.

Approved Amount	The lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) for a covered drug or service. The drug cost, dispensing fee and incentive fee are set according to our contracts with pharmacies. The approved amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Copayments that may be required of you are subtracted from the approved amount before we make our payment.
BCBSM	Blue Cross Blue Shield of Michigan.
Certificate	This book, which describes your benefit plan, and any riders that amend this certificate.
Claim for Damages	A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.
Clinical Trial	<p>A study conducted on a group of patients to determine the effect of a treatment. For purposes of this certificate, clinical trials include:</p> <ul style="list-style-type: none">• Phase II - a study conducted on a larger number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.• Phase III - a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of a conventional or standard treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Contraceptive Medication	A medication intended to prevent pregnancy
Contract	This certificate and any related riders, your signed application for coverage and your BCBSM ID card.
Conventional Service	A service that has been scientifically demonstrated to be safe and effective for treatment of the patient's condition.
Copayment	<p>The portion of the approved amount that you must pay for a covered drug or service. Your copayment is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.</p> <p>NOTE: A separate copayment is not required for covered disposable needles and syringes when dispensed at the same time as insulin or chemotherapeutic drugs.</p> <p>Your copayment will be reduced by one-half (1/2) for the initial fill (15 days) of select specialty drugs once applicable deductible(s) have been met.</p>
Cosmetic Drugs	Prescription drugs that are used primarily for improving appearance rather than for treating a disease.
Covered Drug	<p>Injectable insulin, any state-controlled or FDA-approved drug, select over-the-counter drugs, or such drugs that BCBSM designates as covered, if the following conditions are met:</p> <ul style="list-style-type: none">• A prescription must be issued by a prescriber who is legally authorized to prescribe drugs for human use.• The cost of the drug must not be included in the charge for other services or supplies provided to you.• The drug is not entirely consumed at the time and place where the prescription is written.

26

Covered Drug
(continued)

The drug must also be approved by the Federal Food and Drug Administration for treatment of the condition for which it is prescribed or recognized for treatment of the condition for which it is prescribed by one of the following sources:

- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

NOTE: Any compounded drugs are covered if they meet all the above requirements, subject to the provisions and exclusions of this certificate.

Covered Services

Drugs or supplies used to treat medical conditions, such as disposable needles and syringes when dispensed with insulin, or chemotherapeutic drugs.

Diagnostic Agents

Substances used to diagnose rather than treat a condition or disease.

Dispensing Fee

The amount we pay to a provider for filling a prescription.

Effective Date

The date your coverage begins under this contract. This date is established by BCBSM.

Emergency Pharmacy Services

Services needed immediately because an injury or illness occurred suddenly and unexpectedly.

Experimental or Investigational	A service that has not been scientifically demonstrated to be as safe and effective for treatment of the patient's condition as conventional or standard treatment.
First Priority Security Interest	<p>The right to be paid before any other person from any money or other valuable consideration recovered by:</p> <ul style="list-style-type: none">• Judgment or settlement of a legal action• Settlement not due to legal action• Undisputed payment <p>This right may be invoked without regard for:</p> <ul style="list-style-type: none">• Whether plaintiff's recovery is partial or complete• Who holds the recovery• Where the recovery is held
Food and Drug Administration (FDA)	An agency within the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.
Generic Equivalent	A prescription drug that contains the same active ingredients, is identical in strength and dosage form and is administered in the same way as the brand name drug.
Group	A collection of subscribers under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.
Impotence Drugs	Drugs that improve sexual potency.
In-Network Pharmacy	A provider selected by BCBSM to provide covered drugs through our PPO program. In-network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to members.

Handwritten signature

Lien	A first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid as a result of the plaintiff's injuries.
Maximum Allowable Cost (MAC)	The most BCBSM will pay for certain covered drugs we have identified under the Maximum Allowable Cost Program.
Maximum Allowable Cost Drugs	Certain generically equivalent drugs we have identified under the Maximum Allowable Cost Program.
Maximum Allowable Cost Program	A BCBSM cost containment program that encourages the use of generic drugs. The MAC Program places a cost limit on certain drugs for which a generically equivalent drug is available at a lower cost.
Medically Necessary	<p>A drug must be medically necessary to be covered, as determined by pharmacists and physicians acting for BCBSM, based on criteria and guidelines developed by pharmacists and physicians for BCBSM. The covered drug must be accepted as necessary and appropriate for the patient's condition and not mainly for the convenience of the member or physician.</p> <p>In the absence of established criteria, medical necessity will be determined by pharmacists and physicians according to accepted standards and practices.</p>
Member	Any person eligible for services under this certificate. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered drugs or services.
Off-Label	The use of a drug or device for clinical indications other than those stated in the labeling approved by the Federal Food and Drug Administration.
Out-of-Network Pharmacy	A provider that has not been selected for participation and has not signed an agreement to provide covered drugs through our PPO program. Out-of-network pharmacies have not agreed to accept the approved amount as payment in full for covered drugs or services provided to members.

DB

Section 5: The Language of Health Care

Over-the-Counter (OTC) Drug	A drug that does not require a prescription under federal law.
Patient	The subscriber or eligible dependent who is awaiting or receiving covered drugs or services.
Pharmacy	A licensed establishment where a licensed pharmacist dispenses prescription drugs under the laws of the state or country where the pharmacist practices.
Plaintiff	The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.
Preferred Provider Organization (PPO)	A limited group of pharmacies that have been selected for this program and have agreed to provide covered drugs or services to BCBSM members and accept the approved amount as payment in full.
Prescriber	A health care professional authorized by law to prescribe FDA-approved or state-approved drugs for the treatment of human conditions.
Prescription	An order for medication or supplies written by a prescriber, as defined in this section.
Provider	A pharmacy legally licensed to dispense drugs.
Qualifying Beneficiary	Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).

OK

Qualifying Event

One of the following events that allows a qualified beneficiary to receive COBRA coverage:

- Termination of employment, other than for gross misconduct, or reduction of hours
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The employee becomes entitled to coverage under Medicare

Remitting Agent

Any individual or organization that has agreed, on behalf of the subscriber, to:

- Collect or deduct premiums from wages or other sums owed to the subscriber
- Pay the subscriber's BCBSM bill

Rider

A document that amends this certificate by adding, limiting, deleting or clarifying benefits.

Right of Reimbursement

The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

Specialty Pharmaceuticals

Biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include chemotherapy drugs used in the treatment of cancer but excludes injectable insulin. **Select specialty pharmaceuticals require preauthorization from BCBSM.**

**Specialty
Pharmaceuticals**
(continued)

Examples of specialty pharmaceuticals include, but are not limited to, the following:

- Drugs administered by home infusion therapy providers
- Drugs administered in the office by health care practitioners
- Certain drugs to treat highly complex disorders, such as multiple sclerosis, lupus and immune deficiency
- Chemotherapy specialty pharmaceuticals dispensed at the pharmacy and self-administered, or administered by a health care practitioner at an approved facility or a physician's office

NOTE: BCBSM will cover these drugs under the certificate that applies to the benefit. For example, drugs administered in the office by a health care practitioner are covered under the certificate that applies to your medical benefits.

**Specialty
Pharmacy**

Companies that specialize in specialty medications and the associated clinical management support.

**State-
Controlled
Drugs**

Drugs that are usually sold over-the-counter, but require a prescription under state law when certain quantities are dispensed.

Subrogation

The assumption by BCBSM of your right, or the right of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

Subscriber

The person who signed and submitted the application for coverage.

We, Us, Our

Used when referring to Blue Cross Blue Shield of Michigan.

You and Your

Used when referring to any person covered under the subscriber's contract.

AV

Section 6: How to Reach Us

This section lists phone numbers and addresses to help you get information quickly. You may call us or visit our BCBSM Customer Service center.

To Call

Most of our BCBSM Customer Service lines are open for calls from 8:30 a.m. to noon and from 1 p.m. to 5 p.m., Monday through Friday. Please have your ID card with your group and contract numbers ready when you call.

Area code 248, 313, 586, 734, 810 or 947

Southeast Michigan toll-free 1-877-790-2583

Area code 231, 269 or 616

West Michigan toll-free 1-800-972-9797

Area code 517 or 989

Central Michigan toll-free 1-800-258-8000

Area code 906

Upper Peninsula toll-free 1-800-562-7884

To Visit

BCBSM Customer Service centers are located throughout Michigan. Check the following list or visit our website at bcbsm.com to find the center nearest you. The centers are open Monday through Friday, 9 a.m. to 5 p.m.

Detroit

500 E. Lafayette Blvd., Detroit 48226

Downtown, three blocks north of Jefferson at St. Antoine

Flint

4520 Linden Creek Parkway, Suite A, Flint 48507

Grand Rapids

86 Monroe Center N.W., Grand Rapids 49503

Holland

151 Central Ave., Holland 49423

To Visit
(continued)

Lansing
232 S. Capitol Ave., Lansing 48933

Marquette
415 S. McClellan Ave., Marquette 49855
Up on the hill

Portage
8175 Creekside Drive, Suite 100, Portage 49024

Southfield
20500 Civic Center Drive, Southfield 48076

Traverse City
City Centre Plaza, 202 State St., Traverse City 49686

Utica
6100 Auburn Road, Utica 48317
Diagonally across from the AAA Building

Form No. 834E



Bureau Approved TBD

PREFERRED RX LG

10

OK

Prescription Drugs

Group Name: City Of Novi

Group Number: 007003469

Enrollee: Keith Wuotinen

Enrollee ID: XYQ-890788249

4 Family member(s) on this plan

What's covered - prescription benefits

View your prescription benefits, such as deductibles, copays or how many days your refills will last.

Price a drug and view additional benefit requirements

This is an easy way to find coverage and pricing information for drugs within your benefit plan. You'll also be able to determine if your drug is part of the formularies or needs prior authorization or step therapy.

Research a drug

This is a great way to learn about your drugs and become aware of potential drug interactions and side effects.

Prescription drug history

Want a history of your prescriptions? You can view a list of your previous retail and mail order prescriptions.

Where to go for care

Find a Pharmacy

We'll take you to the website for your prescription drug coverage. Then you'll be able to search for a pharmacy that works with your plan.

Mail order

Want to order your prescriptions online? You can use Express Scripts.

Mail order specialty drugs

You can mail order specialty drugs through Walgreens Specialty Pharmacy. Specialty drugs typically treat complex or rare diseases such as cancer, arthritis, hepatitis C and many others. If you want to learn more about ordering these specialty drugs, please call 1-866-515-1355 or visit walgreenshealth.com

Need More Help?

If you have questions about your benefits, [contact us](#).

Need Pharmacy/Prescription Help?

To learn more about pharmacies or prescription services, check out the [Pharmacy FAQ](#) in our Help Center.

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Vision

Group Name: City Of Novi
Group Number: 007003469
Enrollee: Keith Wuotinen
Enrollee ID: XYQ-890788249
4 Family member(s) on this plan

Available Coverage

Is it time to go back to the eye doctor? Use the table below to see who's used their vision benefits during this eligibility period. That way, you'll know which benefits are still available.

For a detailed list of your vision benefits, see [What's Covered](#).

	Eye Exam	Lenses	Frames
Keith	Not Used	Not Used	Not Used
Laura	Not Used	Not Used	Not Used
Lucas	Not Used	Not Used	Not Used
Matthew	Not Used	Not Used	Not Used

A status of Not Used doesn't always mean the benefit is available to you, just that our records show you haven't used it yet. You might be able to find more up-to-date information at the VSP or Heritage websites.

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OK



Vision

Group Name: City Of Novi
Group Number: 007003469
Enrollee: Keith Wuolinen
Enrollee ID: XYQ-890789249
4 Family member(s) on this plan

What's Covered

Choose a benefit category from the list below to view more details about what's covered by your plan.

For a legal definition of your benefits, see your Summary of Benefits and Coverage or your Certificates and Riders under [Plan Documents](#).

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Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval before they are provided is available online at bcbsm.com/importantinfo. Select

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Vision Coverage

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Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

Member's responsibility (copays)

Benefits	Participating provider	Nonparticipating provider
Eye exam	20% of approved amount	25% of approved amount after it has been reduced by member's 20% copay
Prescription glasses (lenses and/or frames)	20% of approved amount	50% of approved amount
Medically necessary contact lenses	20% of approved amount	50% of approved amount

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Benefits	Participating provider	Nonparticipating provider
Eye exam by a physician or optometrist	80% of approved amount	75% of approved amount after 20% copay (member responsible for difference)
	One eye exam in any period of 24 consecutive months	

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Lenses and Frames

Benefits	Participating provider	Nonparticipating provider
Standard lenses, not to exceed 85 mm in diameter, when prescribed or dispensed by a physician, optometrist or optician. Lenses may be molded or ground, glass or plastic.	80% of approved amount, up to program specifications	The lesser of 50% of approved amount or 75% of the average covered vision expense benefit paid to participating providers for comparable lenses (member responsible for difference)
	One pair of lenses, with or without frames, in any period of 24 consecutive months	
Standard frames	80% of approved amount, up to program specifications	The lesser of 50% of approved amount or 75% of the average covered vision expense benefit paid to participating providers for comparable frames (member responsible for difference)
	One frame in any period of 24 consecutive months	

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Contact Lenses

Benefits	Participating provider	Nonparticipating provider
Medically necessary contact lenses (must meet criteria of medically necessary)	80% of approved amount, up to program specifications	Individual consideration
	One pair of contact lenses in any period of 24 consecutive months	
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	80% of approved amount, up to a maximum payment of \$35 (member responsible for difference)	80% of approved amount, up to a maximum payment of \$35 (member responsible for difference)
	One pair of contact lenses in any period of 24 consecutive months	

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Vision care services not covered

The following are not covered under your vision plan unless otherwise noted as an included benefit:

- Additional charges for:
 - Lenses tinted darker than Rose tint #2 (such as sunglasses)
 - Oversize lenses (81 mm and larger)
 - Blended lenses
 - Photochromic lenses
 - Coating/laminating of a lens or lenses
 - Cosmetic lenses/processes
 - Two pair of glasses instead of bifocals
 - Antireflective lenses
- Medical-surgical treatment
- Medications administered during any service except an eye exam

- Services not prescribed by an ophthalmologist or optometrist
- Special services, such as orthoptics, vision training, aniseikonic lenses and tonography
- Replacement of broken or lost lenses or frames
- Services received as a result of an eye disease, defect or injury due to an act of war, declared or undeclared
- Services available at no cost to you or for which no charge would be made in the absence of BCBSM coverage
- Charges for lenses or frames ordered while you were eligible for benefits but delivered more than 60 days after coverage ends
- Charges for completing insurance forms
- Aphakic lenses when the patient lacks a natural lens
- Charges for experimental or poor quality services
- Medically unnecessary services, glasses or contact lenses

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IMPORTANT

BCBSM ADMINISTRATIVE FORM

NOT FOR EXTERNAL PUBLICATION

ADMINISTRATIVE FORM VC1

AMENDS

**VISION CARE GROUP BENEFITS CERTIFICATE
4790**

Administrative Form VC1 is for **internal purposes only**. It supports BCBSM's internal activities related to the migration of the Vision Care Group Benefits Certificate onto the Michigan Operating System platform.



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Handwritten signature or initials

The sole purpose of Administrative Form VC1 is to support BCBSM's internal activities related to migration of the Vision Care Group Benefits Certificate onto the Michigan Operating System platform

GENERAL

All the terms, definitions, limitations, exclusions and conditions of the member's certificate and related riders are **not affected** by Administrative Form VC1.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 226E



**Administrative form.
OFIR approval not required.**

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Effective Date: 01/01/2016

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Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

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Services from a provider for which there is no Michigan PPO network and 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 are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Eligibility information

Member

Dependents

Sponsored dependents

Eligibility Criteria

- Subscriber's legal spouse
- **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26
- Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits

Deductibles

In-network

\$100 for one member,
\$200 for the family (when two or more members are covered under your contract) each calendar year

Out-of-network

\$250 for one member,
\$500 for the family (when two or more members are covered under your contract) each calendar year

Note: Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance abuse services that are equivalent to an office visit and performed in an in-network physician's office.

Note: Out-of-network deductible amounts also count toward the in-network deductible

Flat-dollar copays

- \$20 copay for office visits and office consultations
- \$20 copay for online visits
- \$20 copay for chiropractic and osteopathic manipulative therapy
- \$50 copay for emergency room visits
- \$20 copay for urgent care visits

- \$50 copay for emergency room visits

Coinsurance amounts (percent copays)

- 50% of approved amount for private duty nursing care
- 10% of approved amount for mental health care and substance abuse treatment
- 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)

- 50% of approved amount for private duty nursing care
- 30% of approved amount for mental health care and substance abuse treatment
- 30% of approved amount for most other covered services

Note: Coinsurance amounts apply once the deductible has been met.

Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts

\$500 for one member,
\$1,000 for the family (when two or more members are covered under your contract) each calendar year

\$1,000 for one member,
\$2,000 for the family (when two or more members are covered under your contract) each calendar year

Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.

Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable

\$6,350 for one member,
\$12,700 for the family (when two or more members are covered under your contract) each calendar year

\$12,700 for one member,
\$25,400 for the family (when two or more members are covered under your contract) each calendar year

Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.

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Benefits	In-network	Out-of-network
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Gynecological exam	<p>Note: Additional well-women visits may be allowed based on medical necessity.</p> 100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

Benefits

Routine mammogram and related reading

In-network

100% (no deductible or copay/coinsurance)

Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance

One per member per calendar year

Out-of-network

70% after out-of-network deductible

Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.

Colonoscopy - routine or medically necessary

100% (no deductible or copay/coinsurance), for the first billed colonoscopy

Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.

One per member per calendar year

70% after out-of-network deductible

Physician office services**Benefits**

Office visits - must be medically necessary

Online visits - must be medically necessary

Outpatient and home medical care visits - must be medically necessary

Office consultations - must be medically necessary

Urgent care visits - must be medically necessary

In-network

\$20 copay per office visit

\$20 copay per online visit

90% after in-network deductible

\$20 copay per office consultation

\$20 copay per urgent care visit

Out-of-network

70% after out-of-network deductible

70% after out-of-network deductible

70% after out-of-network deductible

70% after out-of-network deductible

70% after out-of-network deductible

Emergency medical care**Benefits**

Hospital emergency room

Ambulance services - must be medically necessary

In-network

\$50 copay per visit (copay waived if admitted or for an accidental injury)

90% after in-network deductible

Out-of-network

\$50 copay per visit (copay waived if admitted or for an accidental injury)

90% after in-network deductible

Diagnostic services**Benefits**

Laboratory and pathology services

Diagnostic tests and x-rays

Therapeutic radiology

In-network

90% after in-network deductible

90% after in-network deductible

90% after in-network deductible

Out-of-network

70% after out-of-network deductible

70% after out-of-network deductible

70% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife**Benefits**

Prenatal care visits

Postnatal care visits

Delivery and nursery care

In-network

100% (no deductible or copay/coinsurance)

100% (no deductible or copay/coinsurance)

90% after in-network deductible

Out-of-network

70% after out-of-network deductible

70% after out-of-network deductible

70% after out-of-network deductible

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Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	90% after in-network deductible	70% after out-of-network deductible Unlimited days
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	90% after in-network deductible	70% after out-of-network deductible
Chemotherapy	90% after in-network deductible	70% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	90% after in-network deductible Limited to a maximum of 120 days per member per calendar year	90% after in-network deductible
Hospice care	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay/coinsurance)
Home health care:	90% after in-network deductible	90% after in-network deductible
<ul style="list-style-type: none"> must be medically necessary must be provided by a participating home health care agency 		
Infusion therapy:	90% after in-network deductible	90% after in-network deductible
<ul style="list-style-type: none"> must be medically necessary must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) may use drugs that require preauthorization - consult with your doctor 		

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	90% after in-network deductible	70% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Voluntary sterilization for males	90% after in-network deductible	70% after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Elective Abortions	Not covered	Not covered

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	70% after out-of-network deductible

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Benefits	In-network	Out-of-network
Specified oncology clinical trials	90% after in-network deductible	70% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	90% after in-network deductible	70% after out-of-network deductible

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health or substance abuse service is considered by BCBSM to be comparable to an office visit, we will process the claim under your office visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance abuse treatment	90% after in-network deductible	70% after out-of-network deductible Unlimited days
Residential psychiatric treatment facility:	90% after in-network deductible	70% after out-of-network deductible
<ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility treatment must be preauthorized subject to medical criteria 		
Outpatient mental health care:		
<ul style="list-style-type: none"> Facility and clinic 	90% after in-network deductible	90% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Physician's office 	90% after in-network deductible	70% after out-of-network deductible
Outpatient substance abuse treatment - in approved facilities only	90% after in-network deductible	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	90% after in-network deductible	90% after in-network deductible
Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	90% after in-network deductible	70% after out-of-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited
Other covered services, including mental health services, for autism spectrum disorder	90% after in-network deductible	70% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	<ul style="list-style-type: none"> 90% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training 	70% after out-of-network deductible
Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider.		
Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.		
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit Limited to a combined 24-visit maximum per member per calendar year	70% after out-of-network deductible
Outpatient physical, speech and occupational therapy - when provided for rehabilitation	90% after in-network deductible	70% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a combined 60-visit maximum per member per calendar year
Durable medical equipment	90% after in-network deductible	90% after in-network deductible
Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.		
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

BCBSM Preferred RX Program

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Specialty Pharmaceutical Drugs - The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits	In-network pharmacy	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
Tier 2 - Preferred brand-name drugs	You pay \$20 copay	You pay \$20 copay plus an additional 25% of BCBSM approved amount for the drug
Tier 3 - Nonpreferred brand-name drugs	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Copay for up to a 90 day supply: <ul style="list-style-type: none">• You pay \$10 copay for Tier 1 (generic) drugs• You pay \$20 copay for Tier 2 (formulary brand) drugs• You pay \$40 copay for Tier 3 (nonformulary brand) drugs	Not covered

Note: An in-network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	75% of approved amount
FDA-approved generic and select brand name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved brand name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/ coinsurance	75% of approved amount less plan copay/ coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

Note: Needles and syringes have no copay/ coinsurance.

Note: An in-network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs

Features of your prescription drug plan

Custom Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> • Tier 1 (generic) - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • Tier 2 (preferred brand) - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • Tier 3 (nonpreferred brand) - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Drug interchange and generic copay/ coinsurance waiver	<p>BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Features of your prescription drug plan

Prior authorization/step therapy

A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy.

Vision Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

Member's responsibility (copays)

Benefits	Participating provider	Nonparticipating provider
Eye exam	20% of approved amount	25% of approved amount after it has been reduced by member's 20% copay
Prescription glasses (lenses and/or frames)	20% of approved amount	50% of approved amount
Medically necessary contact lenses	20% of approved amount	50% of approved amount

Eye exam

Benefits	Participating provider	Nonparticipating provider
Eye exam by a physician or optometrist	80% of approved amount	75% of approved amount after 20% copay (member responsible for difference)

One eye exam in any period of 24 **consecutive** months

Lenses and Frames

Benefits	Participating provider	Nonparticipating provider
Standard lenses, not to exceed 65 mm in diameter, when prescribed or dispensed by a physician, optometrist or optician. Lenses may be molded or ground, glass or plastic.	80% of approved amount, up to program specifications	The lesser of 50% of approved amount or 75% of the average covered vision expense benefit paid to participating providers for comparable lenses (member responsible for difference)
	One pair of lenses, with or without frames, in any period of 24 consecutive months	
Standard frames	80% of approved amount, up to program specifications	The lesser of 50% of approved amount or 75% of the average covered vision expense benefit paid to participating providers for comparable frames (member responsible for difference)

One frame in any period of 24 **consecutive** months

Contact Lenses

Benefits	Participating provider	Nonparticipating provider
Medically necessary contact lenses (must meet criteria of medically necessary)	80% of approved amount, up to program specifications	Individual consideration
	One pair of contact lenses in any period of 24 consecutive months	
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	80% of approved amount, up to a maximum payment of \$35 (member responsible for difference)	80% of approved amount, up to a maximum payment of \$35 (member responsible for difference)
	One pair of contact lenses in any period of 24 consecutive months	

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: Beginning 01-01-2016
Coverage for: Individual/Family | **Plan Type:** PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$100 Individual/ \$200 Family	\$250 Individual/ \$500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$6,350 Individual/ \$12,700 Family	\$12,700 Individual/ \$25,400 Family	The <u>out-of-pocket</u> limit is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket</u> limits until the overall family <u>out-of-pocket</u> limit has been met.
What is not included in the <u>out-of-pocket</u> limit?	<u>Premiums</u> , <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Will you pay less if you use a <u>network</u> provider?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of <u>network</u> providers.		This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network</u> provider, and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network</u> provider might use an <u>out-of-network</u> provider for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /office visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	Specialist visit	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	Preventive care/ screening/ immunization	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	May require <u>preauthorization</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	\$10 <u>copay</u> for retail 30-day supply; \$10 <u>copay</u> for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	<u>Preauthorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. 90-day supply not covered out of network.
	Preferred brand-name drugs	\$20 <u>copay</u> for retail 30-day supply; \$20 <u>copay</u> for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
	Non preferred brand-name drugs	\$40 <u>copay</u> for retail 30-day supply; \$40 <u>copay</u> for retail or mail order 90-day supply.	In-Network <u>copay</u> plus an additional 25% of the approved amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted or for an accidental injury
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Mileage limits apply
	<u>Urgent care</u>	\$20 <u>copay/visit</u> ; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	10% <u>coinsurance</u> ; <u>deductible</u> does not apply	10% <u>coinsurance</u> ; <u>deductible</u> does not apply	Your cost share may be different for services performed in an office setting
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	No Charge; <u>deductible</u> does not apply;	30% <u>coinsurance</u>	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. <u>Cost sharing</u> does not apply to certain maternity services considered to be <u>preventive</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	10% <u>coinsurance</u> for Applied Behavioral Analysis; 10% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	10% <u>coinsurance</u> for Applied Behavioral Analysis; 30% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to <u>preauthorization</u> .
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	<u>Preauthorization</u> is required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-------------------------|-------------------------|------------------------|
| • Acupuncture treatment | • Hearing aids | • Routine foot care |
| • Cosmetic surgery | • Infertility treatment | • Weight loss programs |
| • Dental care (Adult) | • Long term care | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|--|---|----------------------------|
| • Bariatric surgery | • If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses - like the deductible, co-payments, or co-insurance, or benefits not otherwise covered | • Routine eye care (Adult) |
| • Chiropractic care | | |
| • Coverage provided outside the United States. See http://provider.bcbs.com | • Non-emergency care when traveling outside the U.S | |
| | • Private duty nursing | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccoio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$100
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
--------------------	----------

In this example, Peg would pay:

Cost Sharing

Deductibles	\$100
Copayments	\$70
Coinsurance	\$1,000

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$1,230

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$100
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
--------------------	---------

In this example, Joe would pay:

Cost Sharing

Deductibles	\$100
Copayments	\$700
Coinsurance	\$200

What isn't covered

Limits or exclusions	\$60
The total Joe would pay is	\$1,060

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$100
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic tests (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
--------------------	---------

In this example, Mia would pay:

Cost Sharing

Deductibles	\$100
Copayments	\$200
Coinsurance	\$100

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$400

The plan would be responsible for the other costs of these EXAMPLE covered services.

**BLUE CROSS AND BLUE SHIELD
OF MICHIGAN**



**VISION CARE
GROUP BENEFIT
CERTIFICATE**

[Handwritten signature]

CERTIFICATE DECLARATIONS
BLUE CROSS AND BLUE SHIELD
OF MICHIGAN

VISION CARE GROUP BENEFIT
CERTIFICATE

4

THIS CONTRACT, made between the subscriber named in the application and Blue Cross and Blue Shield of Michigan, a nonprofit hospital and medical care corporation, entitles the subscriber and, if listed on the application, the subscriber's eligible dependents, to have, upon payment of the subscription rate and subject to the terms, limitations and definitions set forth in this contract, the services provided under this contract for a period of one (1) month following the effective date and thereafter.

In Witness Whereof, Blue Cross and Blue Shield of Michigan has caused this certificate to be executed by its duly authorized officer.

BLUE CROSS AND BLUE SHIELD
OF MICHIGAN

John C. McCabe
President

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Section I. DEFINITIONS

The following terms shall have the following meaning when used in this Contract.

1. "Acquisition Cost" is the actual cost of the lenses and/or frames to the provider.
2. "BCBSM" is Blue Cross and Blue Shield of Michigan.
3. "Benefit" is a service which is covered under this Contract and is provided to an eligible member.
4. "Blue Cross Plan" is any nonprofit hospital service plan that is, at the time service is provided under this Contract, officially approved as such by the Blue Cross Association.
5. "Blue Shield Plan" is any nonprofit medical service plan that is, at the time service is provided under this Contract, officially approved as such by the Blue Shield Association.
6. "Certificate" is this document and any riders or supplements to it.
7. "Contact Lenses" are ophthalmic corrective lenses, either glass or plastic, ground or molded as prescribed by a physician or optometrist to be fitted directly to the patient's eyes; these are subject to the same limitations and exclusions that are applicable to lenses generally.
8. "Contract" is the application submitted as the basis for issuing this Certificate, this Certificate, and the identification card.
9. "Co-Payment" is the balance of charges for covered vision expense services for which the subscriber is responsible after determination of vision care benefits under this Certificate.
10. "Covered Vision Expense" means the charges incurred for vision testing examinations, lenses, and frames with lenses for which benefits are payable by BCBSM as provided in Section II of this Certificate.

11. "Dependent" is only the following:

- a. The spouse of a subscriber.
- b. Unmarried eligible children until the end of the calendar year in which they reach 19 years of age, or at any age if they are totally and permanently disabled by any medically determined physical or mental condition which prevents the children from engaging in substantial gainful activity and which can be expected to result in death or to be of long, continued or indefinite duration. BCBSM may require the subscriber to submit evidence satisfactory to BCBSM of a child's total and permanent disability.

Eligible children are:

- i. Children of the subscriber or the subscriber's spouse by birth, legal adoption, or legal guardianship while they legally reside with and are dependent upon the subscriber or the subscriber's spouse.
 - ii. Children of the subscriber by birth, legal adoption, or legal guardianship who do not reside with the subscriber, but for whom it is the subscriber's legal responsibility to provide medical care (such as children of divorced parents, children for whom the subscriber is the legal guardian, children in school, children confined to training institutions).
 - c. Children residing with and related to the subscriber by blood or marriage for whom the subscriber provides principal support (as defined by the Internal Revenue Code of the United States) and who were reported as dependents on the subscriber's most recent income tax return or who qualify in the current year for dependent tax status.
12. "Dispensing Fee" is a fee predetermined by BCBSM for dispensing lenses and/or frames obtained while coverage is in effect as provided for in this Certificate.

13. "Effective Date" is the date on which coverage begins under this Contract. This date is determined by BCBSM.

14. "Frames" are standard eyeglass frames into which two covered lenses may be fitted.

15. "Group" is all of the subscribers enrolled in this health care benefit plan at the place where the subscriber made application, and for whom an employer submits or a remitting agent collects subscription rates for remittance to BCBSM on behalf of the subscriber.

16. "Lenses" are ophthalmic corrective lenses, either glass or plastic, ground or molded as prescribed by a physician or optometrist to be fitted into frames.

17. "Medicare" is the federal program established by Title XVIII of Public Law 89-97, as amended, which provides health insurance for the aged and disabled and includes Part A, Hospital Insurance Benefits for the Aged and Disabled, and Part B, Supplementary Medical Insurance Benefits for the Aged and Disabled.

18. "Member" is each person eligible for services under this Contract.

19. "Optical Laboratory" is any person or organization that supplies lenses and frames on a wholesale basis, grinds or molds lenses to prescription, grinds or molds lenses to fit frames, assembles frames and lenses to prescription or order, manufactures lenses, lens glass and/or frames, or conducts or performs other similar activities in support of the optical services rendered by opticians, optometrists, and ophthalmologists.

20. "Optician" means any individual, partnership, proprietorship, or corporation lawfully and regularly engaged to dispense corrective lenses prescribed by a physician or optometrist to improve visual acuity, to grind or mold the lenses or have them ground or molded according to the prescription, to fit them into the lens frame and to adjust the frames to fit the face. In states where licens-

ing of opticians is required, such individuals must hold a currently valid ophthalmic dispensing license.

21. "Optometrist" is any person licensed to practice optometry in the state in which the service is rendered.
22. "Participating Provider" is any physician, optometrist, or optician who, at the time a member receives services covered under this Certificate, has entered into an agreement with BCBSM to provide such services and to accept direct reimbursement from BCBSM and specified co-payments from members as payment in full for covered services.
23. "Physician" is any licensed doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified to practice medicine, who within the scope of his or her license performs vision testing examinations and prescribes lenses to improve visual acuity.
24. "Remitting Agent" is any individual, institution, organization or company which has agreed, on behalf of the subscriber, to collect and remit the subscription rate to BCBSM.
25. "Services" includes vision testing examinations, lenses, and frames with lenses.
26. "Subscriber" is the individual making the application accepted by BCBSM.
27. "Vision Testing Examination" is a professional evaluation by a physician or optometrist of visual acuity and such evaluation is the basis for prescribing lenses, when necessary, for corrective purposes.

Section II. SERVICE BENEFITS AND LIMITATIONS

A. Covered Vision Expense Service Benefits

1. BCBSM will make payment for charges incurred for vision testing examinations, lenses and frames with lenses, except as otherwise indicated, as described below:

a. Vision Testing Examination

- i. Must be performed by a physician or optometrist who determines the need for correction of visual acuity, and prescribes lenses, if needed.
- ii. The professional evaluation must include: history, testing of visual acuity, external examination of the eye; binocular measure; ophthalmoscopic examinations; tonometry when indicated; medication for dilating the pupils and desensitizing the eyes for tonometry, if applicable, and summary and findings.

b. Lenses

- i. Prescribed lenses must be intended for use in correcting or improving vision and may be either glass or plastic, ground or molded, either for insertion into a standard eyeglass frame or to be fitted directly to the patient's eyes.
- ii. Coverage is limited to white (colorless) glass, or plastic lenses when prescribed, for standard eyeglass eyewear unless therapeutic need exists for tinted prescription lenses equal to Rose Tints #1 and #2.
- iii. Coverage is limited for the lens blank size for lenses for standard eyeglass eyewear to a size of not more than 65 millimeters in diameter. If a larger lens blank size is chosen, any additional charges for such lenses do not constitute covered vision expense.

- iv. When dispensed, lenses must (1) be of a quality equal to the first quality lens series manufactured by American Optical (Tillyer), Bausch & Lomb (Orthogon) or Univis and (2) meet the applicable current standards of the American National Standards Institute: Z80.1 — Requirements for First Quality Prescription Ophthalmic Lenses or Z80.2 — Prescription Requirements for First Quality Contact Lenses.

c. Frames

- i. The frame must be adequate to hold the covered lenses prescribed in proper position on the head in front of the eyes.

2. Limitations

a. Frequency

Benefits will be provided only once in any 24 month period for a vision testing examination, lenses or frames respectively.

- i. Only one vision testing examination is payable during a 24 month period. However, if an optometrist as a result of his or her vision testing examination recommends that the member be examined by an ophthalmologist with respect to a vision problem, and the ophthalmologist's examination occurs within 60 days of the optometrist's examination, both vision testing examinations are covered vision expense.
- ii. During any 24 month period a member may obtain either contact lenses or eyeglasses but not both.

b. Prescription Change Required

- i. Benefits are not payable for lenses more than once, except where lenses differ by reason of a prescription

change, in which case benefits for lenses are payable only if received more than 24 months after lenses were last received as a covered vision expense.

B. Payment of Benefits

1. Payment for covered vision expense services will be made by BCBSM on the basis of the service rendered the member who will be responsible for applicable co-payments.

- a. A vision testing examination is reimbursable based on BCBSM's determination of what constitutes a reasonable and customary charge for such service.

- b. The actual acquisition cost of lenses and frames to the providers will be an element of reimbursement for lenses and frames. In addition, BCBSM will determine a dispensing fee payable for the dispensing of lenses and frames.

2. In determining what constitutes the "reasonable and customary charge," BCBSM will take into consideration:

- a. The usual amount that the provider most frequently charges the majority of his or her patients or customers for the vision testing examination, and
- b. The prevailing range of charges made in the same area by providers of similar training and experience for the vision testing examination rendered, and
- c. Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular vision testing examination rendered.

3. Payment for covered vision expense services will be made directly to a participating provider.

4. BCBSM will make payment directly to the member for covered vision expense services rendered by a non-participating provider.

5. BCBSM's determination of the amount of the reasonable and customary charge for a covered vision expense service shall be conclusive.

C. Plan and Member Liabilities

1. When services are received from a participating provider, BCBSM will pay the provider as follows:
 - a. For a vision testing examination, 80% of the reasonable and customary charge.
 - b. For lenses, 80% of the acquisition cost to the provider.
 - c. For contact lenses:
 - i. When the member's visual acuity cannot otherwise be corrected to at least 20/70 in the better eye, 80% of the acquisition cost to the provider.
 - ii. When the member's visual acuity can be otherwise corrected to at least 20/70 in the better eye, 80% of the acquisition cost to the provider but not to exceed a total payment of \$35 when combined with 80% of the dispensing fee for lenses and frames to the provider.
 - d. For frames, 80% of the acquisition cost to the provider, up to a maximum acquisition cost of \$12.50.
 - e. For lenses, contact lenses, and frames, 80% of the dispensing fees for usual services in dispensing such lenses or frames.

A participating provider has agreed to accept, as payment in full, BCBSM's determination of the amount payable for covered vision expenses, subject to the applicable co-payment. Where BCBSM makes payment of 80% of the reasonable and customary charge, dispensing fee, or acquisition cost, the member is financially responsible for the payment of the corresponding 20% to the participating pro-

vider. The member also shall pay the full additional charge of the provider if the member elects to order lenses, frames, or any unusual service exceeding program specifications.

2. When services are received from a non-participating provider, BCBSM will pay to the subscriber:

- a. For a vision testing examination, 75% of the reasonable and customary charge after it has been reduced by the member's co-payment of 20%.
- b. The lesser of 50% of the provider's reasonable and customary charge for covered lenses and frames or 75% of the average covered vision expense benefit paid to participating providers for comparable lenses and frames.

The member is financially responsible for payment of any additional charge of the provider in excess of the amount paid by BCBSM.

Section III. EXCEPTIONS AND EXCLUSIONS AND OTHER LIMITATIONS

The term "covered vision expense" as used herein shall not include, and no benefits are payable for, in addition to those elsewhere excluded, the following:

A. Charges for sunglasses, to the extent the charge for such lenses exceeds the benefit amount for the regular lenses, as provided in Section II. For the purpose of this exclusion tinted lenses with a tint other than the equivalent of Rose Tints #1 or #2 are deemed to be sunglasses.

B. Charge for photosensitive or anti-reflective lenses, to the extent the charge for such lenses exceeds the benefit amount for regular lenses as provided in Section II.

C. Charges for medical or surgical treatment.

D. Charges for drugs or any other medication not administered for the purpose of a vision testing examination.

E. Charges for procedures determined by BCBSM to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonic lenses and tonography.

F. Charges for services furnished for any condition, disease, ailment or injury arising out of and in the course of employment.

G. Charges for vision testing examinations and lenses or frames ordered.

1. before the member's effective date of coverage or

2. after termination of coverage.

H. Charges for lenses or frames ordered while coverage is in effect but delivered more than 60 days after coverage terminated.

I. Charges for services for which no charge is made that the member is legally obligated to pay or for which no charge would be made in the absence of this coverage.

J. Charges for services which are not necessary, according to accepted standards of ophthalmic practice, or which are not ordered or prescribed by the attending physician or optometrist.

K. Charges for services which do not meet accepted standards of ophthalmic practice, including charges for any such services or supplies which are experimental or research in nature.

L. Charges for services received as a result of eye disease, defect or injury due to an act of war, declared or undeclared.

M. Charges for services from any governmental agency which are obtained by a member without cost by compliance with laws or regulations enacted by any federal, state, municipal or other governmental body.

N. Charges for any services to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof.

O. Charges for replacement of lenses or frames which are lost or broken, unless at the time of such replacement the member is otherwise eligible under the frequency and prescription change limitations set forth in Section II.

P. Charges for the completion of any insurance forms.

Section IV. SUBROGATION AND ASSIGNMENT

A. Subrogation: In the event of any benefit payments for services or supplies under this Certificate, BCBSM shall be subrogated to all the member's right of recovery thereof against any person or organization except against insurers on policies of insurance issued to and in the name of the member (i.e., BCBSM will have the member's right to recover for benefit payments). All sums recovered by suit, settlement or otherwise, on account of such benefit payments, shall be paid over to BCBSM. Members shall furnish any information and assistance and execute any instruments, assignments, and other papers that BCBSM may request to facilitate enforcement of its subrogation rights under this provision. The member shall take no action prejudicing the rights and interest of BCBSM.

B. Assignment: The services to be provided under the Certificate are for the personal benefit of the member and cannot be transferred or assigned; any attempt to assign this Certificate shall automatically terminate all rights hereunder. No rights of the member to payment from or claim or cause of action of any member against BCBSM may be assigned by said member to any physician, optometrist or optician except under the provisions hereof, and without limiting the generality of the foregoing, Section II hereof.

Section V. COORDINATION OF BENEFITS

Coordination of Benefits: The service benefits of this Contract and any riders or supplements to it will not be payable to the extent they are available under any other group plan had a claim for benefits been duly made to the other group Plan. In such an instance, BCBSM will combine with the

other group plan so that all covered services incurred by the member during any claims determination period are paid.

1. Allowable expenses include the reasonable and necessary charges for items of expense which are covered, in whole or in part, under this Contract and any other group plan to which this provision applies.
2. As used in this section, "group plan" means any plan covering individuals as members of a group and providing benefits for services or medical care by a physician, hospital or other provider through group, blanket or franchise insurance coverage, group practice or other prepayment coverage on a group basis or under a labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan. If this contract is issued in conjunction with a BCBSM basic hospital and/or medical-surgical benefit contract which has a provision indicating that the coordination of benefits provision does not apply to group coverage for which the member pays one-half (1/2) or more of the cost of the premium or subscription rate, the same provision shall apply to this contract.
3. As used in this section, "claims determination period" means calendar year. However, a claims determination period does not begin before nor extend beyond the period of the member's coverage under this Contract.
4. In determining the benefits available under this provision, the following applies:
 - a. If another group plan does not contain a provision in its contract similar to this provision, the benefits of the other group plan will be determined prior to BCBSM's benefits. BCBSM's benefits will be reduced to the extent necessary so that the sum of the reduced BCBSM benefits and all the benefits payable for allowable expenses do not exceed the total of the covered services.
 - b. If another group plan contains a provision in its contract which coordinates benefits with those of this Contract so

that, according to the other group plan's rules, its benefits would be determined after BCBSM's benefits have been determined, and under the rules of paragraph 4 c would require BCBSM to determine its benefits before the other group plan, then benefits of the other group plan will be ignored for the purpose of determining benefits under this BCBSM contract.

- c. In all other cases the following applies in determining benefits:
 - i. The benefits of a group plan covering the person making the claim other than as a dependent will be determined before the benefits of the group plan covering the person as a dependent.
 - ii. The benefits of a group plan covering the person making the claim as a dependent of a male person will be determined before the benefits of the group plan covering the person as a dependent of a female person.
 - iii. When rules i and ii do not establish the order for determining benefits, the benefits of the group plan which has covered the person for the longer period of time will be determined before the benefits of the group plan covering the person for a shorter period of time.
- d. If a member covered under this Contract is also covered under another Blue Cross or Blue Shield group contract which provides other than cash benefits to the member, the rules of subparagraph c will establish the order of benefit determination whether or not the other Blue Cross or Blue Shield group contract contains a provision coordinating its benefits with those of this Contract.
- e. If it is determined that benefits under this Contract should have been reduced because of benefits provided under another group plan, BCBSM will have the right to recover any payment already made which is in excess of its liability.

Similarly, whenever benefits which are payable under this Contract have been provided under another group plan, BCBSM may make reimbursement directly to the insurance company or other organization providing benefit under the other plan.

- f. For the purpose of this provision, BCBSM may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person information which may be necessary regarding coverage, expenses and benefits.

Any person claiming benefits under this Contract must furnish BCBSM with any information necessary for the purpose of administering this provision.

Section VI. TERM AND TERMINATION

- A. Term: Subject to the provisions of paragraph C of this Section VI, this Contract shall constitute an agreement for one month from its effective date and shall be renewed automatically thereafter each month, unless written notice of election to terminate the same is given by the remitting agent or subscriber to BCBSM, or by BCBSM to the subscriber or the remitting agent, not less than thirty (30) days prior to the monthly renewal date, on which date termination is to be effective.
- B. Work in Progress: Charges for lenses or frames and the fitting thereof which were ordered while coverage is in force but finally delivered more than 60 days after termination of coverage are excluded.
- C. Termination
1. This Contract shall be terminated automatically in the event of:
 - a. failure to pay the applicable rate referred to in Section VIII hereof; or
 - b. termination of eligibility of the subscriber as a member of the group through which the subscriber enrolled.

In the event of termination under the provisions of this subparagraph 1, such termination shall become effective at the end of the payment period in which failure to pay occurred or at the time termination of eligibility occurred based on the provisions of the group through which enrolled, without further action by BCBSM.

2. BCBSM shall not terminate this Contract as long as the subscriber is an active member of the group through which he enrolled except:
 - a. in the event such group shall terminate enrollment under the provisions of this section, or
 - b. upon the occurrence of one of the events mentioned in subparagraph 1 of this paragraph C or in paragraph B of section IV hereof; provided, however, that nothing contained in the Contract shall limit or restrict the right of BCBSM to terminate the enrollment of the entire group.
3. BCBSM may reinstate this Contract after termination without the execution of a new application or the issuance of a new identification card or any notice to the subscriber, by the unqualified acceptance of an additional payment from the remitting agent. No such reinstatement shall create any rights to service for periods prior to the reinstatement date determined by BCBSM, which shall become the effective date for all subsequent purposes hereof.

Section VII. CHANGE OF STATUS OR TRANSFER

- A. The subscriber must notify or cause the remitting agent to notify BCBSM within thirty (30) days after the occurrence of the event of a change in his or her or a dependent's status under this contract resulting from marriage, divorce, retirement, death or change of address or entrance into or return from Military Service, or any of the events affecting termination of coverage for dependent children as provided in definition (11) of Section I hereof.

B. In the event the member is no longer eligible as a member of the group through which the subscriber enrolled, the benefits available under this contract may not be transferred to a direct payment contract.

Section VIII. SUBSCRIPTION RATE

The subscriber or the remitting agent agrees to pay BCBSM monthly in advance, unless otherwise provided, the applicable subscription rate for the applicable coverage based upon the subscriber's status. The applicable rate payable at the time of issuance of this Certificate shall be as indicated upon the Rate Schedule delivered to the subscriber or remitting agent contemporaneously herewith which is part hereof and receipt of which is acknowledged. The applicable rate shall be subject to adjustment from time to time by the giving of thirty (30) days written notice to the subscriber or remitting agent. The subscriber by acceptance hereof agrees that notice to the remitting agent of the amount of any such adjustments applicable to the group will be notice to the subscriber of the amount applicable to him.

Section IX GENERAL CONDITIONS

A. Reports: A provider or subscriber claiming payment from BCBSM shall furnish proof and report of claim to BCBSM in such form as BCBSM shall prescribe which shall remain confidential (except for the purpose of determining rights and liabilities arising under this Contract), relative to diagnosis and services given the member, and it is agreed that request for such service is authorization to the provider to make such report. Such proof and report shall be made to BCBSM by the provider or subscriber within 90 days from the date of the service reported thereon as having been rendered to the member named therein. The provider shall certify upon such report that he is entitled to payment under this Contract and that the service therein reported was rendered to the member named therein. A subscriber seeking payment from BCBSM shall furnish or cause the provider to furnish a report to BCBSM in such form as BCBSM shall prescribe and by the filing of such report shall consent and direct that BCBSM may have full access to the data disclosed by the records and files of the provider.

B. Identification: The subscriber's Identification Card should be presented to the provider when service is requested.

C. Contest: No action or suit at law or in equity shall be commenced upon or under this Contract until sixty (60) days after notice of claim and written proof of claim has been furnished to BCBSM, nor shall such action be brought at all later than three (3) years from the expiration of the time stated in paragraph A of this Section IX.

D. Contract, Continuity of Benefits: This Certificate, the identification card, the application, and supplements or riders to the Certificate, if any, shall constitute the entire contract between the parties. No agent or employee is authorized to vary, add to, or change this Contract as set forth in any manner or degree.

E. Changes in the Contract: The rate of payment by the subscriber and any other terms and conditions of this Contract may be changed at any time by BCBSM on not less than thirty (30) days notice to the subscriber or remitting agent.

BCBSM may from time to time provide additional service or benefits by rider or other notice. Such additional service or benefits may be withdrawn at any time after notice given and deemed adequate by BCBSM.

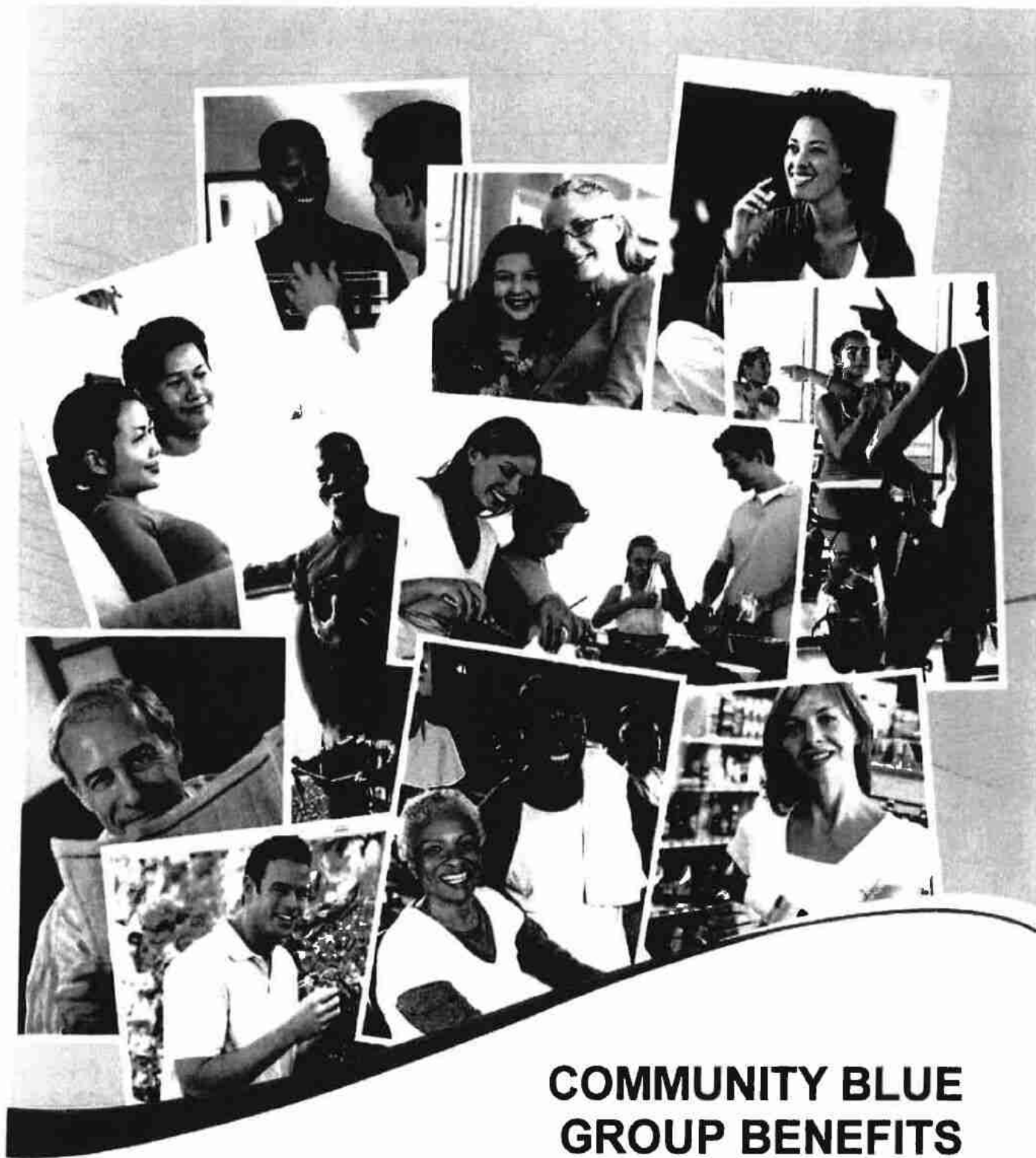
F. Contract Ratification: Payment of subscription rate on behalf of the subscriber by the remitting agent constitutes acceptance of the terms and conditions of this Contract by the subscriber.

G. Waiver of Personal Application: BCBSM may, at its discretion, waive personal application by the subscriber, accept application on behalf of the subscriber, and accept proof of eligibility for covered services from the subscriber's employer. If personal application is waived by BCBSM, the subscriber by acceptance hereof, appoints his group as his agent to handle all matters regarding this BCBSM coverage.

H. Notice: Any notice required or permitted to be given by BCBSM hereunder shall be deemed to have been duly given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, ad-

dressed to the remitting agent or to the subscriber at the last address of record at the principal office of BCBSM; and such notice be deemed to be given when so personally delivered or mailed.

I. Headings: The catchline headings and captions in no way shall be considered to be a part of this Certificate, but are inserted only for purposes of convenience.



**COMMUNITY BLUE
GROUP BENEFITS
CERTIFICATE LG**
(for large insured group customers)



BDI

Dear Subscriber:

We are pleased you have selected Blue Cross Blue Shield of Michigan for your health care coverage. Your coverage provides many benefits for you and your eligible dependents. These benefits are described in this book, which is your **certificate**.

Your certificate, your signed application and your BCBSM identification card are your **contract** with us.

You may also have **riders**. Riders make changes to your certificate and are an important part of your coverage. When you receive riders, keep them with this book.

This certificate will help you understand your benefits and each of our responsibilities **before** you require services. Please read it carefully. If you have any questions about your coverage, call us at one of the BCBSM customer service telephone numbers listed in the "How to Reach Us" section of this book.

Thank you for choosing Blue Cross Blue Shield of Michigan. We are dedicated to giving you the finest service and look forward to serving you for many years.

Sincerely,



Daniel J. Loepp
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan





About Your Certificate

This certificate is arranged to help you locate information easily. You will find:

- **A Table of Contents** — for quick reference
- **Information About Your Contract**
- **What You Must Pay**
- **What BCBSM Pays For**
- **General Services We Do Not Pay For**
- **How Providers Are Paid**
- **General Services We Do Not Pay For**
- **General Conditions of Your Contract**
- **Definitions** — explanations of the terms used in your certificate
- **Other Information You Should Know About Your Coverage**
- **How to Reach Us**
- **Index**

This certificate provides you with the information you need to get the most from your BCBSM health care coverage. Please call us if you have any questions.

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Section 1: Information About Your Contract

This section provides answers to general questions you may have about your contract. Topics include:

- **ELIGIBILITY**
 - Who is Eligible to Receive Benefits
 - End Stage Renal Disease (ESRD)
- **CANCELLATION**
 - How to Cancel Coverage
 - Cancellation
 - Rescission
- **CONTINUATION OF BENEFITS**
 - When You are Totally Disabled
 - Consolidated Omnibus Budget Reconciliation Act (COBRA)
 - Individual Coverage

Section 1: Information About Your Contract

ELIGIBILITY

Who is Eligible to Receive Benefits

You, your spouse (this does not include a person who marries a member who has coverage as a surviving spouse) and your children listed on your contract are eligible. You will need to complete an application for coverage.

BCBSM will review your application for coverage to determine if you, your spouse and your dependents are eligible for coverage. This determination is based upon the terms of your benefit plan, which include this certificate and any underwriting policies that are in effect at the time of your application.



If you, your group or someone applying for coverage on your behalf commits fraud or makes an intentional misrepresentation of material fact in completing the application, your coverage may be rescinded as described on Page 6, under "Rescission."

Children are covered through the end of the calendar year in which they turn 26 years of age if, and as long as, the subscriber continues to be covered under this certificate and the children are related to you by birth, marriage, legal adoption or legal guardianship.



Your child's spouse and your grandchildren are not covered under this certificate.

Disabled, unmarried children may remain on your contract beyond the end of the calendar year in which they turn age 26 if all of the following apply:

- They are diagnosed as totally and permanently disabled due to a physical disability or developmental disability and are incapable of supporting themselves.
- They are dependent on you for support and maintenance.



Physician certification, verifying the child's physical disability or developmental disability must be submitted to us no later than 31 days after the end of the calendar year in which the child turns age 26. The information will be evaluated to determine if the dependent meets this definition.

You may also request group coverage for yourself or your dependents within 60 days of the following event:

- Your Medicaid coverage or your dependents' CHIP coverage (Children's Health Insurance Program) is terminated due to loss of eligibility.

ODK

Section 1: Information About Your Contract

Who is Eligible to Receive Benefits (continued)

You must notify your group if there is a change in your family such as birth, divorce, death, etc. We must receive notice from your group within 30 days of when a dependent is removed from your contract and within 31 days of when a dependent is added. Contract changes take effect as of the date of the event. Any change in rates resulting from contract changes will take effect as of the effective date of the contract change.

If a dependent becomes ineligible for coverage under your contract, as in the case of a divorce, the dependent may be eligible for his or her own contract.

End Stage Renal Disease (ESRD)

We will coordinate our payment with Medicare for all covered services used by members with ESRD, including hemodialysis and peritoneal dialysis. Therefore, it is important that members with ESRD file a valid application for Medicare with the Social Security Administration. Dialysis services must be provided in a hospital, an in-network or participating freestanding ESRD facility or in the home.

When Medicare Coverage Begins

For members with ESRD, Medicare coverage begins the first day of the fourth month of dialysis, provided you file a valid application for Medicare with the Social Security Administration.



Dialysis begins February 12. Medicare coverage begins May 1.

The period before Medicare coverage begins (up to three months) is the Medicare waiting period.

If you begin a self-dialysis training program in the first three months of your regular course of dialysis, the Medicare waiting period is waived. In this case, Medicare coverage begins on the first day of the month in which you begin your regular course of dialysis.

If you are admitted to a Medicare-approved hospital for a kidney transplant or for related health care services you need prior to a transplant, Medicare coverage begins on the first day of the month in which you are admitted to the hospital. Your transplant must take place that month or within the following two months.

If your transplant is delayed more than two months after you are admitted to the hospital for the transplant or for related health care services you need prior to the transplant, Medicare coverage begins two months before the month of your transplant.

When BCBSM Coverage is the Primary or Secondary Plan

If your BCBSM group coverage is provided through an employer and you are entitled to Medicare because you have ESRD, your BCBSM coverage is your primary plan for all covered services for up to 33 months, which includes the three-month (maximum) waiting period and the 30-month coordination period. (A medical evidence report may be used to establish the coordination period.) After the 30-month coordination period ends, BCBSM is your secondary plan and Medicare is your primary plan.

Section 1: Information About Your Contract

End Stage Renal Disease (ESRD) (continued)

Dual Entitlement

If you have dual entitlement to Medicare and have employer group health plan benefits, the following conditions apply:

- If entitlement based on ESRD occurs at the same time as or prior to entitlement based on age or disability, the plan provided by the employer group is the primary plan through the end of the 30-month coordination period.



You retired at age 62 and continued your coverage through your employer as a retiree. You start a regular course of dialysis on June 12, 2012, and on Sept. 1, 2012, you become entitled to Medicare because you have ESRD. In February 2013 you become entitled to Medicare because you turn 65. In this situation, even though you turn 65 during the 30-month coordination period, your employer's plan will be your primary plan for the entire 30-month coordination period from Sept. 1, 2012, through February 2015. Your employer's plan will be your secondary plan starting March 1, 2015.

- If entitlement based on ESRD occurs after entitlement based on age or disability, primary plan status is determined as follows:
 - If you are a working aged or working disabled individual in your first month of dual entitlement, the plan provided by your employer group is your primary plan and remains your primary plan through the end of the 30-month coordination period.



You became entitled to Medicare in June 2012, when you were 65 years old. You have coverage through your employer's plan and, because you are still working, your employer's plan is your primary plan. On May 27, 2014, you are diagnosed with ESRD and begin a regular course of dialysis. On Aug. 1, 2014, you become entitled to Medicare because you have ESRD. Your employer's plan remains your primary plan for the 30-month coordination period, from Aug. 1, 2014, through Jan. 31, 2017. Medicare becomes your primary plan on Feb. 1, 2017.

- If you are not a working aged or working disabled individual in the first month of dual entitlement, Medicare is your primary plan.



You retired at age 62 and continued your coverage through your employer as a retiree. In August 2012, when you turn 65, you become entitled to Medicare. In January 2013, you begin a regular course of dialysis. On April 1, 2013, you become entitled to Medicare because you have ESRD. Because Medicare was already your primary plan when you became dually entitled, Medicare will remain your primary plan both during and after the coordination period.

ODP

CANCELLATION

How to Cancel Coverage

Send your written request to cancel coverage to your employer or group. We must receive it from your employer or group within 30 days of the requested cancellation date. Your coverage will then be canceled on the requested date and all benefits under this certificate will end. However, if you are an inpatient at a hospital or facility on the date your coverage ends, please see the General Condition "Services Before Coverage Begins or After Coverage Ends."

Cancellation

We will cancel your coverage if:

- Your group does not qualify for coverage under this certificate
- Your group does not pay its bill on time



If you are responsible for paying all or a portion of the bill then you must pay it on time or your coverage will be cancelled. For example, if you are a retiree or enrolled under COBRA and you pay all or part of your bill directly to BCBSM, we must receive your payment on time.

- You are serving a criminal sentence for defrauding BCBSM
- You no longer qualify to be a member of your group
- Your group changes to a non-BCBSM health plan
- We no longer offer this coverage
- You misuse your coverage
Misuse includes illegal or improper use of your coverage such as:
 - Allowing an ineligible person to use your coverage
 - Requesting payment for services you did not receive
- You fail to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to your rights under the appeal process.
- You are satisfying a civil judgment in a case involving BCBSM
- You are repaying BCBSM funds you received illegally
- You no longer qualify as a dependent

Section 1: Information About Your Contract

Cancellation (continued)

Your coverage will end on the last day covered by the last payment made by your group, employer, or remitting agent. However, if you are an inpatient at a hospital or facility on the date your coverage ends, please see the General Condition "Services Before Coverage Begins or After Coverage Ends" in Section 6.

Rescission

We will rescind your coverage if you, your group or someone seeking coverage on your behalf has:

- Performed an act, practice, or omission that constitutes fraud, or
- Made an intentional misrepresentation of material fact to BCBSM or another party, which results in you or a dependent obtaining or retaining coverage with BCBSM or the payment of claims under this or another BCBSM certificate.



Your coverage may be rescinded back to the effective date of your contract after we have provided you with 30 days' prior notice. You will be required to repay BCBSM for its payment for any services you received during this period.

CONTINUATION OF BENEFITS

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is a federal law that affects most employers with 20 or more employees. It extends the opportunity for continued group coverage to all qualified beneficiaries when such coverage is lost due to a qualifying event. This group continuation option must be selected within 60 days of the qualifying event or the date the COBRA notice is sent by the plan administrator, whichever is later. It provides the following coverage at the covered member's expense:

- 18 months of coverage for an employee who is terminated, other than for gross misconduct, or whose hours are reduced
- 29 months of coverage for all qualified beneficiaries if one member is determined by the Social Security Administration to be disabled at the time of the qualifying event or within 60 days thereafter
- 36 months of coverage for qualified beneficiaries in case of the death of the employee, divorce, legal separation, loss of dependency status, or employee entitlement to Medicare

COBRA coverage can be terminated because:

- The 18, 29 or 36 months of COBRA coverage end
- The required premium is not paid on time

Section 1: Information About Your Contract

Continuation of Benefits (continued)

COBRA (continued)

- The employer terminates its group health plan
- The qualified beneficiary becomes entitled to Medicare coverage
- The qualified beneficiary obtains coverage under a group health plan.

Please contact your employer for more details about COBRA.

Individual Coverage

If you choose not to enroll in COBRA, or if your COBRA coverage period ends, coverage may be available through a BCBSM individual plan. Contact BCBSM Customer Service for information about what plan best meets your needs.

Section 2: What You Must Pay

You have PPO coverage under this certificate. PPO coverage uses a "Preferred Provider Organization" provider network. What you must pay depends on the type of provider you choose. If you choose an "in-network" provider, you most often pay less money than if you choose an "out-of-network" provider.

The types of providers you may get services from are in the chart below.

Choosing Your Provider		
If you receive services from an In-Network Provider	If you receive services from an Out-of-Network Provider	
Provider accepts the BCBSM approved amount as payment in full. You will pay the <u>least</u> out-of-pocket costs: <ul style="list-style-type: none"> • Lower deductible • Lower copayment and coinsurance amounts • No copayment or coinsurance for certain preventive care benefits No claim forms to file	Participating Provider*	Nonparticipating Provider*
	This out-of-network provider participates with BCBSM. Provider accepts the BCBSM approved amount as payment in full. You will pay <u>more</u> out-of-pocket costs than what you pay if you see an in-network provider (unless you are referred by a PPO in-network provider): <ul style="list-style-type: none"> • Higher deductible, unless noted • Increased out-of-network copayment and coinsurance amounts • No deductible, copayment or coinsurance for certain preventive care benefits No claim forms to file	This out-of-network provider chooses <u>not</u> to participate with BCBSM. Provider does <u>not</u> accept the BCBSM approved amount as payment in full** You will pay the <u>highest</u> out-of-pocket costs (unless you are referred by a PPO in-network provider): <ul style="list-style-type: none"> • Higher deductible • You pay all charges that exceed the amount we pay for a service. • Increased copayment and coinsurance amounts, unless noted (e.g., see emergency services on Page 105). You must file claim forms
*Important: Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our approved amount plus your out-of-network deductible, copayment and coinsurance as payment-in-full for covered services. Nonparticipating providers have not signed an agreement and can bill you for any differences between their charges and our approved amount. ** Some nonparticipating providers participate on a per claim basis.		

For more information about providers, see Section 4, "How Providers Are Paid." This will include our payment practices for physicians and other professional providers, *and* hospitals, facilities and alternative to hospital care providers.

What you must pay for covered services is described in the following pages.

Section 2: What You Must Pay

The basic deductibles, copayments and coinsurances you must pay each calendar year are illustrated in the chart below and explained in more detail in the pages that follow. These are standard amounts associated with this certificate. The amounts for which you are responsible may differ depending on what riders your particular plan has.

	In-network	Out-of-network
Deductibles	\$100 for one member \$200 for the family (when two or more members are covered under your contract)	\$250 for one member \$500 for the family (when two or more members are covered under your contract)
Copayment	\$10 per office visit, urgent care visit or office consultation \$50 per emergency room visit	\$50 per emergency room visit
Coinsurance (Percent copays)	50% of approved amount for private duty nursing 10% of approved amount for most other covered services	50% of approved amount for private duty nursing 30% of approved amount for most other covered services
Annual Out-of-pocket maximums	\$600 for one member \$1,200 for the family (when two or more members are covered under your contract)	\$1,250 for one member \$2,500 for the family (when two or more members are covered under your contract)
Lifetime dollar maximum	None	

For additional benefit-specific cost-sharing requirements, please see Page 15.

Deductible Requirements

In-Network Providers

You are required to pay the following deductible each calendar year for covered services provided by in-network providers:

- \$100 for one member
- \$200 for the family (when two or more members are covered under your contract)
 - Two or more members must meet the family deductible
 - If the one member deductible has been met, but not the family deductible, we 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.

Section 2: What You Must Pay

Deductible Requirements (continued)

In-network Providers (continued)



Amounts applied toward an annual deductible for out-of-network services also count toward the deductible for in-network services. However, deductible amounts for in-network services are not applied toward the deductible for out-of-network services.

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

- Covered services performed in an in-network physician's office, including presurgical consultations
- Services in an in-network physician's office, except mental health and substance abuse services that are not equal to an office visit. These services will require payment of your deductible.
- Services subject to a copayment requirement
- 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 spinal manipulation
- Prenatal and postnatal care visits
- Allergy testing and therapy
- Therapeutic injections
- Hospice care benefits
- Preventive care services (specific services are listed in Section 3 of your certificate)
- Provider-delivered care management services performed by designated in-network providers, as identified by BCBSM for services rendered in Michigan or the local Blue Cross/Blue Shield plan for services rendered out-of-state.



If you have a rider that adds a deductible for in-network services, it will be waived for covered provider-delivered care management services.

We will not apply charges toward your in-network deductible if one of the following applies:

- The charges exceed our approved amount.
- The charges are for noncovered services.

Section 2: What You Must Pay

Deductible Requirements (continued)

Out-of-network Providers

You are required to pay the following deductible each calendar year for covered services provided by out-of-network providers:

- \$250 for one member
- \$500 for the family (when two or more members are covered under your contract)
 - Two or more members must meet the family deductible.
 - If the one member deductible has been met, but not the family deductible, we 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.

You will not be required to pay an out-of-network deductible for covered out-of-network services when:

- An in-network provider refers you to an out-of-network provider



You must obtain the referral **before** receiving the referred service or the service will be subject to the out-of-network deductible requirements.

- You receive 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
- You receive services from a provider for which there is no PPO network
- You receive 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.

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Section 2: What You Must Pay

Deductible Requirements (continued)

Out-of-network Providers (continued)

In limited instances, out-of-network deductible requirements may not be imposed 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.



While the out-of-network deductible requirements may not be imposed, covered services will be subject to applicable in-network deductible requirements (if any).

You may contact BCBSM for information regarding these professional services.

We will not apply charges toward your in-network or out-of-network deductible if one of the following applies:

- The charges exceed our approved amount.
- The charges are for noncovered services.

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Copayment and Coinsurance Requirements

In-network Providers

You are required to pay the following copayment or coinsurance (percentage) amounts for covered services provided by in-network providers:

- \$50 copayment per visit for facility services in a hospital emergency room. The \$50 copayment is not applied if:
 - The patient is admitted or
 - Services were required to treat an accidental injury



Copayments are **not** applied to emergency services received from physicians, whether in-network or out-of-network, for treatment for a medical emergency or accidental injury.

- \$10 copayment per office visit (see Page 63 for details) **except** for:
 - First aid and medical emergency treatment
 - Prenatal and postnatal care visits
 - Allergy testing and therapy
 - Therapeutic injections
 - Presurgical consultations
- 50 percent of the approved amount for private duty nursing care
- 10 percent of the approved amount for most other covered services

This 10 percent coinsurance does not apply to:

- Services in an in-network physician's office, except mental health and substance abuse services that are not equal to an office visit. These services will require payment of your coinsurance.
- Services subject to a copayment requirement
- 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 spinal manipulation
- Prenatal and postnatal care visits
- Allergy testing and therapy
- Therapeutic injections
- Hospice care benefits
- Preventive care services (specific services are listed in Section 3 of your certificate)
- Presurgical consultations

In-network copayments and coinsurance amounts will not be imposed for provider-delivered care management services performed by designated in-network providers, as identified by BCBSM for services rendered in Michigan or the local Blue Cross/Blue Shield plan for services rendered out-of-state.

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Section 2: What You Must Pay

Copayment and Coinsurance Requirements (continued)

Out-of-network Providers

For out-of-network providers, you must pay the following amounts for covered services:

- \$50 copayment per visit for facility services in a hospital emergency room. For your requirements on services in a Michigan nonparticipating hospital, see Page 121. The \$50 copayment is not applied if:
 - The patient is admitted or
 - Services were required to treat a medical emergency or accidental injury

NOTE

You do not have to pay a copayment for physician services, in- or out-of-network, for treatment for a medical emergency or accidental injury.

- 50 percent of the approved amount for private duty nursing care
- 30 percent of the approved amount for most other services

You will not be required to pay the 30 percent coinsurance for covered out-of-network services when:

- An in-network provider refers you to an out-of-network provider

NOTE

You must obtain the referral **before** receiving the referred service or the service will be subject to the out-of-network coinsurance requirements.

- You receive facility and 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 female member of your contract obtains a prescription contraceptive device from an out-of-network provider
- You receive services from a provider for which there is no PPO network
- You receive 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.

BPV

Section 2: What You Must Pay

Copayment and Coinsurance Requirements (continued)

Out-of-network Providers (continued)

In limited instances, out-of-network copayment requirements may not be imposed 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.

NOTE

While the out-of-network copayment requirements may not be imposed, covered services will be subject to applicable in-network copayment requirements (if any).

You may contact BCBSM for information regarding these professional services.

We will not apply charges toward your copayments that:

- Exceed our approved amount or
- Are for noncovered services

Benefit-Specific Cost-Sharing Requirements

Certain benefits have specific cost-sharing requirements as follows:

Chiropractic and Osteopathic Manipulation Therapy

You must pay a \$10 copayment for each chiropractic spinal manipulation visit or osteopathic manipulative treatment in an **in-network** physician's office. Out-of-network services are subject to out-of-network cost-sharing.

NOTE

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.

Section 2: What You Must Pay

Benefit-Specific Cost-Sharing Requirements (continued)

Contraceptive Devices

Services performed by an in-network provider are not subject to any deductible, copayment or coinsurance requirements. Services performed by an out-of-network provider are subject to the out-of-network deductible requirements of your certificate, however, your out-of-network copayment and coinsurance are waived.

Contraceptive Injections

Services performed by an in-network provider are not subject to any deductible, copayment or coinsurance requirements. Services performed by an out-of-network provider are subject to the out-of-network deductible, coinsurance or copayment requirements of your certificate.

Hospice Services

Hospice services received from physicians and other approved professional providers or approved facilities are not subject to any deductible, coinsurance or copayment requirements.

Mental Health Services and Substance Abuse Treatment

Mental health services and substance abuse treatment are subject to the same annual deductible, coinsurance and copayment requirements and maximums that apply to all other in-network and out-of-network services.



Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.

This means when these services are performed by an in-network provider, you have no in-network deductible. You will be responsible for the flat-dollar member copayment that applies to office visits. When these services are performed by an out-of-network provider, you will be responsible for your annual out-of-network deductible and the coinsurance amount that applies to covered out-of-network services.

Outpatient Diabetes Management Program (ODMP)

Diabetes self-management training under the ODMP benefit, when performed by an in-network provider, is not subject to any deductible, copayment or coinsurance requirements.

When performed by an out-of-network provider, diabetes self-management training is subject to the out-of-network cost-sharing requirements of this certificate.

All other services and supplies of the ODMP benefit are subject to the cost-sharing requirements of this certificate as described on Page 10.

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Benefit-Specific Cost-Sharing Requirements (continued)

Prescription Drugs

See the "Prescription Drugs" section beginning on Page 74 for conditions affecting what you pay for prescribed drugs.



Prescribed drugs obtained from a pharmacy are not covered in this certificate but may be covered in a prescription drug program certificate that accompanies this certificate.

Any deductible, coinsurance, or copayment requirements for prescription drugs are specified in a rider or riders that accompany this certificate.

Presurgical Consultations

Presurgical consultations received from in-network providers are **not** subject to any deductible, coinsurance or copayment requirements.

Specified Organ Transplants

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

Voluntary Sterilization for Females

Hospital and physician benefits for voluntary sterilizations for females are payable at 100 percent of the BCBSM approved amount as follows:

- Services performed by an in-network provider are not subject to any deductible, copayment or coinsurance requirements.
- Services performed by an out-of-network provider are subject to the out-of-network deductible, copayment and coinsurance requirements.

BP

Section 2: What You Must Pay

Annual Maximums

Out-of-pocket Maximums for In-network Services

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

- \$600 for one member
- \$1,200 for the family (when two or more members are covered under your contract)
 - Two or more members must meet the family out-of-pocket maximum.
 - If the one member out-of-pocket maximum has been met, but not the family out-of-pocket maximum, we will not require any more cost-sharing amounts for that member the remainder of the calendar year.
 - Cost-sharing for the remaining family members will be required until the full family annual out-of-pocket maximum has been met.

Your **deductible, copayment and coinsurance** requirements for covered services performed by in-network providers are combined to meet the annual in-network out-of-pocket maximum.

Out-of-pocket Maximums for Out-of-network Services

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

- \$1,250 for one member
- \$2,500 for the family (when two or more members are covered under your contract)
 - Two or more members must meet the family out-of-pocket maximum.
 - If the one member out-of-pocket maximum has been met, but not the family out-of-pocket maximum, we will not require any more cost-sharing amounts for that member the remainder of the calendar year.
 - Cost-sharing for the remaining family members will be required until the full family annual out-of-pocket maximum has been met.

Your **deductible, copayment and coinsurance** requirements for covered services performed by out-of-network providers are combined to meet the annual out-of-network out-of-pocket maximum.

Section 2: What You Must Pay

Annual Maximums (continued)

Your cost-sharing requirements under your BCBSM prescription drug certificate also contribute to the annual in-network and out-of-network maximums stated above.

NOTE

Specific prescription drug expenses that will not apply toward your annual out-of-pocket maximum include the following:

- Payment for noncovered drugs or services
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- The 25 percent member liability for covered drugs obtained from a nonparticipating pharmacy.

NOTE

Cost-sharing amounts applied toward the annual out-of-pocket maximum for out-of-network services also count toward the out-of-pocket maximum for in-network services. However, amounts applied toward the in-network out-of-pocket maximum do not count toward the out-of-network out-of-pocket maximum.

Once these amounts are satisfied, all covered benefits under this certificate and any applicable BCBSM prescription drug program certificate will be covered at 100% of the approved amount for the remainder of the calendar year.

Maximums for Days of Care or Visits

If annual maximums (days or visits) or lifetime maximums (days or visits) apply for specific services, they are described elsewhere in your certificate.

END

Section 3: What BCBSM Pays For

This section describes the services we pay for and the extent to which they are covered.

- The services listed in this section are covered when services are provided in accordance with certificate requirements and, when required, are preauthorized or approved by BCBSM; however emergency services do not need to be preauthorized.
- Services provided in accordance with the terms of this certificate are covered services only when they are medically necessary (see the definition in Section 7), including BCBSM-approved noncontractual services that may be described in your treatment plan for case management. Some exceptions include voluntary sterilization, screening mammography, preventive care services, or contraceptive services.

NOTE

Medically necessary services that can be provided safely in an outpatient or office location are not payable when provided in an inpatient setting.

- We pay our approved amount (see the definition in Section 7) for the services you receive that are covered in this certificate and also may be covered in any **riders** you may have in addition to your certificate. Riders make changes to your certificate and are an important part of your coverage.

You are responsible for copayments, coinsurance and/or deductible for many of the benefits listed. For what you may be required to pay, see Section 2: "What You Must Pay."

We pay for services received from:

- Hospitals and other facilities

Except for emergency room care, covered services performed in or by facilities must be prescribed by the attending physician and provided during an inpatient hospital stay or in the outpatient department of a hospital or other approved facility.

NOTE

If you or anyone covered under your contract receives medically necessary services from a hospital-based physician who does not participate with BCBSM, we pay our approved amount but you may be required to pay the balance. See "Nonparticipating Physicians and Other Providers" in Section 4.

- Physicians and other professional providers

Covered services must be provided by persons who are legally qualified or licensed to provide them.

APB

Allergy Testing and Therapy

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For other diagnostic services, see Page 35.

Locations: We pay for allergy testing and allergy therapy in a hospital (inpatient or outpatient), ambulatory surgery facility or a physician's office subject to the conditions described below.

We pay for:

The following allergy testing and therapy services, performed by or under the supervision of a physician.

- 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

We do not pay for:

- 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

APG

Section 3: What BCBSM Pays For

Ambulance Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For emergency treatment services, see Page 41.

We pay for:

Ambulance services to transport a patient up to 25 miles. We will pay for a greater distance if the destination is the nearest medical facility capable of treating the patient's condition.

In any case the following conditions must be met:

- The service must be medically necessary because transport by any other means would endanger the patient's health.
- The fee must be only for the transportation of the patient, and does not include additional services that may be provided by physicians or other professionals and billed as ambulance services.
- The service must be to transport the patient to a hospital or to transfer the patient from a hospital to another treatment location such as another hospital, skilled nursing facility, medical clinic or the patient's home.

NOTE

When ambulance service is used only to **transfer** the patient, the attending physician must prescribe the transfer.

- The service must be provided in a vehicle qualified as an ambulance and that is part of a licensed ambulance operation.

We pay for ambulance services when the ambulance has responded and the patient is stabilized and transport is not necessary or is refused, and in instances where the ambulance company arrives but the person that needed treatment has expired.

Air Ambulance

When transportation by air ambulance is required, the following conditions must be met:

- The use of an air ambulance is medically necessary and ordered by the attending physician
- No other means of transport is available, or the patient's condition requires transport by air rather than ground ambulance
- The patient is transported to the nearest facility capable of treating the patient's condition and
- The provider is licensed as an air ambulance service and is not a commercial airline

We do not pay for:

Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of a voluntary donation.

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Anesthesiology Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for anesthesiology services in a hospital (inpatient or outpatient), a participating ambulatory surgery facility, or a physician's office subject to the conditions described below.

We pay for:

- Anesthesiology during surgery

Services for giving anesthetics to patients undergoing covered surgery are payable to either:

- A physician other than the operating physician

NOTE

If the operating physician gives the anesthetics, the service is included in our payment for the surgery.

- A physician who orders and supervises anesthesiology services
- A certified registered nurse anesthetist (CRNA) in an

- Inpatient hospital setting
- Outpatient hospital setting
- Participating ambulatory surgery facility
- Physician's office

CRNA services must be performed under the medical direction of a licensed physician or under the general supervision of a licensed physician responsible for anesthesiology services.

NOTE

Anesthesiology services performed by a qualified employee of a hospital or facility are payable to the hospital or facility.

- Anesthesia during infusion therapy

We pay for local anesthetics administered only when needed as part of infusion therapy done in a physician's office.

- Other Services

We pay for covered anesthesiology services performed by a CRNA in a physician's office.

Anesthesia services may also be covered as part of electroshock therapy (see Page 55) and for covered dental services (see Page 33).

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Section 3: What BCBSM Pays For

Audiologist Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for audiologist services performed by an audiologist in a physician's office or other approved outpatient location.

We pay for:

- Services performed by an audiologist who when they are prescribed by a provider who is legally authorized to prescribe the services.

Autism Disorders

Covered Autism Spectrum Disorders

We pay for the diagnosis and outpatient treatment of Autism Spectrum Disorders, including: Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified, as described below.

Covered Services

Diagnostic services must be provided by a licensed physician or a licensed psychologist and include: assessments and evaluations or tests, including the Autism Diagnostic Observation Schedule.



Before applied behavior analysis services will be covered, a BCBSM-approved autism evaluation center must evaluate and diagnose the member as having one of the covered autism spectrum disorders.

Treatment includes the following evidence-based care if prescribed or ordered by a licensed physician or licensed psychologist for a member who has been diagnosed with one of the covered autism spectrum disorders:

- **Applied behavior analysis treatment:** It must be provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.



Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.

- **Applied behavior analysis treatment** is covered subject to the following requirements:
 - **Treatment Plan** – Applied behavior analysis treatment must be included in a treatment plan recommended by a BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition. If requested by BCBSM, the cost of treatment review will be paid by BCBSM.
 - **Prior Authorization** – Applied behavioral analysis treatment must be approved for payment through BCBSM's prior authorization process. If prior authorization is not obtained, rendered services will not be covered and the member will be responsible to pay for those services. Prior authorization is not required for any other covered autism services.
 - **Behavioral health treatment.** It includes evidence-based counseling that must be provided or supervised by a licensed psychologist, so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

Section 3: What BCBSM Pays For

Autism Disorders (continued)

Covered Services (continued)

- **Psychiatric care.** It includes evidence-based direct or consultative services provided by a psychiatrist licensed in the state where the psychiatrist practices.
- **Psychological care.** It includes evidence-based direct or consultative services provided by a psychologist licensed in the state where he/she practices.



Benefits for autism disorders are in addition to any psychiatric, psychological and non-applied behavior analysis benefits that may be available under your certificate or related riders.

- **Therapeutic care.** It includes evidence-based physical therapy, occupational therapy, speech and language pathology, or other care performed by a licensed certified speech therapist, occupational therapist, physical therapist or social worker. Therapeutic care also includes nutritional therapy performed by a physician and genetic testing as recommended in the treatment plan.

Coverage 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.



Services or treatments that are deemed experimental or investigational by BCBSM, such as applied behavior analysis treatment, are covered only when they are approved by BCBSM and included in a treatment plan recommended by the BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition.

Limitations and Exclusions

In addition to those listed in this certificate and any other riders that you may have, the following limitations and exclusions apply:

- Benefits for applied behavior analysis treatment are limited to children through the age of 18. This age limitation does not apply to psychiatric, psychological non-applied behavior analysis services and services to diagnose autism.

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Autism Disorders (continued)

Limitations and Exclusions (continued)

- All autism benefits including, but not limited to, medical-surgical services and/or behavioral health treatment covered under this certificate are subject to any hospital/medical deductibles and copayments imposed under this certificate.
- Any treatment that is not a covered benefit by BCBSM, including, but not limited to, sensory integration therapy and chelation therapy will not be paid.
- Conditions such as Rett's Disorder and Childhood Disintegrative Disorder are not payable under this certificate.
- When a member is treated with approved 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.
- All autism services performed in Michigan must be provided by providers who are registered with BCBSM as a participating or nonparticipating provider.
- All autism services performed outside of Michigan must be provided by providers that participate with their local Blue Cross/Blue Shield plan.

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Section 3: What BCBSM Pays For

Cardiac Rehabilitation

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for cardiac rehabilitation in a participating hospital (inpatient or outpatient), or a clinic subject to the conditions described below.

We pay for:

- Cardiac rehabilitation services begun during a hospital admission for an invasive cardiovascular procedure (e.g., heart surgery) or an acute cardiovascular event (e.g., heart attack)
- Cardiac rehabilitation services given when intensive monitoring (i.e., through the use of EKGs) and/or supervision during exercise is required. Services may be given in:
 - An outpatient hospital setting
 - A physician-directed clinic (one in which a physician is on-site)

We do not pay for:

- Cardiac rehabilitation services that require less than intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable

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Chemotherapy

For high dose chemotherapy used in bone marrow transplants, see Pages 107 – 112.

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

We pay for chemotherapeutic drugs. Since specialty pharmaceuticals may be used in chemotherapy treatment, please see the preauthorization requirement for Chemotherapy Specialty Pharmaceuticals described on Page 76.

To be payable, the drugs must be:

- 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, BCBSM's Medical Policy department determines the appropriateness of the drug for that disease 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.

We also pay for:

- 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 on Pages 39 to 40.

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Section 3: What BCBSM Pays For

Chiropractic Services and Osteopathic Manipulative Therapy

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for chiropractic services and osteopathic manipulative therapy in a physician's office subject to the conditions described below.

For chiropractic services performed in conjunction with physical therapy, see Page 72.

We pay for:

Osteopathic manipulative therapy on any location of the body and chiropractic spinal manipulation to treat misaligned or displaced vertebrae of the spine, with a combined maximum of 24 visits (in-network and out-of-network providers combined) per member per calendar year.

- Chiropractic office visits:
 - For new patients, we pay for one office visit every 36 months. A new patient is one who has not received chiropractic services within 36 months.
 - For established patients, we pay for one office visit per year. An established patient is one who has received chiropractic services within 36 months.
- Mechanical traction once per day when it is performed with chiropractic spinal manipulation. Visits for mechanical traction are applied toward your 60-visit benefit limit for physical, speech and language pathology, and occupational therapy services.
- Radiological services when X-rays are medically necessary to treat the spinal misalignment.

BPE

Clinical Trials (Routine Patient Costs)

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For oncology clinical trial services, see Page 64.

We cover the routine costs of items and services related to Phase I, II, III or IV clinical trials whose purpose is to prevent, detect or treat cancer or other life-threatening disease or condition. The member receiving the items or services must be a qualified individual, as defined in this certificate



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.

Benefits are subject to the conditions described below.

We pay for:

All routine services covered under this certificate and related riders that would be covered even if the member were not enrolled in an approved clinical trial



See definitions of approved clinical trial, life-threatening disease, routine patient costs, and qualified individual Section 7.

We do not pay for:

- 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.



If one or more BCBSM-contracted (participating or in-network) providers participate in an approved clinical trial, BCBSM may require members to participate in the trial through one of those providers unless the trial is conducted outside of Michigan.

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Section 3: What BCBSM Pays For

Contraceptive Services

See Page 16 in Section 2 for what you may be required to pay for these services.

We pay for contraceptive services for women as part of your preventive care benefit. Please see the preventive care benefit description of contraceptive services on Page 81 for more details.

Dental Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For dental surgery, see Page 101.

Locations: We pay for emergency dental care given in a hospital, ambulatory surgery facility or to treat accidental injuries when treatment is given in a dentist's office. We pay for other dental services in a participating hospital or a provider's office subject to the conditions described below.

We pay for:

- **Emergency Dental Care**

Emergency dental care to treat accidental injuries within 24 hours of the injury to relieve pain and discomfort. We also pay for follow-up treatment completed within six months of the injury.



A dental accidental injury occurs when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

- **Dental Services in a Hospital**

- Treatment 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.
- Facility and anesthesia services may be payable if a hospitalized patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting.



In these cases we pay for facility and anesthesia services to the hospital or facility **only**, not for the services of a dentist or other dental professional.

Examples of such medical conditions are:

- Bleeding or clotting abnormalities
- Unstable angina
- Severe respiratory disease
- Known reaction to analgesics, anesthetics, etc.

Medical records must verify the patient's adverse medical or dental condition which would require the above services.

Procedures that are payable in the circumstances explained above include:

- Alveoplasty
- Diagnostic X-rays
- Multiple extractions or removal of unerupted teeth

Section 3: What BCBSM Pays For

Dental Services (continued)

We pay for: (continued)

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 (see Page 72 for physical therapy services)
 - Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint)

We do not pay for:

- 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.)

Diagnostic Services

For allergy testing services, see Page 21.

For diagnostic radiology services, see Page 89.

For mental health diagnostic services, such as psychological testing, see Page 55.

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for diagnostic services in a hospital (inpatient or outpatient), ambulatory surgery facility, skilled nursing facility that participates with BCBSM or a physician's office subject to the conditions described below.

We pay for:

Diagnostic Testing

We pay for diagnostic services used by a physician 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

We pay for EMG and nerve conduction tests performed by an independent physical therapist if ordered by a physician. The independent physical therapist must be certified by the American Board of Physical Therapy Specialties to perform these tests.

Diagnostic Laboratory and Pathology Services

We pay for laboratory and pathology tests and services needed to diagnose a disease, illness, pregnancy or injury. Services must be provided:

- In a hospital (under the direction of a pathologist employed by the hospital) or
- By the patient's in-network physician or by another physician if your in-network physician refers you to one, or by an in-network laboratory at your in-network physician's direction.
 - Standard office laboratory tests approved by BCBSM performed in an in-network physician's office are payable. Other laboratory tests must be sent to an in-network laboratory.
 - You will be required to pay the out-of-network copayment if services are provided by an out-of-network laboratory or in an out-of-network hospital.

Section 3: What BCBSM Pays For

Dialysis Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Important: Services for the treatment of End Stage Renal Disease (ESRD) are covered in coordination with Medicare. It is important that individuals with ESRD apply for Medicare coverage through the Social Security Administration. (Please see Pages 3 – 4 for a detailed explanation of ESRD.)

Locations: We pay for dialysis services in an in-network or participating hospital (inpatient or outpatient), an in-network or participating freestanding ESRD facility, or in a home subject to the conditions below.

We pay for:

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

Covered services to treat patients with chronic, irreversible kidney disease are payable until the patient becomes eligible for Medicare (a maximum of three months from the date of applying for Medicare). After that services are covered in coordination with Medicare. Individuals with ESRD should apply for Medicare coverage through the Social Security Administration. See Pages 3 – 4 for details about ESRD.

ESRD treatment may be provided in:

- An in-network or participating hospital, inpatient or outpatient
- An in-network or participating freestanding ESRD facility
- The home (when provided by a program participating with BCBSM to provide such services)

Services Provided in a Freestanding ESRD Facility

We pay for medically necessary facility services provided by a BCBSM network or participating end stage renal (kidney) disease facility. ESRD facility services are provided to treat patients with chronic, irreversible kidney disease. (See Section 2 for how these services are paid).

We pay for:

- Use of the freestanding end stage renal disease facility
- Ultrafiltration
- Equipment

Section 3: What BCBSM Pays For

Dialysis Services (continued)

Services Provided in a Freestanding ESRD Facility (continued)

We pay for: (continued)

- Solutions
- Routine laboratory tests
- Drugs
- Supplies
- Other medically necessary services related to dialysis treatment
- 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

We do not pay for:

- 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.

Section 3: What BCBSM Pays For

Dialysis Services (continued)

Services Provided in the Home

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

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

We pay for:

- Placement and maintenance of a dialysis machine in the patient's home
- Expenses to train the patient and one other person who will assist the patient 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

We do not pay for:

- Services provided by persons under contract with the hospital, agencies or organizations assisting in the dialysis or acting as "back ups" including hospital personnel sent to the patient'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 patient's home
- Physician services not paid by the hospital

Durable Medical Equipment

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for durable medical equipment in the following locations subject to the conditions described below:

- In-network or participation hospital (inpatient or outpatient)
- Participating skilled nursing facility (see Page 91)
- In the home or for home infusion therapy (see Page 50).
- Hospice care (see Page 44)

We pay for:

- Use of durable medical equipment while you are in the hospital.
- Rental or purchase of durable medical equipment from a hospital (at the time of discharge) or from a DME supplier who meets BCBSM qualification standards, when prescribed by a physician or certified nurse practitioner.
- Medicare Part B: In many instances we cover the same items covered by Medicare Part B as of the date of purchase or rental. In some instances, however, BCBSM guidelines may differ from Medicare. Please call your local customer service center for specific coverage information.

DME items must meet the following guidelines:

The prescription includes a description of the equipment and the reason for the need or the diagnosis.

The physician writes a new prescription when the current prescription expires; otherwise, we will stop payment on the current expiration date, or 30 days after the date of the patient's death, whichever is earlier.

NOTE

If the equipment is:

- Rented, we 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.
- Purchased, we will pay to have the equipment repaired and restored to use, but not for routine periodic maintenance

APB

Section 3: What BCBSM Pays For

Durable Medical Equipment (continued)

We pay for: (continued)

Continuous Positive Airway Pressure (CPAP)

When prescribed by a physician, the CPAP device, humidifier (if needed) and related supplies and accessories are covered as follows:

- We will cover the rental fee only for the CPAP device and humidifier. Our total rental payments will not exceed our approved amount to purchase the device and humidifier. Once our rental payments equal the approved purchase price, you will own this equipment and no additional payments will be made by BCBSM for the device or humidifier.
 - We 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 BCBSM to continue to cover the equipment and the purchasing of supplies and accessories. The CPAP device supplier 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.
 - If you fail to comply with treatment requirements, we will also no longer cover the purchase of supplies and accessories.

We do not pay for:

- 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
- Physician's equipment, such as stethoscopes
- Self-help devices not primarily medical in nature, such as sauna baths and elevators
- Experimental equipment

Section 3: What BCBSM Pays For

Emergency Treatment

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For urgent care services, please see Page 116.

Locations: We pay for services to treat medical emergencies and accidental injuries in a hospital, participating ambulatory surgery facility, urgent care center or physician's office subject to the conditions described below. (A participating ambulatory surgery facility is considered an in-network provider.)

We pay for:

Facility and physician services to examine and treat a medical emergency or accidental injury.

For a definition of "emergency services," see Section 7.

Section 3: What BCBSM Pays For

Home Health Care Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for care and services provided in the patient's home as an alternative to long-term hospital care. Home health care must be:

- Prescribed by the attending physician
- Provided and billed by a **participating** home health care agency
- Medically necessary (as defined in Section 7)

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, physician's 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.

We pay for:

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 BCBSM 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
- Physical therapy, speech and language pathology services and occupational therapy, as described on Pages 60, 72 and 95 are payable when provided for rehabilitation.

Home Health Care Services (continued)

We pay for: (continued)

- If equipment for therapy and speech evaluation cannot be taken to the patient's home, therapy and speech evaluation in an outpatient department of a hospital or a freestanding outpatient physical therapy facility are covered under outpatient benefits and are subject to the 60-visit maximum as described on Page 74.
- Part-time health aide services, including preparing meals, laundering, bathing and feeding if:
 - The patient is receiving skilled nursing care or physical or speech therapy
 - 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

We pay the following covered 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

We do not pay for:

- 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 3: What BCBSM Pays For

Hospice Care Services

See Page 16 in Section 2 for what you may be required to pay for these services.

Locations: We pay for hospice care services in a hospice facility, hospital, or skilled nursing facility that participates with BCBSM. We also pay for hospice care services in the home (see Page 129 for when services may be payable in a nursing home) subject to the conditions described below.

We pay for services for the terminally ill 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 patient 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 BCBSM:

For the first 90 days of hospice care coverage:

A written certification stating that the patient is terminally ill, signed by the:

- Medical director of the hospice program or
- Physician of the hospice interdisciplinary group and
- Attending physician, if the patient 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

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Hospice Care Services (continued)

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 patient or his or her representative must sign a "Waiver of Benefits" form acknowledging that the patient has been given a full explanation of hospice care. This waiver confirms the patient's (or family's) understanding that regular Blue Cross Blue Shield benefits for conditions related to the terminal illness are not in force while hospice benefits are being used.



BCBSM benefits for conditions not related to the terminal illness remain in effect.

We pay for:

Counseling, evaluation, education and support services for the patient and his or her family from the hospice staff before the patient elects to use hospice services. These services are limited to a 28-visit maximum.

When a patient elects to use hospice care services, regular BCBSM 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 skilled nursing facility contracting with the hospice program
- Short-term general inpatient care when the patient is admitted for pain control or to manage symptoms. (These services are payable if they meet the plan of care established for the patient.)
- Five days of occasional respite care during a 30-day period

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Section 3: What BCBSM Pays For

Hospice Care Services (continued)

We pay for: (continued)

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 patient 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 patient)
- BCBSM-approved durable medical equipment furnished by the hospice program for use in the patient's home
- Physical therapy, speech and language pathology services and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional skills
- Bereavement counseling for the family after the patient's death

The above services are limited to a maximum amount that is reviewed and adjusted periodically. Once you reach the maximum, hospice benefits will continue to 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 patient comfortable and to manage the terminal illness and related conditions

NOTE

Payable services do not include physician services provided by a member of the hospice interdisciplinary team.

Payment for professional services is limited to a maximum amount, determined by BCBSM, which is reviewed and adjusted periodically. Once you reach the maximum, hospice benefits will continue to 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.

Hospice Care Services (continued)

How to Cancel or Reinstate Hospice Care Services

Hospice care services may be canceled at any time by the patient 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.

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

We do not pay for services:

- Other than those furnished by the hospice program. (Remember, the services covered are those provided primarily in connection with the condition causing the patient's terminal illness.)
- Of a hospice program other than the one designated by the patient. (If the designated program arranges for the patient to receive the services of another hospice program, the services are covered.)
- That are not part of the plan of care established by the hospice program for the patient

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Section 3: What BCBSM Pays For

Hospital Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For services in a long-term acute care hospital (LTACH), see Page 51.

The services in this section are in addition to all other services listed in this certificate that are payable in a participating hospital, including surgery beginning on Page 100.

Locations: The following services are payable in a participating hospital or an approved outpatient location as listed below.

We pay for:

Inpatient hospital services:

- Medical care by your attending physician 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
- Electroshock therapy
- 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)

Section 3: What BCBSM Pays For

Hospital Services (continued)

We pay for: (continued)

Outpatient hospital services:

Services that are payable in an inpatient hospital are also payable as outpatient services (except for those related to inpatient room, board, and inhalation therapy). In addition, the following services are payable:

- Services to treat chronic conditions are payable when they require repeated visits to the hospital.

Temporary Benefits for Hospital Services:

Under conditions where a hospital terminates its participating contract with BCBSM, you will have temporary benefits for designated services, emergency care and travel and lodging that will end six months from the date the contracted hospital terminates its contract with BCBSM. See Page 103 for more information on "Temporary Benefits for Hospital Services."

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Section 3: What BCBSM Pays For

Infusion Therapy

Infusion therapy services given by a participating BCBSM-approved infusion therapy provider are considered in-network services and will be subject to applicable in-network deductible and copayment requirements.

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for infusion therapy services in an ambulatory infusion center, or from a home infusion provider whether or not you are confined to the home. (see Page 129 for when services may be payable in a nursing home.)

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

- Prescribed by the attending 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 (as defined in Section 7)
- Given by a **participating** infusion therapy provider

We pay for:

- Drugs required for infusion therapy. Since specialty pharmaceuticals may be used in infusion therapy, please see the Preauthorization for Specialty Pharmaceuticals requirement described on Page 76.
- Nursing services needed to administer infusion therapy and treat infusion therapy-related wound care

NOTE

Nursing services must meet BCBSM's medical necessity guidelines to be payable.

- Durable medical equipment, medical supplies and solutions needed for infusion therapy

NOTE

Except for chemotherapeutic drugs, services provided for infusion therapy under the home health care benefit are not covered separately elsewhere in this certificate.

- Infusion therapy services given by a participating BCBSM-approved infusion therapy provider are considered in-network services and will be subject to applicable deductible and copayment requirements for such services.

We do not pay for services rendered by **nonparticipating** infusion therapy providers.

Long-Term Acute Care Hospital Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services. Long-term acute care hospital services count toward any benefit maximums that apply to inpatient hospital services.

Locations: We pay for services provided in a long-term acute care hospital (LTACH) subject to the conditions described below.

We pay for:

All inpatient and outpatient services provided in a long-term acute care hospital that are payable in a participating hospital.

The services are payable only if the following conditions are met:

- The long-term acute care hospital must be located in Michigan and participate with BCBSM, except under extenuating circumstances as determined by BCBSM.
- The provider must request and receive preapproval for inpatient services

We do not pay for:

- Services in a nonparticipating long-term acute care hospital including emergency services, unless there are extenuating circumstances as determined by BCBSM.
- Inpatient admissions that BCBSM has not preapproved
- Services if the patient's primary diagnosis is a mental health or substance abuse condition.

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Section 3: What BCBSM Pays For

Maternity Care

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for facility and professional services for maternity care and related services and for routine newborn nursery care during a mother's eligible hospital stay in an inpatient hospital or approved birthing center subject to the conditions described below.

Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a vaginal delivery
- 96 hours following a delivery by cesarean section

However, we may pay for a shorter stay if the attending provider (e.g., your physician or certified nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Also, we may not set the level of benefits or out-of-pocket costs so that any portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, we may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain preapproval. For information on preapproval, contact your BCBSM customer service representative (see Section 8).

We pay for:

- Obstetrics

We pay for covered services provided by a physician or certified nurse midwife attending the delivery. These covered services include but are not limited to:

- Normal vaginal delivery when provided in:
 - An inpatient hospital setting
 - A hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital, as defined by BCBSM
- Pre-natal care
- Post-natal care, including a Papanicolaou (PAP) smear during the six-week visit

Section 3: What BCBSM Pays For

Maternity Care (continued)

- Newborn Examination

A newborn's routine care is payable when provided during the mother's inpatient hospital stay. The exam must be provided by a doctor other than the anesthesiologist or the mother's attending physician.



The baby must be eligible for coverage and must be added to your contract within 31 days of the birth. Ask your employer or call BCBSM to learn how to add the baby to your contract.

Section 3: What BCBSM Pays For

Medical Supplies

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For medical supplies for outpatient diabetes treatment, see Page 69.

For medical supplies for infusion therapy, see Page 50.

Locations: We pay for medical supplies in a hospital, hospice, outpatient facility, or skilled nursing facility that participates with BCBSM or in a physician's office or in the home subject to the conditions described below.

We pay for:

We pay up to the approved amount for medically necessary quantities of medical supplies and dressings used in a hospital, hospice, approved outpatient facility or physician's office, skilled nursing facility or in your home for the treatment of a specific medical condition. Medical supplies include but are not limited to gauze, cotton, fabrics, plaster and other materials used in dressings and casts.

Refer to Section 7 for the definition of "medically necessary."

Mental Health Services

See Page 16 in Section 2 for what you may be required to pay for these services.

For Autism Disorders, please see Page 25.

For Substance Abuse treatment, please see Page 98.

Locations: We pay for mental health services in an inpatient or outpatient hospital, an approved inpatient facility, a participating residential psychiatric treatment facility, in a physician's, fully licensed psychologist's or CLMSW's office, and an outpatient facility subject to the conditions described below.



Mental health services that are the equivalent of an office visit are covered as an office visit. Please see "Office, Outpatient and Home Medical Care Visits" on Page 63.

We pay for:

- **Inpatient mental health services**

The following inpatient mental health services are payable when provided by a physician or by a fully licensed psychologist who has hospital privileges:

- Individual psychotherapeutic treatment
- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Psychological testing when prescribed or performed by a physician and the tests are directly related to the condition for which the patient is admitted or have a full role in rehabilitative or psychiatric treatment programs
- Electroshock therapy and its related anesthetics only when rendered by a physician
- Inpatient consultations when your physician requires assistance in diagnosing or treating your mental health condition. The assistance is required because of the special skill or knowledge of the consulting physician or fully licensed psychologist.

We do not pay for:

- Staff consultations required by a facility's or program's rules
- Marital counseling
- Services beyond the period required to evaluate or diagnose mental deficiency or redevelopmental disability or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Services provided by a nonparticipating hospital, inpatient facility or outpatient facility

Section 3: What BCBSM Pays For

Mental Health Services (continued)

- **Residential psychiatric treatment**

Residential psychiatric treatment is covered only after it has been preauthorized 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).

We pay for:

- 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 in connection with the member's treatment plan

We do not pay for:

- Staff 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 residential psychiatric facility or services provided by such a facility that have not been preauthorized by BCBSM or its representative before they occur
- 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

Mental Health Services (continued)

Residential psychiatric treatment (continued)

We do not pay for: (continued)

- Services to treat a disorder that is not amenable to favorable modification, according to generally accepted professional, evidence-based literature, such as certain personality disorders or certain types of intellectual impairment
- Services or treatment that are cognitive in nature or supplies related to such services or treatment
- Services, treatment, or supplies that are court-ordered or related to a court order
- 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
- 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 and educational or preparatory courses or classes. These services may be paid as part of a treatment program but they are not payable separately.

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Section 3: What BCBSM Pays For

Mental Health Services (continued)

- **Psychiatric day treatment or psychiatric night treatment in a participating hospital.**

We pay for:

- Services provided by facility staff
- Ancillary services to patients who are admitted and discharged on the same day of treatment
- Prescribed drugs given by the hospital in connection with the treatment plan
- Electroshock therapy when administered by, or under the supervision of, a physician
- Anesthetics for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy
- Psychological testing
- Family counseling

For patients admitted to a psychiatric night treatment facility, we also pay for:

- A semiprivate room
- Nursing services and
- Meals, including special diets

- **Outpatient Mental Health Services**

Services in an outpatient mental health facility are payable only when the facility that provides and bills for them is a **participating** facility. (See Page 25 for special rules that apply to autism disorders.) Outpatient mental health services are also payable in an office setting (as applicable).

Mental Health Services (continued)

Outpatient Mental Health Services (continued)

We pay for:

- Services provided by the facility's staff
- Mental health services provided by a physician, fully licensed psychologist, clinical licensed master's social worker or other professional provider as determined by BCBSM in an office setting or in a participating outpatient mental health facility:
 - Individual psychotherapeutic treatment of less than 20 minutes when provided only in a participating outpatient mental health facility
 - Individual psychotherapeutic treatment of more than 20 minutes
 - Family counseling for members of a patient's family
 - Group psychotherapeutic treatment
 - Psychological testing by:
 - A physician or a fully licensed psychologist or
 - A limited licensed psychologist when prescribed and performed under, and billed by, a physician or fully licensed psychologist
- Family counseling for members of the patient's family
- Ancillary services for patients who are admitted and discharged on the same day of treatment
- Prescribed drugs given by the facility in connection with treatment

We do not pay for:

- Services beyond the period required to evaluate or diagnose mental deficiency or developmental disability, or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Services provided in a skilled nursing facility or through a residential substance abuse treatment program
- Marital counseling
- Staff consultations required by a facility or program's rule

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Section 3: What BCBSM Pays For

Occupational Therapy

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For physical therapy services, see Page 72.

For speech-language pathology services, see Page 95.

Special rules apply when occupational therapy services are provided to treat autism (see Page 25).

Locations: We pay for facility and professional occupational therapy services in the following locations subject to the conditions described below:

- A participating hospital, inpatient or outpatient



Inpatient therapy must be used to treat the condition for which the member is hospitalized.

- A participating freestanding outpatient physical therapy facility
- An office of a physician or an independent occupational therapist
- A participating skilled nursing facility
- The patient's home (see Page 129 for when services may be payable in a nursing home)

We pay for:

- Medically necessary occupational therapy services when you are an inpatient in a hospital or skilled nursing facility subject to conditions described further down in this section
- A maximum of 60 outpatient visits per member per year.

Important:

This 60-visit outpatient maximum is a combined maximum for all outpatient visits for occupational therapy, physical therapy and speech-language pathology whether obtained from an in-network or out-of-network provider (see Note below about treatment dates and initial evaluations). Visits for mechanical traction performed by a chiropractor in conjunction with spinal manipulation are applied toward this maximum. All of these therapy services provided in any outpatient location (hospital, facility, office or home) are combined to meet the 60-visit maximum. This benefit maximum renews each calendar year.



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 (continued)

We pay for: (continued)

Occupational therapy must be:

- For inpatient services, prescribed by a physician licensed to prescribe it
- For outpatient services, prescribed by a physician (M.D., D.O. or a podiatrist) or a dentist
- 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



Both the occupational therapist and the occupational therapy assistant must be certified by the National Board of Occupational Therapy Certification and licensed in the state of Michigan or the state where the care is provided.

- For outpatient services, an athletic trainer under the direct supervision of an occupational therapist in an outpatient setting

We do not pay for:

- 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 or freestanding outpatient physical therapy facility

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Section 3: What BCBSM Pays For

Occupational Therapy (continued)

We do not pay for: (continued)

- Services received from other 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



We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan and is medically necessary to treat severe deficits in patients who have certain conditions that are identified by BCBSM.

- Recreational therapy
- Patient education and home programs

Office, Outpatient and Home Medical Care Visits

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for office, outpatient and home medical care visits and therapeutic injections by a physician. Office visits include:

- Urgent care visits
- Office consultations



Only medically necessary services are payable

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

- First aid and medical emergency treatment

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

We do not pay for routine eye refractions and audiometric tests, **except** in connection with a medical diagnosis, pregnancy, or injury

Mental Health and Substance Abuse Treatment

Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health or substance abuse service is considered by BCBSM to be comparable to an office visit, we will process the claim under your office visit benefit.

Section 3: What BCBSM Pays For

Oncology Clinical Trials

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For general surgery services, see Page 100.

For transplant services, see Page 107.

Locations: We pay for services performed in a designated cancer center (see the definition of a designated cancer center in Section 7) subject to the conditions described below.

Benefits for specified oncology clinical trials provide coverage for preapproved, specified bone marrow and peripheral blood stem cell transplants, their related services and FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial.

Mandatory Preapproval

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

The preapproval process allows you and your provider to know if we will cover proposed services, hospital admissions and lengths of stay in a hospital before treatment begins. If preapproval is not obtained **before** you receive services or are admitted to a hospital, the services, admission and length of stay will **not** be covered.

A decision to preapprove services, an admission or length of stay will be based on the information your provider submits to us. BCBSM reserves the right to request other information to determine if preapproval is appropriate.

If your condition or proposed treatment plan changes after preapproval is granted, your provider must submit a new request for preapproval. Failure to do so will result in the transplant, related services, 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.

Oncology Clinical Trials (continued)

Mandatory Preapproval (continued)

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

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program
Mail Code 504C
600 Lafayette East
Detroit, MI 48226

Fax: (866) 752-5769

Preapproval will be granted if:

- The patient is an eligible BCBSM member.
- 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 admission to a designated cancer center and the length of stay at the center are medically necessary (in those cases requiring inpatient treatment). A request for an admission and length of stay must be preapproved by BCBSM before the admission occurs.

We pay for:

- Antineoplastic drugs. Coverage is not limited or precluded when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.
- Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).
- **Autologous Transplants**
 - Infusion of colony stimulating growth factors
 - Harvesting (including peripheral blood stem cell phereses) and storage of bone marrow and/or peripheral blood stem cells
 - Purging or positive stem cell selection of bone marrow or peripheral blood stem cells
 - High-dose chemotherapy and/or total body irradiation
 - Infusion of bone marrow and/or peripheral blood stem cells
 - Hospitalization

Section 3: What BCBSM Pays For

Oncology Clinical Trials (continued)

We Pay For: (continued)

- **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 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. (We will cover harvesting and storage even if it is not covered by the donor's insurance.)

NOTE

The recipient of harvested material must be a BCBSM member.

- 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**

We will pay up to a total of \$5,000 for travel and lodging expenses 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.

We will pay the expenses of an adult patient and another person, or the expenses of a patient under the age of 18 years 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

NOTE

These daily allowances may be adjusted periodically. Please contact BCBSM for the current maximums allowed.

Oncology Clinical Trials (continued)

We do not pay for:

In addition to the limitations and exclusions listed elsewhere in your certificate and/or riders, we do not pay for:

- 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 7 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 by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitters or day care services, services provided by family members, reimbursement of food stamps; mail/UPS services; internet connection, and entertainment (such as cable television, books, magazines and movie rentals).
- Any other services, admissions or length of stay related to any of the above exclusions

Section 3: What BCBSM Pays For

Optometrist Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

We pay for:

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

The medical and surgical services performed by the optometrist must be provided within the state of Michigan.

The optometrist must be licensed in the state of Michigan and certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents.

Services performed by the optometrist will be considered services obtained from a nonparticipating provider if the optometrist does not participate under BCBSM's vision program.

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Outpatient Diabetes Management Program

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

All cost-sharing for diabetes self-management training is waived when performed by an in-network provider.

Locations: We pay for services provided in a home or (for training) in a group setting subject to the conditions described below.

We pay for:

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. Refer to Section 7 for the definition of "medically necessary".

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

Section 3: What BCBSM Pays For

Outpatient Diabetes Management Program (continued)

Diabetes services and medical supplies include: (continued)

- 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 be certified by the Michigan Department of Community Health.



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

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Section 3: What BCBSM Pays For

Pain Management

For infusion therapy services, see Page 50.

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for services to manage pain in an inpatient and outpatient participating hospital setting, approved participating outpatient facility or a physician's office subject to the conditions described below.

We pay for:

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

We do not pay for:

- Services and devices for pain management provided by a nonparticipating hospital or facility.

Section 3: What BCBSM Pays For

Physical Therapy

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For physical therapy services provided in a home, see Page 42.

For occupational therapy services, see Page 60.

For speech-language pathology services, see Page 95.

For autism disorders, see Page 25.

Locations: We pay for physical therapy services in:

- A hospital, inpatient or outpatient



Inpatient therapy must be used to treat the condition for which the member is hospitalized.

- A skilled nursing facility
- A freestanding outpatient physical therapy facility



For freestanding facilities, we pay the facility directly for the service, not the individual provider who rendered the service.

- An office of a physician or an independent physical therapist

We pay for:

- Medically necessary physical therapy services subject to conditions described further down in this section



Special rules apply when physical therapy, occupational therapy or speech and language pathology services are provided to treat autism. Please see Autism Disorders on Page 25.

- A maximum of 60 outpatient visits per member per year.

Important: This 60-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy and speech-language pathology whether obtained from an in-network or out-of-network provider (see Note below about treatment dates and initial evaluations). Visits for mechanical traction performed by a chiropractor in conjunction with spinal manipulation are applied toward this maximum. All of these therapy services provided in any outpatient location (hospital, facility, office or home) are combined to meet the 60-visit maximum. This benefit maximum renews each calendar year.

Physical Therapy (continued)

We pay for: (continued)



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)

- Physical therapy must be:
 - Prescribed by a physician licensed to prescribe it or by a physician assistant who is supervised by a physician
 - 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
 - Given by the approved providers in the locations listed below:

Locations	Providers
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • A doctor (M.D., D.O. or a podiatrist) • A dentist or optometrist • A chiropractor doing mechanical traction • 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.

Section 3: What BCBSM Pays For

Physical Therapy (continued)

We do not pay for:

- 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 or any other facility independent of a hospital or in 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

Physical Therapy (continued)

We do not pay for: (continued)

- 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



We 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 that are identified by BCBSM
- Patient education and home programs (such as home exercise programs)
 - Sports medicine for purposes such as prevention of injuries or for conditioning
 - Recreational therapy

Prescription Drugs

For chemotherapy services, see Page 29.

For contraceptive services, see Page 81.

Prescription drugs obtained from a pharmacy are not payable under this certificate. They may be payable if you have prescription drug coverage in addition to this certificate.

Locations: We pay for medically necessary prescription drugs obtained in a hospital or other approved locations and subject to the conditions described below.

We pay for:

- **Drugs Received in a Hospital (Inpatient or Outpatient)**

We pay for 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**

Drugs are also payable:

- In a participating freestanding ambulatory surgery facility when directly related to surgery (see Page 102)
- In a participating freestanding ESRD facility in conjunction with dialysis services (see Page 36)
- In a participating skilled nursing facility (see Page 91)
- As part of home health services when services are provided by a participating hospital (see Page 42)
- When required for infusion therapy (see Page 50)
- In a participating hospice for the comfort of the patient (see Page 44)
- In a participating residential substance abuse treatment facility or as part of a participating outpatient substance treatment program (see Page 55).

Section 3: What BCBSM Pays For

Prescription Drugs (continued)

- **Drugs Administered by a Physician**

- **Injectable Drugs:** We pay for covered injectable drugs or biologicals and their administration. The injectable drugs and biologicals must be FDA approved in order to be covered. The injectable drug or biological must be ordered or furnished by a physician and administered by the physician or under the physician's supervision.
- **Specialty Pharmaceuticals:** We pay for BCBSM-approved specialty pharmaceuticals administered by an in-network or participating professional provider (see definition in Section 7).
 - We pay for the drug and its administration when ordered and billed by the physician, or
 - We pay for the drug when billed by the specialty pharmacy provider and we pay the physician for administration of the drug.



Self-injected drugs are not covered

- **Hemophilia Medication**

We pay for hemophilia factor product obtained from an in-network, out-of-network, participating or nonparticipating professional provider (see definitions in Section 7).

The cost of the hemophilia factor product includes the supplies necessary for infusion. We will reimburse a participating provider directly; if the provider is nonparticipating, we will reimburse the member.

- **Preauthorization for Specialty Pharmaceuticals**

Preauthorization is required for select specialty pharmaceuticals administered in locations as determined by BCBSM, including but not limited to the following: office, clinic or home. The preauthorization requirement affects all in-state and out-of-state services. The prescribing physician should contact BCBSM and follow BCBSM's utilization management processes in order to obtain preauthorization of the specialty pharmaceuticals. We will notify the prescribing physician whether the request has been granted after receiving all the information needed to evaluate the request. Only FDA-approved medications are eligible for preauthorization and of those drugs, only the specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition will be preauthorized.

- If preauthorization is requested, but not approved by BCBSM, you have the right to appeal under applicable law. If the preauthorization is not approved via the appeal, you will be responsible for the full cost of the specialty pharmaceuticals.
- If preauthorization is not sought, BCBSM will deny the claim and you will be responsible for the full cost of the specialty pharmaceuticals.

Prescription Drugs (continued)

Drugs administered by a Physician (continued)

Preauthorization for Specialty Pharmaceuticals (continued)

- Retrospective reviews will be available. If preauthorization is not sought and you appeal the denial, BCBSM will review the claim retrospectively to determine if benefits are payable. If BCBSM upholds the denial, you have the right to appeal under applicable law.



Preauthorization is not required if Medicare is your primary payer.

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 approval is not obtained before the drug is dispensed, the drug will not be covered.

You, your designee, or the provider who prescribes a drug that is not on BCBSM's drug list should contact BCBSM and follow BCBSM's exception request process. We will notify you or your designee, the prescribing provider or the provider's designee whether the request has been granted within 24 hours after receiving all of the information needed to decide whether your request should be granted.

Only FDA-approved drugs are eligible for an exception and of those drugs, only drugs that meet BCBSM's medical policy criteria and are clinically appropriate for the treatment of the member's condition will be approved.

If approval is not obtained before the drug is dispensed, the drug will not be covered. If the exception request is approved, any deductibles, coinsurances or copayments required under your benefit package will apply.

To learn more about this process, visit www.bcbsm.com or call the Customer Service number on the back of your card

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Section 3: What BCBSM Pays For

Preventive Care Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

To see a list of the preventive benefits and immunizations that are mandated by the Patient Protection and Affordable Care Act (PPACA), you may go to the following website: www.HealthCare.gov/center/regulations/prevention.html. You may also contact BCBSM customer service.

Most preventive care services are covered only when performed by an in-network provider. However, colonoscopies, mammograms, and women's contraceptive services that are preventive in nature are covered whether performed by an in-network or out-of-network provider. This section describes what we cover for all preventive care services.

Locations: We pay for facility and professional services for preventive care in the following locations subject to the conditions described below:

- A participating outpatient hospital or participating facility
- A professional provider's office

We also pay for the analysis of a laboratory test when rendered by an independent laboratory.

We pay for:

We pay for the preventive care services listed below, along with the related reading and interpretation of your test results, only when rendered by in-network providers. However, if an in-network provider performs a covered preventive test, but an out-of-network provider reads and interprets the results, we will pay the out-of-network claim as if the service was performed by an in-network provider. This means your out-of-network deductible and out-of-network copayment will not be imposed.

Deductibles and copayments are not required for these services when performed by an in-network provider.

Health Maintenance Examination

One examination per member, per calendar year. This comprehensive history and physical examination includes blood pressure measurement, skin exam for malignancy, breast exam, testicular exam, rectal exam and health counseling regarding potential risk factors.

Preventive Care Services (continued)

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

- We pay for one routine mammogram and the related reading, once per member per calendar year to screen for breast cancer. This service is not subject to any deductible or copayment requirements when provided by in-network providers. Mammography services performed by an out-of-network provider are subject to the out-of-network deductible and copayment requirements of your certificate.

NOTE

Readings and interpretations by out-of-network providers are payable only when the screening mammogram itself is performed 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

We pay for 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
- Visits beyond 47 months are limited to one per member, per calendar year under the health maintenance examination benefit

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Section 3: What BCBSM Pays For

Preventive Care Services (continued)

Immunizations

We pay for childhood and adult immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM.

We pay for all other immunizations and preventive care benefits mandated by PPACA at the time services are performed.

Prostate Specific Antigen Screening

We pay for one routine prostate specific antigen screening per member, per calendar year.

Routine Laboratory and Radiology Services

We pay for 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 BCBSM approved amount as follows:

- We pay for one routine screening colonoscopy once per member per calendar year, whether performed by an in-network or out-of-network provider.
- Services performed by an in-network provider are not subject to any deductible or copayment requirements.
- Services performed by an out-of-network provider are subject to the out-of-network deductible and copayment requirements of your certificate.
- Subsequent medically necessary colonoscopies performed during the same calendar year by an in-network or out-of-network provider are subject to your deductible and copayment requirements.

Preventive Care Services (continued)

Women's Preventive Care Contraceptive Services

– Voluntary Sterilization for Females

We pay for hospital, facility, and physician benefits for voluntary sterilizations for females. See Page 17 for your cost-sharing requirements.

– Contraceptive Devices

We pay for a contraceptive device requiring a prescription by a physician, certified nurse midwife, or other legally authorized professional provider and for the insertion and removal of a device by a physician, certified nurse midwife, or other eligible provider.

– Contraceptive Injections

We pay for contraceptive injections given by a physician, certified nurse midwife, or other legally authorized professional provider, including the cost of the medication when provided by the physician, nurse midwife or other eligible provider. Contraceptive medication you obtain from the pharmacy is not covered. When the physician, certified nurse midwife, or other legally authorized professional provider injects contraceptive medication you purchased from a pharmacy, only the injection is payable.

– Genetic Testing

We pay for BRCA (counseling about genetic testing) – for women at higher risk

We do not pay for:

- Screening services other than the ones listed above.

Section 3: What BCBSM Pays For

Private Duty Nursing Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for private duty nursing services in your home or in a hospital subject to the conditions described below:

We pay for:

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 us for services. **All progress notes must be submitted with the claim form.** We will pay the approved amount to you.

We do not pay for:

- Custodial care

Professional Services

The services in this section are in addition to all other services listed in this certificate that are payable to a professional provider.

- **Certified Nurse Practitioner Services:** We pay for covered services provided by a certified nurse practitioner.
- **Inpatient and Outpatient Consultations:** We pay for inpatient and outpatient consultations when your physician requires assistance in diagnosing or treating your condition. The assistance is required because of the special skill and knowledge of the consulting physician or professional provider.

We do not pay for staff consultations required by a facility's or program's rules.



Consultations in an in-network physician's office are subject to copayment requirements.

Section 3: What BCBSM Pays For

Prosthetic and Orthotic Devices

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For durable medical equipment services, see Page 39.

Locations: We pay for prosthetic and orthotic devices while you are in a participating hospital or for use outside of the hospital subject to the conditions described below.

We pay for:

Prosthetic and orthotic devices prescribed by a physician or certified nurse practitioner and permanently implanted in the body or those used externally as part of regular hospital equipment. 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
- Repairs, limited to the cost of a new device



For purposes of ocular prostheses only, the definition of physician includes an optometrist who is also a prosthetist.

The replacement of a prosthetic device is payable if necessary 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

BCBSM covers external prosthetic and orthotic devices that are generally considered payable by Medicare Part B as of the date of purchase or rental. In some instances however BCBSM guidelines may differ. Please call your local customer service center for specific coverage information.

To be covered, custom-made devices must be furnished by a provider that is fully accredited, or 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, D.O.s, podiatrists, prosthetists and orthotists who meet BCBSM qualification standards.

Prosthetic and Orthotic Devices (continued)

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. These 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 or for hygienic reasons

- Prefabricated custom-fitted orthotic devices
- Artificial eyes, ears, noses and larynxes
- Ostomy sets and accessories, catheterization equipment and urinary sets
- Prescription lenses (eyeglasses or contacts) following cataract surgery for any disease of the eye or to replace a missing organic lens. Optometrists may provide these devices.
- External cardiac pacemakers
- Therapeutic shoes, shoe modifications and inserts for persons with diabetes
- Maxillofacial prostheses (as defined in Section 7) when approved. Dentists may provide these devices.
- Some prefabricated items, such as wrist braces, ankle braces, or shoulder immobilizers, are payable when provided by an M.D., D.O., or podiatrist because the patient has an urgent need for the devices. Please call your local customer service center for information on which devices are covered.

Section 3: What BCBSM Pays For

• Prosthetic and Orthotic Devices (continued)

We do not pay for:

- Nonrigid devices and supplies such as elastic stockings, garter belts, arch supports, and corsets.
- Hearing aids
- Spare prosthetic devices
- Routine maintenance of the prosthetic device
- Prosthetic devices that are experimental
- Hair prostheses such as wigs, hair pieces, hair implants, etc.

Provider-Delivered Care Management

See Section 2 beginning on Page X for what you may be required to pay for these services.
See Section 7 for the definition of Provider-Delivered Care Management (PDCM).

Provider-delivered care management services are covered only when performed by designated in-network providers, as identified by BCBSM for services rendered in Michigan or the local Blue Cross/Blue Shield plan for services rendered out of state. A care manager is a trained clinician, such as a registered nurse, clinical licensed master's of social worker, certified nurse practitioner or physician assistant. This section describes what we cover for all provider-delivered care management services.

Locations: We pay for professional services for provider-delivered care management in the following locations, subject to the conditions described below:

- A professional provider's office
- An outpatient hospital or participating facility
- A patient's home
- Other locations as designated by BCBSM for services rendered in Michigan or the local Blue Cross/Blue Shield plan for services rendered out of state

We pay for:

Care management services identified by BCBSM that providers render to BCBSM members, only when performed by:

- In-network BCBSM-designated providers in Michigan, or
- Out-of-state providers who are designated by their local Blue Cross/Blue Shield plan to render care management services.

Deductibles, copayments and coinsurances (if any) are not required for these in-network services. Out-of-network services are not covered.

Provider-delivered care management services may include:

- Telephonic, individual face-to-face, and group interventions
- Medication assessments to clarify the appropriateness of the drug, the correct dosage to take, when to take it and to identify potential conflicts
- Care transitions after a hospital discharge to ensure an understanding of discharge instructions and the member's follow-up with his or her primary care physician
- Action plans that help the member better manage his or her health and set goals for improvement

Section 3: What BCBSM Pays For

Provider-Delivered Care Management Services (continued)

Goal-setting and self-management support is included in most PDCM services. In-person contact will be encouraged between members and their care managers, whenever possible. Services are subject to change.

Eligibility

You are eligible to receive PDCM services if you have:

- Active BCBSM coverage
- One or more conditions that indicate that care management services have the potential to improve well-being
- 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

Termination of Provider-Delivered Care Management

You may opt-out of PDCM at any time. BCBSM may also terminate PDCM services based on your nonparticipation in PDCM, cancellation of your BCBSM coverage, or other factors.

We do not pay for:

- Services rendered by providers not designated for provider-delivered care management



For more information on Provider-Delivered Care Management services, you may contact BCBSM customer service.

Radiology Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For radiology services in an ambulatory surgical facility, see Page 102.

Locations: We pay for hospital, facility and physician diagnostic and therapeutic radiology services in:

- A participating hospital, inpatient or outpatient, or participating outpatient facility
- A BCBSM-approved physician's office

We pay for:

Diagnostic Radiology Services

We pay for facility and physician diagnostic radiology services to diagnose disease, illness, pregnancy or injury. The services must be provided by your physician or by another physician if prescribed 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

Restrictions

- Complex radiology such as CAT, MRI and PET scans must be performed in participating facilities. You or your physician may call us for a list of participating facilities. Also you may call us for information about any restrictions.
- Select radiology procedures, such as CAT, MRI and PET scans are payable if:
 - The provider requests preapproval. However, preapproval is not required for radiology procedures:
 - Performed out-of-state
 - Performed in cases of emergency
 - Payable through Medicare because it is your primary coverage

Section 3: What BCBSM Pays For

Radiology Services (continued)

Diagnostic Radiology Services (continued)

Restrictions (continued)

- The procedures for which preapproval was requested fall within BCBSM medical policy guidelines and
- We approve the procedures
- The procedures are performed in a participating facility. (You or your physician may call us about the status of a specific facility.)

If any of these requirements are not met, BCBSM will **not** pay for the procedure. You will not be responsible for paying the provider for a procedure that has not been preapproved.

You may call us for information about any restrictions.

We do not pay for:

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).

Therapeutic Radiology Services

We pay for physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. The services must be provided by your physician or by another physician if prescribed by your physician.

Skilled Nursing Facility Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for facility and professional services in a skilled nursing facility.

Requirements:

We pay for 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

We require written confirmation of the need for **skilled care** from the patient's attending physician.

Length of Stay

We pay only for the period that is necessary for the proper care and treatment of the patient up to a maximum of 120 days per member, per calendar year.

We pay for:

- 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 (Page 72), speech and language pathology services (Page 95) or occupational therapy (Page 60) when medically necessary



The physical therapy, occupational therapy or speech-language pathology services performed in a skilled nursing facility are considered inpatient benefits. Only when these services are provided in any outpatient location does the 60-visit benefit maximum apply.

Section 3: What BCBSM Pays For

Skilled Nursing Facility Services (continued)

We do not pay for:

- Custodial care
- Care for senility or developmental disability
- Care for substance abuse
- 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

Special Foods for Metabolic Diseases

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

We pay for:

Special medical foods, including special infant formulas and low-protein modified food products, for the dietary treatment of inherited metabolic diseases of childhood, after a complete medical evaluation by the physician of the patient's condition. These foods will not be covered unless they are prescribed by a physician after he or she has performed a complete medical evaluation.

The following criteria apply:

- The cost of special medical foods must be higher than the cost of foods that are not special medical foods.
- Medical documentation must support the diagnosis of a covered condition that requires special medical foods, as identified by BCBSM.
- A medical formula will be provided for infants from birth through 24 months maximum when the formula represents at least 50 percent of the child's caloric intake.
- Special medical foods and low-protein modified foods will be covered for pediatric patients up to and including age 18.

You must submit a prescription from the treating physician along with receipts for all special dietary purchases to BCBSM for handling. Mail your receipts along with a "Member Application for Payment Consideration" to:

Blue Cross Blue Shield of Michigan
Regular Claims, Special Programs, Mail Code 608A
600 E. Lafayette Blvd
Detroit, MI 48226

You can obtain the above-mentioned form by visiting our Web site at bcbsm.com and clicking on "Member Forms" under the "Member Secured Services" tab. If you can't access the Web site or you have trouble finding what you need, please contact customer service at one of the telephone numbers listed in Section 8.

Section 3: What BCBSM Pays For

Special Foods for Metabolic Diseases (continued)

We do not pay for:

- Nutritional products, supplements, medical foods, infant formulas or low-protein modified foods for medical conditions not identified by BCBSM as being related to inherited metabolic diseases of childhood
- Foods used by patients with inherited diseases of childhood that are not special medical foods, special infant formulas or low-protein modified foods
- Nutritional products, supplements or foods used for the patient's convenience or for weight reduction programs

Diabetes mellitus is excluded as a payable diagnosis for this benefit.

Speech and Language Pathology

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For occupational therapy services, see Page 60.

For physical therapy services, see Page 72.

Special rules apply when speech and language pathology services are provided to treat autism (see Page 25).

Locations: We pay for facility and professional speech and language pathology services in the following locations subject to the conditions described below:

- A participating hospital, inpatient or outpatient, or a participating skilled nursing facility



For inpatient therapy given in a hospital, the therapy must be used to treat the condition for which the member is hospitalized.

- A participating freestanding outpatient physical therapy facility



For freestanding facilities, we pay the facility directly for the service, not the individual provider who rendered the service.

- A professional provider's office
- A home (see Page 129 for when services may be payable in a nursing home.)

We pay for:

- Medically necessary speech and language pathology services when you are an inpatient in a hospital or skilled nursing facility subject to conditions described further down in this section
- We pay for a maximum of 60 outpatient visits per member per year.

Important: This 60-visit outpatient maximum is a combined maximum for all outpatient visits for speech and language pathology, physical therapy and occupational therapy whether obtained from an in-network or out-of-network provider (see Note below about treatment dates and initial evaluations). Visits for mechanical traction performed by a chiropractor in conjunction with spinal manipulation are applied toward this maximum. All of these therapy services provided in any outpatient location (hospital, facility, office or home) are combined to meet the 60-visit maximum. This benefit maximum renews each calendar year.

Section 3: What BCBSM Pays For

Speech and Language Pathology (continued)

We pay for: (continued)



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 physician (M.D. or D.O.) or a dentist
- 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 clinical fellowship year occurs after a speech-language pathologist completes all graduate requirements for the master's degree. This year of practice is under the supervision of a certified speech-language pathologist.

We do not pay for:

- 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



We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan and is medically necessary to treat severe deficits in patients who have certain conditions that are identified by BCBSM.

- Recreational therapy
- Patient education and home programs

Speech and Language Pathology (continued)

We do not pay for: (continued)

- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities



For certain pediatric patients with severe developmental disability of speech development, a BCBSM medical consultant may determine that speech and language pathology services can be used to treat chronic, developmental or congenital conditions.

- 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
- 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
- Services received from other facilities independent of a hospital

Section 3: What BCBSM Pays For

Substance Abuse Treatment Services

See Page 16 in Section 2 for what you may be required to pay for these services.

For Mental Health services, please see Page 55.

Locations: We pay for substance abuse treatment services in an inpatient or outpatient hospital and a residential or outpatient treatment program subject to the conditions described below.



Substance abuse treatment services that are the equivalent of an office visit are covered as an office visit. Please see "Office, Outpatient and Home Medical Care Visits" on Page 63.

Inpatient Substance Abuse Treatment Services

We pay for treatment of substance abuse in a participating hospital.

Outpatient and Residential Substance Abuse Treatment Services

We pay for treatment of substance abuse in participating residential or outpatient substance abuse treatment programs. The following criteria for the program must be met:

- Your attending physician must assign a diagnosis of substance abuse and must certify whether the treatment required is residential or outpatient
- Your attending physician must:
 - Provide an initial physical exam
 - Provide and supervise your care during detoxification and
 - Provide follow-up care during rehabilitation
- The services must be medically necessary for treatment of your condition
- The services must be approved by BCBSM and provided by a participating substance abuse treatment program

We pay for:

We pay for the following services provided and billed by an approved program:

- Lab exams
- Diagnostic exams
- Supplies and equipment used for detoxification or rehabilitation
- Professional and trained staff services and program services necessary for care and treatment
- Individual and group therapy or counseling
- Counseling for family members
- Psychological testing

Substance Abuse Treatment Services (continued)

Outpatient and Residential Substance Abuse Treatment Services (continued)

We also pay for the following in a residential substance abuse treatment program:

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

We also pay for the following in an outpatient substance abuse treatment program:

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

We do not pay for:

- 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

Section 3: What BCBSM Pays For

Surgery

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For transplant services, see Page 107.

Locations: We pay for hospital, facility and professional services for surgery in:

- A participating hospital, inpatient or outpatient
- A participating freestanding ambulatory surgery facility
- A professional provider's or physician's office

We pay for:

Presurgical Consultations

When your physician recommends surgery, you have the option of having a presurgical consultation with another physician who is a doctor of medicine, osteopathy, podiatry or an oral surgeon. Deductibles and copayments required under this certificate do not apply to presurgical consultations obtained from in-network physicians.

- You may obtain presurgical consultations if the surgery will take place in an inpatient or outpatient hospital setting or ambulatory surgery facility and is covered under this certificate.
- 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

We pay for:

- 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

•
Surgery (continued)

We pay for: (continued)

Surgery (continued)

- Sterilization (whether or not medically necessary)

NOTE

Voluntary sterilization for females is covered as part of your preventive services benefit – see Page 81.

- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration related to surgery
- **Cosmetic surgery** is only payable 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

NOTE

Cosmetic surgery and related services are **not** payable when the services are primarily performed to improve appearance.

- **Dental Surgery:** 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 (see Page 33 for examples)
 - For surgery and treatment related to the treatment of temporomandibular joint (jaw joint) dysfunction (TMJ), see Page 34.
- **Gender reassignment:** Surgery for gender reassignment is payable only for reconstructive procedures of the genitalia. Surgical procedures involving face, vocal cords, breasts, abdomen, hips or other nongenital areas are **not** payable.
- **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, an additional physician provides technical assistance to the surgeon. We pay the approved amount for TSA, provided according to BCBSM guidelines, in a hospital inpatient or outpatient setting or in an ambulatory surgery facility. A list of covered TSA surgeries is available from your local customer service center.

Section 3: What BCBSM Pays For

- **Surgery (continued)**

We pay for: (continued)

We do 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

We pay for medically necessary facility services provided by a BCBSM **participating** ambulatory surgery facility. A patient must be under the care of a licensed doctor of medicine, osteopathy, podiatry or oral surgery to be admitted to an ambulatory surgery facility. The services must be directly related to performing surgical procedures identified by BCBSM as covered ambulatory 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

We do not pay for:

- Services by a nonparticipating ambulatory surgery facility

Temporary Benefits for Out-of-network Hospital Services

The following rules will apply when a participating hospital terminates its contract with BCBSM.

Temporary hospital benefits from a noncontracted hospital are payable for designated services, emergency care and travel and lodging that will end **six months** from the date the hospital terminates its participating contract with BCBSM. (Also see "Section 3: What We Pay For.")

Mandatory Preapproval

Preapproval of the services described in this certificate (except emergency care or ambulance services) must be obtained from BCBSM before we will consider them for payment. If the required approval is not obtained, you must pay for these services.

Our customer service representatives can provide you and your physician with the telephone number to call for preapproval (see the "How to Reach Us" section of your certificate). If the request for preapproval relates to a bone marrow or organ transplant, please ask your customer service representative for the telephone number of the Human Organ Transplant Program (see Page 107 for more information on transplants).



Preapproval of services is not a guarantee that a claim for them will be paid. All claims are subject to a review of the reported diagnosis, medical necessity verification, the availability of benefits at the time the claim is processed as well as the requirements, conditions, limitations, exclusions, maximums, deductibles and copayments under your certificate.

Preapproval must be obtained as follows:

- **Designated Services**

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

- **Travel and Lodging**

You must obtain preapproval for any travel and lodging expenses before they are incurred. If you do not obtain preapproval, travel and lodging will not be covered and you will be responsible for these costs. Please call BCBSM to obtain preapproval.

A handwritten signature in dark ink, appearing to be "B. B." or similar, located at the bottom right of the page.

Section 3: What BCBSM Pays For

Temporary Benefits for Out-of-network Hospital Services (continued)

Payable Services

- **Designated Services and Emergency Care**

Coverage Requirements

We will pay for designated services and emergency care that you receive from a noncontracted area hospital when all of the following criteria are met:

- The services are medically necessary and would be covered if the noncontracted area hospital was a BCBSM in-network or participating hospital
- The designated services are preapproved, as previously described
- The noncontracted area hospital is within 75 miles of your primary residence (this applies only to designated services)

Payment for Designated Services and Emergency Care

When the above criteria are met, we will pay the subscriber as follows:

- **Designated Services**

We will pay our approved amount, less any deductibles and copayments required under your certificate. Our approved amount may be less than the hospital's bill. You are required to pay the difference.

- **Emergency Care**

We pay the greater of the:

- Median in-network rate
- Usual, customary and reasonable rate
- Medicare rate

This amount may be less than the hospital's bill. You will be required to pay the difference.



You will not have to pay any out-of-network deductible, copayments and coinsurances that apply to these services. However, you must pay any in-network deductible, copayments or coinsurances that apply.

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Temporary Benefits for Out-of-network Hospital Services (continued)

Payable Services (continued)

Designated Services and Emergency Care (continued)

Transport from a Noncontracted Area Hospital

If you are receiving designated services or emergency care and your physician determines you are medically stable, you may choose to be transferred from the noncontracted area hospital to the nearest participating or in-network hospital equipped to treat your condition. We will pay our approved amount for your one-way ambulance transport to that hospital.

If you use a nonparticipating ambulance for your transport, its bill may be more than our approved amount. You are required to pay the difference.



If you transfer to a participating out-of-network hospital, we will waive the deductible, copayments and coinsurances that apply to out-of-network services. However, you will still be required to pay any deductibles, copayments or coinsurances applicable to in-network services.

BCBSM certificates will 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, we will pay you at the nonparticipating rate. Our rate may be less than the hospital charges. You will have to pay the difference.

Limitations and Exclusions

- If you get services from a noncontracted hospital that are not designated services, we will pay only the amount we pay for nonparticipating hospital services. These amounts are described in Section 2. You will have to pay the difference between what we pay and the hospital's charge. This difference may be substantial since we do not pay for nonemergency services in a nonparticipating hospital.
- We do not pay for designated services that were not preapproved, as previously described.
- We 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 any deductibles or copayments.

• **Travel and Lodging**

If you need to obtain services at an out-of-area hospital, we will pay for the cost of travel and lodging if all of the following are met:

- You live within 75 miles of the noncontracted area hospital
- You cannot reasonably obtain covered services from a contracted area hospital or other participating provider within 75 miles of the noncontracted area hospital and your physician directs you to an out-of-area hospital, and
- You obtain services from the out-of-area BCBSM in-network or participating hospital that is closest to the noncontracted area hospital.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|---------------------|--|---|
| - Acupuncture | - Dental Care (Adult) | - Private-Duty Nursing |
| - Chiropractic Care | - Long-Term Care | - Routine Foot Care (Only when meets Plan guidelines) |
| - Cosmetic Surgery | - Non-Emergency Care When Traveling Outside the U.S. | - Vision Hardware (Unless additional rider purchased) |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------|---|------------------------|
| - Bariatric Surgery | - Infertility Treatment (Only when meets Plan guidelines) | - Weight Loss Programs |
| - Hearing Aids | - Routine Eye Care (Adult) | |

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-422-4641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact HAP at 1-800-422-4641 or visit us at www.hap.org

For more information regarding grievance and appeals, contact the plan at 1-800-422-4641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Office of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: <http://michigan.gov/difs> or e-mail difs-HICAP@michigan.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,360
- Patient pays \$180

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$30
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$180

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,820
- Patient pays \$580

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$500
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$580

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hap.org or by calling 1-800-422-4641.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,600 person / \$13,200 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, Balance Billed Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Does this plan use a <u>network of providers</u> ?	Yes. See www.hap.org or call 1-800-422-4641 for a list of preferred providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay per visit	Not Covered	-----None-----
	Specialist visit	\$10 copay per visit	Not Covered	-----None-----
	Other practitioner office visit	\$10 PCP Other Practitioner copay per visit/ \$10 Specialist Other Practitioner copay per visit	Not Covered	Chiropractic Care and Acupuncture Not Covered
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org .
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Some services require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org .	Generic Drugs	\$2 copay/prescription (retail)	Not Covered	Applies to all categories below. Retail: 35 day supply for non-maintenance drugs at 1 copay; 35 day supply or 100 doses, whichever is greater, for eligible maintenance drugs at 1 copay. Mail Order: 90 day supply for non-maintenance drugs at 3 copays less \$5.00; 90 day supply of eligible maintenance drugs at 1 copay
	Preferred brand drugs	\$2 copay/prescription (retail)	Not Covered	
	Non-preferred brand drugs	\$2 copay/prescription (retail)	Not Covered	
	Specialty drugs	\$2 copay/prescription (retail)	Not Covered	

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need immediate medical attention	Emergency room services	\$50 copay per visit	\$50 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency Transport Only
	Urgent care	\$10 copay per visit	\$10 copay per visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fee	No Charge	Not Covered	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder outpatient services	\$10 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
If you are pregnant	Prenatal and postnatal care	\$10 copay per visit	Not Covered	No Charge for Prenatal care
	Delivery and all inpatient services	No Charge	Not Covered	Some services require prior authorization.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	-----None-----
	Rehabilitation services	No Charge	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services- Up to 730 days, renewable after 60 days
	Durable medical equipment	No Charge	Not Covered	Coverage provided for approved equipment based on HAP's guidelines. Some services require prior authorization.
	Hospice service	No Charge	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Eye exam	\$10 copay per visit	Not Covered	No Charge for preventive eye exam
	Glasses	Covered	Not Covered	Coverage for one pair of eye glasses each year. Detailed information regarding coverage of lenses and Collection Frames can be found in your policy or plan documents.
	Dental check up	Not Covered	Not Covered	-----None-----

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-----------------------|--|---|
| - Acupuncture | - Hearing Aids | - Private-Duty Nursing |
| - Chiropractic Care | - Long-Term Care | - Routine Foot Care (Only when meets Plan guidelines) |
| - Cosmetic Surgery | - Non-Emergency Care When Traveling Outside the U.S. | - Vision Hardware (Unless additional rider purchased) |
| - Dental Care (Adult) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---|----------------------------|------------------------|
| - Bariatric Surgery | - Routine Eye Care (Adult) | - Weight Loss Programs |
| - Infertility Treatment (Only when meets Plan guidelines) | | |

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Your Rights to Continue Coverage:

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact HAP at 1-800-422-4641 or visit us at www.hap.org.

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

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These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,380
- Patient pays \$160

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$10
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$16.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$5,140
- Patient pays \$260

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$180
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$260

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-800-422-4641 to request a copy.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | Plan Type: HMO

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hap.org or by calling 1-800-422-4641.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,600 person / \$13,200 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, Balance Billed Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Does this plan use a <u>network of providers</u> ?	Yes. See www.hap.org or call 1-800-422-4641 for a list of preferred providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org .

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay per visit	Not Covered	-----None-----
	Specialist visit	\$10 copay per visit	Not Covered	-----None-----
	Other practitioner office visit	\$10 PCP Other Practitioner copay per visit/ \$10 Specialist Other Practitioner copay per visit	Not Covered	Chiropractic Care and Acupuncture Not Covered
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org .
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Some services require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org .	Generic Drugs	\$5 copay/prescription (retail)	Not Covered	Applies to all categories below. Retail: 35 day supply for non-maintenance drugs at 1 copay; 35 day supply or 100 doses, whichever is greater, for eligible maintenance drugs at 1 copay. Mail Order: 90 day supply for non-maintenance drugs at 3 copays less \$5.00; 90 day supply of eligible maintenance drugs at 1 copay
	Preferred brand drugs	\$10 copay/prescription (retail)	Not Covered	
	Non-preferred brand drugs	\$10 copay/prescription (retail)	Not Covered	
	Specialty drugs	\$10 copay/prescription (retail)	Not Covered	

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need immediate medical attention	Emergency room services	\$50 copay per visit	\$50 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency Transport Only
	Urgent care	\$10 copay per visit	\$10 copay per visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fee	No Charge	Not Covered	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder outpatient services	\$10 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
If you are pregnant	Prenatal and postnatal care	\$10 copay per visit	Not Covered	No Charge for Prenatal care
	Delivery and all inpatient services	No Charge	Not Covered	Some services require prior authorization.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	-----None-----
	Rehabilitation services	No Charge	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services- Up to 730 days, renewable after 60 days
	Durable medical equipment	No Charge	Not Covered	Coverage provided for approved equipment based on HAP's guidelines. Some services require prior authorization.
	Hospice service	No Charge	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Eye exam	\$10 copay per visit	Not Covered	No Charge for preventive eye exam
	Glasses	Covered	Not Covered	Coverage for one pair of eye glasses each year. Detailed information regarding coverage of lenses and Collection Frames can be found in your policy or plan documents.
	Dental check up	Not Covered	Not Covered	-----None-----

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|---------------------|--|---|
| - Acupuncture | - Dental Care (Adult) | - Private-Duty Nursing |
| - Chiropractic Care | - Long-Term Care | - Routine Foot Care (Only when meets Plan guidelines) |
| - Cosmetic Surgery | - Non-Emergency Care When Traveling Outside the U.S. | - Vision Hardware (Unless additional rider purchased) |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------|---|------------------------|
| - Bariatric Surgery | - Infertility Treatment (Only when meets Plan guidelines) | - Weight Loss Programs |
| - Hearing Aids | - Routine Eye Care (Adult) | |

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-422-4641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccoio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact HAP at 1-800-422-4641 or visit us at www.hap.org

For more information regarding grievance and appeals, contact the plan at 1-800-422-4641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccoio.cms.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Office of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: <http://michigan.gov/difs> or e-mail difs-HICAP@michigan.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,370
- Patient pays \$170

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$20
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$170

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$5,020
- Patient pays \$380

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$300
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$380

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage for: Individual+Family | **Plan Type:** HMO


This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hap.org or by calling 1-800-422-4641.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$6,600 person / \$13,200 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Balance Billed Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Does this plan use a network of providers?	Yes. See www.hap.org or call 1-800-422-4641 for a list of preferred providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay per visit	Not Covered	-----None-----
	Specialist visit	\$10 copay per visit	Not Covered	-----None-----
	Other practitioner office visit	\$10 PCP Other Practitioner copay per visit/ \$10 Specialist Other Practitioner copay per visit	Not Covered	Chiropractic Care and Acupuncture Not Covered
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org .
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Some services require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org .	Generic Drugs	\$10 copay/prescription (retail)	Not Covered	Applies to all categories below. Retail: 35 day supply for non-maintenance drugs at 1 copay; 35 day supply or 100 doses, whichever is greater, for eligible maintenance drugs at 1 copay. Mail Order: 90 day supply for non-maintenance drugs at 3 copays less \$5.00; 90 day supply of eligible maintenance drugs at 1 copay
	Preferred brand drugs	\$20 copay/prescription (retail)	Not Covered	
	Non-preferred brand drugs	\$40 copay/prescription (retail)	Not Covered	
	Specialty drugs	\$40 copay/prescription (retail)	Not Covered	

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need immediate medical attention	Emergency room services	\$50 copay per visit	\$50 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency Transport Only
	Urgent care	\$10 copay per visit	\$10 copay per visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fee	No Charge	Not Covered	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder outpatient services	\$10 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
If you are pregnant	Prenatal and postnatal care	\$10 copay per visit	Not Covered	No Charge for Prenatal care
	Delivery and all inpatient services	No Charge	Not Covered	Some services require prior authorization.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	-----None-----
	Rehabilitation services	No Charge	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services- Up to 730 days, renewable after 60 days
	Durable medical equipment	No Charge	Not Covered	Coverage provided for approved equipment based on HAP's guidelines. Some services require prior authorization.
	Hospice service	No Charge	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Eye exam	\$10 copay per visit	Not Covered	No Charge for preventive eye exam
	Glasses	Covered	Not Covered	Coverage for one pair of eye glasses each year. Detailed information regarding coverage of lenses and Collection Frames can be found in your policy or plan documents.
	Dental check up	Not Covered	Not Covered	-----None-----

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-----------------------|--|---|
| • Acupuncture | • Hearing Aids | • Private-Duty Nursing |
| • Chiropractic Care | • Long-Term Care | • Routine Foot Care (Only when meets Plan guidelines) |
| • Cosmetic Surgery | • Non-Emergency Care When Traveling Outside the U.S. | • Vision Hardware (Unless additional rider purchased) |
| • Dental Care (Adult) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---|----------------------------|------------------------|
| • Bariatric Surgery | • Routine Eye Care (Adult) | • Weight Loss Programs |
| • Infertility Treatment (Only when meets Plan guidelines) | | |

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-422-4641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact HAP at 1-800-422-4641 or visit us at www.hap.org

For more information regarding grievance and appeals, contact the plan at 1-800-422-4641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Office of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: <http://michigan.gov/difs> or e-mail difs-HICAP@michigan.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,360
- Patient pays \$180

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$30
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$180

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,820
- Patient pays \$580

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$500
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$580

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | Plan Type: HMO

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hap.org or by calling 1-800-422-4641.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,600 person / \$13,200 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, Balance Billed Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Does this plan use a <u>network of providers</u> ?	Yes. See www.hap.org or call 1-800-422-4641 for a list of preferred providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay per visit	Not Covered	-----None-----
	Specialist visit	\$20 copay per visit	Not Covered	-----None-----
	Other practitioner office visit	\$20 PCP Other Practitioner copay per visit/ \$20 Specialist Other Practitioner copay per visit	Not Covered	Chiropractic Care and Acupuncture Not Covered
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org .
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Some services require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org .	Generic Drugs	\$10 copay/prescription (retail)	Not Covered	Applies to all categories below. Retail: 35 day supply for non-maintenance drugs at 1 copay; 35 day supply or 100 doses, whichever is greater, for eligible maintenance drugs at 1 copay. Mail Order: 90 day supply for non-maintenance drugs at 3 copays less \$5.00; 90 day supply of eligible maintenance drugs at 1 copay
	Preferred brand drugs	\$20 copay/prescription (retail)	Not Covered	
	Non-preferred brand drugs	\$40 copay/prescription (retail)	Not Covered	
	Specialty drugs	\$40 copay/prescription (retail)	Not Covered	

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need immediate medical attention	Emergency room services	\$50 copay per visit	\$50 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency Transport Only
	Urgent care	\$20 copay per visit	\$20 copay per visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fee	No Charge	Not Covered	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder outpatient services	\$20 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
If you are pregnant	Prenatal and postnatal care	\$20 copay per visit	Not Covered	No Charge for Prenatal care
	Delivery and all inpatient services	No Charge	Not Covered	Some services require prior authorization.

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	-----None-----
	Rehabilitation services	No Charge	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services- Up to 730 days, renewable after 60 days
	Durable medical equipment	No Charge	Not Covered	Coverage provided for approved equipment based on HAP's guidelines. Some services require prior authorization.
	Hospice service	No Charge	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Eye exam	\$20 copay per visit	Not Covered	No Charge for preventive eye exam
	Glasses	Covered	Not Covered	Coverage for one pair of eye glasses each year. Detailed information regarding coverage of lenses and Collection Frames can be found in your policy or plan documents.
	Dental check up	Not Covered	Not Covered	-----None-----

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-----------------------|--|---|
| - Acupuncture | - Hearing Aids | - Private-Duty Nursing |
| - Chiropractic Care | - Long-Term Care | - Routine Foot Care (Only when meets Plan guidelines) |
| - Cosmetic Surgery | - Non-Emergency Care When Traveling Outside the U.S. | - Vision Hardware (Unless additional rider purchased) |
| - Dental Care (Adult) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---|----------------------------|------------------------|
| - Bariatric Surgery | - Routine Eye Care (Adult) | - Weight Loss Programs |
| - Infertility Treatment (Only when meets Plan guidelines) | | |

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Does this Coverage Provide Minimum Essential Coverage?

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—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

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See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,350
- Patient pays \$190

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$40
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$190

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,720
- Patient pays \$680

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$600
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$680

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AA000752 XR001047

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | Plan Type: HMO

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hap.org or by calling 1-800-422-4641.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,600 person / \$13,200 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, Balance Billed Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Does this plan use a <u>network of providers</u> ?	Yes. See www.hap.org or call 1-800-422-4641 for a list of preferred providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay per visit	Not Covered	-----None-----
	Specialist visit	\$20 copay per visit	Not Covered	-----None-----
	Other practitioner office visit	\$20 PCP Other Practitioner copay per visit/ \$20 Specialist Other Practitioner copay per visit	Not Covered	Chiropractic Care and Acupuncture Not Covered
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org .
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Some services require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org .	Generic Drugs	\$10 copay/prescription (retail)	Not Covered	Applies to all categories below. Retail: 35 day supply for non-maintenance drugs at 1 copay; 35 day supply or 100 doses, whichever is greater, for eligible maintenance drugs at 1 copay. Mail Order: 90 day supply for non-maintenance drugs at 3 copays less \$5.00; 90 day supply of eligible maintenance drugs at 1 copay
	Preferred brand drugs	\$20 copay/prescription (retail)	Not Covered	
	Non-preferred brand drugs	\$40 copay/prescription (retail)	Not Covered	
	Specialty drugs	\$40 copay/prescription (retail)	Not Covered	

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need immediate medical attention	Emergency room services	\$50 copay per visit	\$50 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency Transport Only
	Urgent care	\$20 copay per visit	\$20 copay per visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fee	No Charge	Not Covered	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder outpatient services	\$20 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
If you are pregnant	Prenatal and postnatal care	\$20 copay per visit	Not Covered	No Charge for Prenatal care
	Delivery and all inpatient services	No Charge	Not Covered	Some services require prior authorization.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-800-422-4641 to request a copy.

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	-----None-----
	Rehabilitation services	No Charge	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services- Up to 730 days, renewable after 60 days
	Durable medical equipment	No Charge	Not Covered	Coverage provided for approved equipment based on HAP's guidelines. Some services require prior authorization.
	Hospice service	No Charge	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Eye exam	\$20 copay per visit	Not Covered	No Charge for preventive eye exam
	Glasses	Covered	Not Covered	Coverage for one pair of eye glasses each year. Detailed information regarding coverage of lenses and Collection Frames can be found in your policy or plan documents.
	Dental check up	Not Covered	Not Covered	-----None-----

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-----------------------|--|---|
| - Acupuncture | - Hearing Aids | - Private-Duty Nursing |
| - Chiropractic Care | - Long-Term Care | - Routine Foot Care (Only when meets Plan guidelines) |
| - Cosmetic Surgery | - Non-Emergency Care When Traveling Outside the U.S. | - Vision Hardware (Unless additional rider purchased) |
| - Dental Care (Adult) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---|----------------------------|------------------------|
| - Bariatric Surgery | - Routine Eye Care (Adult) | - Weight Loss Programs |
| - Infertility Treatment (Only when meets Plan guidelines) | | |

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-422-4641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cco.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact HAP at 1-800-422-4641 or visit us at www.hap.org

For more information regarding grievance and appeals, contact the plan at 1-800-422-4641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cco.cms.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Office of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: <http://michigan.gov/difs> or e-mail difs-HICAP@michigan.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,350
- Patient pays \$190

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$40
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$190

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,720
- Patient pays \$680

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$600
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$680

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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October 23, 2015

Ms. Kelley Demiryan
Gallagher Benefit Services Inc.
30150 Telegraph Rd Ste 408
Bingham Farms, MI 48025-5708

Dear Ms. Demiryan,

Thank you for your continued support of Delta Dental. We value our relationship with you and your clients, and we appreciate your business. Please find enclosed a copy of the contract effective January 1, 2016 between Delta Dental and City of Novi, Client Number 1535-0003, 9903.

Please review this contract with your client and return the signed contract to Delta Dental at your earliest convenience. If you have any questions or concerns, please contact me at (248) 489-2064. The signed contract may be sent to my attention at:

Delta Dental
Attn: Karen Campbell
P.O. Box 9085
Farmington Hills, MI 48333-9085

If we are not in receipt of the signed contract by the effective date, we will consider remittance of payment as acceptance of the contract, and we will begin administering the client's dental benefits accordingly. By permitting us to do so, your client accepts the terms of this contract in full and agrees that this contract is binding, even if you do not return a signed copy of the contract to us.

Again, thank you for your business. We look forward to providing your client with the best dental benefits programs and services available.

Sincerely,



Karen Campbell
Account Manager

CC: Mr. Glenn Caldwell



Delta Dental Service Contract For City of Novi

This revised Service Contract ("Contract") is entered into by and between City of Novi (the "Contractor") and Delta Dental Plan of Michigan, Inc., a Michigan non-profit corporation ("Delta Dental"). Delta Dental agrees to perform claims administration services for the Contractor's self-funded dental benefit plan. Contractor and Delta Dental may be singularly referred to herein as "Party" and collectively referred to herein as the "Parties."

This is a legally binding contract between the Contractor and Delta Dental and is effective on January 1, 2016, the ("Effective Date"), replacing any previous declarations, Section I, with the balance of such Contract continued as if fully set forth herein.

SECTION I - DECLARATIONS

The benefits afforded are only with respect to such benefits as are indicated in this Contract, including the Summary of Dental Plan Benefits. Delta Dental's liability is limited to the benefits stated herein; subject to all the terms of this Contract having reference thereto. This Declarations Section and the Summary of Dental Plan Benefits supersedes any contrary provision of the subsequent sections of this Contract.

- A. **Effective Date:** 12:01 A.M. Standard Time, January 1, 2016
- B. **First Renewal Date:** January 1, 2018
- C. **Client Number:** 1535-0003, 9903
- D. **Rate(s):**

Administrative Service Fee: Composite - \$6.99 per month per Subscriber

This rate is contingent upon 100 percent enrollment of the eligible members of the defined group and their eligible dependents with the entire cost of coverage paid by the Contractor. In addition to the Administrative Service Fee, Delta Dental shall invoice Contractor for Cost of Claims for the preceding month on the first (1st) of each month. Payment shall be due on or before the twentieth (20th) of that month. Rates do not include any applicable claims taxes.

These rates are valid only while you are a member of a value purchasing affiliate of the Greater Detroit Area Health Council (GDAH). If you terminate this affiliation, we reserve the right to adjust these rates.

DELTA DENTAL PLAN OF MICHIGAN, INC.

CONTRACTOR

BY:


President and CEO

BY:

(Authorized Signature)

(Title)

BY:

(Witnessed By)

(Title)

DATE: October 23, 2015

DATE: _____

**Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 1535-0003, 9903
City of Novi**

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	75%	75%	75%
Emergency Palliative Treatment – to temporarily relieve pain	75%	75%	75%
Brush Biopsy – to detect oral cancer	75%	75%	75%
Radiographs – X-rays	75%	75%	75%
Basic Services			
Minor Restorative Services – fillings and crown repair	75%	75%	75%
Endodontic Services – root canals	75%	75%	75%
Periodontic Services – to treat gum disease	75%	75%	75%
Oral Surgery Services – extractions and dental surgery	75%	75%	75%
Major Restorative Services – crowns	75%	75%	75%
Other Basic Services – misc. services	75%	75%	75%
Relines and Repairs – to bridges, implants, and dentures	75%	75%	75%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Up to age 19	Up to age 19	Up to age 19

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people up to age 19.

- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,000 per person total per Benefit Year on all services except orthodontics. \$1,500 per person total per lifetime on orthodontic services.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered on the date of hire.

Eligible People – All command officers of the Contractor (0003) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (9903). The Contractor pays the full cost of this plan.

Also eligible at your option are your legal spouse, your dependent children to the end of the calendar year in which they turn 19, and your dependent unmarried children to the end of the calendar year in which they turn 25 if a full-time student and eligible to be claimed by you as a dependent under the U.S. Internal Revenue Code during the current calendar year.

If you and your spouse are both eligible for coverage under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Your dependent children may only be enrolled on one application. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Contract.

Benefits will cease on the last day of the month in which the employee is terminated.

SECTION II - DEFINITIONS

The following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent. Capitalized words and terms not defined below are defined in the Certificate.

ADMINISTRATIVE SERVICE FEE means the fee charged by Delta Dental for the administrative services performed under this Contract.

BENEFITS means payment for Covered Services that have been selected by the Contractor's Dental Plan.

BENEFIT MANAGER TOOLKIT means Delta Dental's online portal used for eligibility updates and Dental Plan information.

CERTIFICATE means the accompanying Certificate and Summary of Dental Plan Benefits, which explain the Benefits of the Contractor's self-funded plan, and which are hereby incorporated by reference.

CLAIM means a request for payment for a Covered Service under the Certificate for Subscriber or Eligible Dependent during the term of this Contract.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CONTRACT means this document and any addendums and exhibits attached hereto, the amendments, the applicable Certificate and endorsements thereto and the materials submitted by the Contractor in applying for coverage, which are hereby incorporated by reference.

COST OF CLAIMS means the total amount of Claims paid by Delta Dental and charged to the Contractor.

COVERED SERVICE means a service or supply covered under Contractor's Dental Plan as set forth in the Certificate.

DENTAL PLAN means the group dental plan established by Contractor.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

PLAN PARTICIPANT means any Subscriber or Eligible Dependents enrolled in the Dental Plan.

SUMMARY OF DENTAL PLAN BENEFITS means a description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of the Certificate, and supersedes any contrary provision of the Certificate.

SECTION III - ERISA

Contractor, or a person designated by Contractor (other than Delta Dental), shall be the Named Fiduciary of the Contractor's Dental Plan as that term is defined by ERISA §402(a)(2). To the extent Contractor has delegated to Delta Dental the responsibility and discretionary authority to make final claims determinations, Delta Dental shall be the named fiduciary with respect to such determinations. Any determination or interpretation made by Delta Dental pursuant to this authority is binding on the Plan Participant and the Contractor unless it is demonstrated that the determination was arbitrary and capricious. In the event final claims determinations are made by any other entity, Delta Dental shall not be a fiduciary with respect to such determinations. Except as otherwise stated herein, Delta Dental shall not have any further discretionary authority or control respecting the management of the Dental Plan or the Dental Plan's assets, if any, and the Contractor retains all responsibility and authority, including all other fiduciary responsibilities, as defined in ERISA, for operation of the Dental Plan.

SECTION IV - PATIENT PROTECTION AND AFFORDABLE CARE ACT

To the extent the Dental Plan is subject to Patient Protection and Affordable Care Act ("PPACA"), the Parties shall mutually agree upon their respective obligations.

Contractor shall be solely responsible for determining and notifying Delta Dental of PPACA's applicability. Contractor shall hold Delta Dental harmless for any failure to comply with Contractor's obligations under this Section.

SECTION V - ELIGIBILITY AND ENROLLMENT

- A. Contractor shall have sole responsibility for determining the eligibility of, and shall manage the enrollment, disenrollment, and contribution obligations of all Plan Participants.
- B. As a condition of enrollment, the Contractor shall require all Plan Participants to provide Delta Dental with all information needed to process claims and administer Benefits. Such information may include, but not be limited to, the Plan Participant's dental records. In the event a Plan Participant fails and/or refuses to provide Delta Dental with requested information, Delta Dental may place the Plan Participant's coverage on hold.
- C. Contractor shall provide Delta Dental with an initial eligibility upload of all Plan Participants. Such eligibility upload shall be in a form and format acceptable to Delta Dental. Thereafter, Contractor shall provide Delta Dental with eligibility updates on an as needed basis, which in no event shall be less than monthly. Contractor shall promptly respond to any requests for information made by Delta Dental concerning the eligibility of a Plan Participant.
- D. Contractor shall be solely responsible for the accuracy and delivery of all eligibility information submitted to Delta Dental. Delta Dental shall not be liable for any losses or damages resulting from eligibility information provided by Contractor and/or any other third party.
- E. No retroactive eligibility updates will be accepted for an effective date more than six months from the date of notification. If the Contractor requests that a Subscriber's eligibility be terminated retroactively and a claim was incurred for that Subscriber or that Subscriber's Eligible Dependent after the requested termination date, the Subscriber's eligibility will continue until the end of the month in which the claim occurred.
- F. Upon reasonable prior written notice, Delta Dental shall have the right to audit the accuracy of Contractor's eligibility information. Contractor's refusal to permit such audit shall be deemed a material breach of this Contract.
- G. Contractor shall be solely responsible for identifying Plan Participants entitled to COBRA continuation benefits. Contractor shall provide all required notices, collect all necessary payments, and otherwise administer all facets of its COBRA program. In the event that Contractor continues to provide eligibility information to Delta Dental for a Plan Participant during the COBRA election period, as opposed to terminating coverage and then retroactively reinstating a Plan Participant upon the Plan Participant's election of COBRA coverage, Contractor shall be liable for any Claim paid during that period if the Plan Participant ultimately does not elect COBRA coverage.

Not all employers are subject to the continuation coverage requirements contained in COBRA. For those that are not, this Section does not apply. Contractor should consult with their legal counsel to determine how and when the law applies.

- H. In the event that a Plan Participant undergoes a change in eligibility, Contractor must notify Delta Dental of such change. Any failure by Contractor to provide timely notice of eligibility changes may result in Benefits being improperly administered. Contractor shall be solely responsible for such failures. Contractor must notify Delta Dental immediately for any change in a Plan

Participant's eligibility. In the event Contractor does not notify Delta Dental immediately, Contractor shall be responsible for any paid Claims.

- I. If the Contractor elects to transmit eligibility information via the Benefit Manager Toolkit, Contractor shall execute all proper authorization forms prior to accessing Delta Dental's systems.
- J. Delta Dental will deliver to the Contractor a Certificate for each Subscriber, unless otherwise agreed to in writing by the Parties.
- K. The Contractor will timely distribute to each of its Subscribers the Certificates and other information provided by Delta Dental regarding the Benefits available under this Contract, unless otherwise agreed to in writing by the Parties.
- L. Delta Dental shall furnish the Contractor with enrollment forms and related informational materials necessary and appropriate to enroll the Contractor's Plan Participants. Delta Dental shall provide reasonable assistance to Contractor on an as needed basis during the enrollment process.
- M. In the event of any material changes in enrollment or composition of Plan Participants or if invoices are not paid as billed, unless otherwise agreed to in writing, Delta Dental shall have the right in its sole discretion to either:
 - 1. Propose an adjustment to the Administrative Service Fee; or
 - 2. Terminate this Contract pursuant to Section X. If the proposed adjustment to the Administrative Service Fee is not accepted by Contractor within 30 days of receipt of the proposed adjustment, Delta Dental reserves the right to terminate this Contract.

SECTION VI - BENEFITS

- A. Delta Dental shall administer and make payment for Benefits in accordance with this Contract and the Certificate attached hereto. Contractor may request changes to the Benefits available to Plan Participants by submitting the request in writing to Delta Dental. Changes to Benefits are subject to Delta Dental's approval and may cause an increase to the Administrative Service Fee. Any changes to Benefits must be agreed to in writing by Delta Dental prior to implementation.

SECTION VII - DELTA DENTAL NETWORK

- A. Delta Dental shall provide Plan Participants with an established network of dentists ("Participating Dentists") who have agreed to accept Delta Dental's Maximum Approved Fees for Covered Services. With exception of Copayments and Deductibles, Participating Dentists shall not charge Plan Participants for any amounts that exceed the Maximum Approved Fee. Delta Dental has complete discretion when setting the Maximum Approved Fees.
- B. Delta Dental shall ensure that there are an adequate number of qualified and credentialed Participating Dentists. All Participating Dentists are required to adhere to Delta Dental credentialing, quality assurance and claims processing policies.
- C. Delta Dental is under no obligation to contract with any particular dentist and/or maintain any particular Participating Dentist in its network. In addition, Delta Dental is under no obligation to recommend or refer any dentist to a Plan Participant.
- D. Contractor acknowledges and agrees that:
 - 1. Delta Dental does not provide, direct, or control the provision of dental services to Plan Participants.

2. All decisions regarding dental services are made solely by the Plan Participant and his or her dentist; and
3. Delta Dental does not guarantee that the dental services received by a Plan Participant from his or her dentist will be rendered in accordance with generally accepted standards or procedures.

SECTION VIII - CLAIMS AND APPEALS

- A. Delta Dental will adjudicate and process all clean Claims submitted for Contractor's Dental Plan, in accordance with this Contract, the Certificate and Delta Dental's standard operating procedures.
- B. Subject to the terms of this Contract, Delta Dental has complete discretion to process Claims received under Contractor's Dental Plan. As such, Delta Dental shall, without limitation, make determinations regarding:
 1. Coordination of benefits.
 2. The applicability of Benefit waiting periods, limitations and exclusions.
 3. The quality of care provided to Plan Participants by a treating dentist; and
 4. The appropriateness and/or necessity of services performed by a treating dentist.
- C. Delta Dental shall provide Pre-Treatment Estimates to Plan Participants and Participating Dentists upon request as set forth in the Certificate. A Pre-Treatment Estimate is a voluntary and optional process where Delta Dental issues a written estimate of Benefits that may be available under the Dental Plan. A Pre-Treatment Estimate is not a prerequisite or condition for approval of future Benefits payment. Receipt of a Pre-Treatment Estimate does not guarantee payment or coverage, and is not a formal adjudication of a Claim. Pre-Treatment Estimates do not assess whether a Plan Participant is specifically eligible for a Covered Service or whether he or she has reached any applicable annual or lifetime maximum payments under the Dental Plan.
- D. Delta Dental will follow established procedures for resolving all adverse Claims determination questions asserted by a dentist, Contractor, or Plan Participant as set forth in the Certificate ("Claims Appeal Procedure"). The Claims Appeal Procedure shall contain processes for appealing initial adverse determinations made by Delta Dental. To the extent the Dental Plan is governed by ERISA, Delta Dental's procedures shall comply with ERISA and any regulations or guidelines thereunder. All determinations made according to the Claims Appeal Procedure will be final and binding on the Participating Dentist, the Contractor, and the Plan Participant; provided, however, that the Plan Participant may exercise any additional legal rights he or she may have.
- E. Payments made directly to a Plan Participant as reimbursement for Covered Services under the Dental Plan are for the personal benefit of such Plan Participant and cannot be transferred or assigned. Delta Dental shall not honor attempts to assign Benefits unless required to by law.
- F. Delta Dental shall use reasonable efforts to recover any overpayments on Contractor's behalf. Delta Dental is under no obligation to engage in litigation in an attempt to recover such payments. Any funds recovered by Delta Dental will be properly credited to Contractor.
- G. Delta Dental does not insure or underwrite risk for Claims submitted on behalf of Plan Participants. The Contractor retains sole responsibility for all Claims paid.

SECTION IX - PAYMENT

- A. The Contractor agrees to reimburse Delta Dental for the actual Cost of Claims and the invoiced Administrative Service Fee as set forth in the Declarations Section of this Contract. Delta Dental

shall not be obligated to accept partial or late payments and acceptance of a partial or late payment will not waive Delta Dental's remedies under this Contract, or otherwise modify the terms herein.

- B. The Contractor shall maintain funds necessary to satisfy its obligations under this Contract.
- C. Payment for Administrative Service Fees shall be due on the fifth of each month. An invoice for the current month's Administrative Service Fees shall be sent on or about the third week of the preceding month.
- D. The Contractor is responsible for the full amount of all invoices regardless of any contribution owed by the Plan Participants to the Contractor. Delta Dental shall not be responsible for collecting any contributions from Plan Participants.
- E. If required by Delta Dental, Contractor shall deposit an amount specified in the Declarations Section of this Contract ("Prefund") with Delta Dental. The Prefund shall serve as a deposit to offset against any untimely or partial payments from Contractor. In the event Delta Dental uses any of the Prefund to offset untimely or partial payments, Delta Dental shall submit an invoice to the Contractor in the amount necessary to replenish the Prefund. If the Contractor fails to timely replenish the Prefund, Delta Dental shall be entitled to all remedies set forth in Section XII.

SECTION X - TERM AND TERMINATION

- A. The term of this Contract shall be as specified in the Declarations Section. Upon completion of the initial term or any subsequent renewal term, Delta Dental shall submit a renewal letter to the Contractor. Such renewal letter shall contain the new term of the Contract as well as any proposed modifications to the terms and conditions contained herein. Execution of the letter or payment to Delta Dental shall constitute acceptance of the renewal terms.
- B. In the event of a Party's material breach, either Party may terminate this Contract following 30 days' advance written notice and opportunity to cure.
- C. This Contract may be terminated by either Party without cause upon 90 days' written notice to the other Party.
- D. There shall be a six month run-out period for all Claims incurred prior to the termination date, except in cases where Delta Dental has terminated this Contract for cause. All Claims paid by Delta Dental during this run-out period shall be invoiced to the Contractor in accordance with Section IX of this Contract. Any Claims for services rendered after the termination date shall be denied. After the conclusion of the six month run out period, Claims shall be denied and Delta Dental shall not have any further obligations to the Contractor.
- E. Following the Claims run-out period, Delta Dental shall prepare a final settlement statement and invoice for Contractor. Such settlement statement and invoice shall detail the final amounts due and owing between the Parties including, to the extent applicable, any remaining Prefund deposited by the Contractor, all outstanding Administrative Service Fees and all remaining Claims payments made during the run-out period.
- F. Any false or misleading statements made by Contractor shall be considered a material breach of this Contract.

SECTION XI - CONFIDENTIALITY AND DISCLOSURE

- A. The Parties have entered into a Business Associate Agreement regarding the permissible use and disclosure of Plan Participant's protected health information as that term is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all subsequent amendments

thereto. The Business Associate Agreement is attached as an Addendum hereto.

- B. The Parties acknowledge that in the course of performing under this Contract each Party may be provided with or given access to information, in oral, recorded or written form, that is proprietary and confidential to the other Party (collectively referred to as the "Confidential Information"). Such Confidential Information includes, but is not limited to: information regarding the other Party's management, business, organizational structure, policies, procedures, business relationships, intellectual property, copyrights, patents, trademarks, software, data, databases, system designs, specifications, documentation, code, architecture, structure, algorithms, techniques, processes, protocols, product materials, notes, slides and ideas.
- C. Confidential Information shall not include any information that:
 - 1. Is already known to the Party at the time of the disclosure (as evidenced by written documentation existing at that time).
 - 2. Is generally available to the public or becomes publicly known through no wrongful act of a Party; or
 - 3. Is received by a Party from a third-party who had a legal right to provide it.
- D. The Parties each will make all reasonable, necessary and appropriate efforts to safeguard each other's Confidential Information. Each Party will safeguard the other's Confidential Information to the same extent that it safeguards information relating to its own business, which in no event will be less than the safeguards that a reasonably prudent business would exercise under similar circumstances.
- E. The Parties each agree not to use, distribute or exploit each other's Confidential Information, in whole or in part, for its own benefit or that of any third party and will not disclose such Confidential Information to any other person, firm or entity without each other's prior written consent. A Party shall be responsible for any breach of this Contract by its employees or authorized subcontractors.
- F. Notwithstanding anything to the contrary in this Section, the Parties shall be permitted to disclose Confidential Information as required by order of a court of law, administrative agency, or other governmental body; provided, however, the Party shall provide reasonable advance written notice to the other Party in order to allow that Party the opportunity to seek a protective order or otherwise limit such disclosure, and the disclosing Party shall reasonably cooperate with the other Party to limit any such disclosure or to seek a protective order.

SECTION XII - RIGHTS AND REMEDIES

- A. In addition to the right of termination described in Section X, Delta Dental shall have the following rights and remedies in the event Contractor fails to timely pay in full any invoice from Delta Dental:
 - 1. Delta Dental may immediately suspend payment of all Claims.
 - 2. Delta Dental may retroactively terminate coverage to the date it last received payment.
 - 3. Delta Dental may retroactively terminate this Contract to the date it last received payment; and
 - 4. Delta Dental may initiate proceedings to recover and collect all payments due and owing, as well as all costs associated with the collection proceedings including, but not limited to, attorneys' fees.

- B. Neither Party shall bring an action, claim or lawsuit against the other without first providing 30 days written notification and an opportunity to cure. In addition, no claim, lawsuit or action, may be brought more than three years after the claim first arose.
- C. Delta Dental's failure to exercise any right or remedy contained herein shall not constitute a waiver of any future rights or remedies available to Delta Dental.

SECTION XIII - GENERAL PROVISIONS

- A. **Subrogation.** The Contractor shall retain all subrogation rights resulting from Claims paid by Delta Dental. In the event the Contractor elects to pursue a subrogation matter, Delta Dental shall provide reasonable assistance to the Contractor. Such assistance shall be limited to providing the Contractor with documents, records and demand letters.
- B. **Right to Review Published Materials.** No materials will be published or distributed by the Contractor concerning this Contract until Delta Dental reviews and approves the materials.
- C. **Cooperation.** The Contractor shall provide Delta Dental with any information it may reasonably require to administer the Dental Plan or otherwise discharge its duties under this Contract.
- D. **Indemnification.**
 - 1. Each Party agrees to defend, indemnify, and hold harmless the other Party and its directors, officers, affiliates, agents, and employees (who are acting in the course of their employment, but not as claimants) from any loss, cost, or expense (including reasonable attorney fees and court costs) ("Losses") resulting from or arising out of or in connection with the indemnifying Party's breach of this Contract, or any negligent act or omission of any of the indemnifying Party's directors, officers, agents or employees, unless liability for such act or omission is expressly assigned elsewhere in this Contract.
 - 2. The indemnifying Party shall provide prompt written notice of relevant information concerning any Losses to the other Party. Reasonable assistance (at the indemnifying Party's expense) may be requested by the other Party in connection with the defense of any Losses. Notwithstanding the foregoing:
 - a. The other Party shall not settle any Losses without the consent of indemnifying Party, which consent shall not be unreasonably withheld, and
 - b. The indemnification obligations of indemnifying Party hereunder shall not extend to Losses attributable solely to the gross negligence, intentional misconduct, or willful malfeasance of the other Party.
- E. **Notice.** Any notice required or permitted to be given under this Contract will be considered given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to the other Party at its last address of record.
- F. **Survival.** The following Sections shall survive expiration or early termination of this Contract: Section IX. Payment; Section XI. Confidentiality & Disclosure; Section XII. Rights and Remedies; and Section XIII. General Provisions.
- G. **Internal Policies and Procedures.** Delta Dental has the right to amend its internal policies and procedures periodically and without notice to the Contractor to the extent the amendment does not affect the delivery of benefits to Plan Participants. Delta Dental will provide advance written notice, to the extent possible, to Contractor of any amendment to Delta Dental's policies or procedures that affect the delivery of benefits to Plan Participants; if advance notice is not possible, Delta Dental will provide written notice as soon as possible after the amendment is adopted.

- H. **Third Party Beneficiaries.** This Contract will not confer any rights or remedies on any third-party, other than the Parties to this Contract and their respective successors and permitted assigns.
- I. **Assignment and Subcontracting.** Unless it has first obtained the written consent of the other Party, neither Party may assign this Contract or any of its rights or obligations under this Contract to any other person, except that Delta Dental may make assignments to its subsidiaries and affiliates without the prior written consent of the Contractor.
- J. **Integration.** This Contract constitutes the entire understanding between the Parties with respect to the subject matter of this Contract and supersedes any prior discussions, negotiations, agreements and understandings.
- K. **Force Majeure.** Neither Delta Dental (including its agents, directors, officers, and employees) nor Contractor shall be liable for delays in performance due to circumstances beyond their reasonable control. Each Party shall be excused from performance under this Contract and shall have no liability to the other Party for any period during which it is prevented from performing any of its obligations (other than payment obligations), in whole or in part, as a result of delays caused by the other Party or by an act of God, war, terrorism, civil unrest, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including failures or fluctuations in electrical power, heat, light, or telecommunications, and such nonperformance shall not be a default under or grounds for termination of this Contract. In the event Contractor is unable to make payment due to circumstances beyond its reasonable control as identified in this Force Majeure section, Delta Dental will accept delayed payment from Contractor within a reasonable period of time. A reasonable period of time shall not exceed 30 days.
- L. **Applicable Law.** This Contract and the obligations of the Parties under this Contract will be governed by and construed in accordance with ERISA to the extent applicable. If it is determined by a court of competent jurisdiction that ERISA does not apply, the law of the State of Michigan will control.
- M. **Venue.** The Parties submit to the jurisdiction and venue of the Circuit Court of Ingham County, State of Michigan, or if original jurisdiction can be established in the United States District Court of Western Michigan.
- N. **Severability.** If any part of this Contract or an amendment of it is found by an arbitrator, court, or other authority to be illegal, void or not enforceable, all other portions of this Contract shall remain in full force and effect.
- O. **Counterparts.** This Contract may be executed in one or more counterparts, each of which will be deemed an original agreement, but all of which will be considered one instrument and will become a binding agreement when one or more counterparts have been signed by each of the Parties and delivered to the other.
- P. **Audits.** To allow the Contractor the right to audit its files, books, and records (both paper and electronic) pertaining to services provided. The Contractor will bear the entire cost of any such audits. The Contractor may assign this right to audit to an agent, provided the agent is a licensed firm and the audit is led by an individual who holds a nationally recognized audit accreditation. Delta Dental will allow the Contractor or the Contractor's agent to audit the work areas at which services under this Contract are performed, within 14 business days of receipt of a fully-signed Authorization, Hold Harmless and Indemnification Agreement. Where applicable, Delta Dental agrees to segregate the Contractor's records from third-party records in order to allow accurate assessment of Contractor-specific processes. Such audits will take place no more than once in a 12-month period, unless both the Contractor and Delta Dental mutually agree that there is reasonable cause to conduct an audit more frequently, in which case the Contractor will give 14 business days' written notice before such audit. During the audit, if claims samples are selected using a financially

stratified methodology, the results will be extrapolated to the entire population of claims during the audit period using a weighted average method for each category.

BUSINESS ASSOCIATE ADDENDUM

THIS BUSINESS ASSOCIATE ADDENDUM ("the ADDENDUM") is an addendum to the most recently executed Agreement between Delta Dental Plan of Michigan, Inc. ("Business Associate") and Contractor ("Covered Entity"). Business Associate and Covered Entity are sometimes collectively referred to herein as the "Parties." This Addendum is effective on the same date as the Contract attached hereto.

I. INTRODUCTION

- A. **WHEREAS**, pursuant to the terms and conditions set forth in the Agreement, Business Associate performs, for or on behalf of Covered Entity, certain services described in the Agreement (the "Services"); and
- B. **WHEREAS**, in performing the Services, Business Associate will receive, create, or access certain Protected Health Information of Participants in Covered Entity's dental plan, and, accordingly, is a business associate as that term is defined in 45 CFR 160.103; and
- C. **WHEREAS**, Covered Entity is a covered entity as that term is defined in 45 CFR 160.103; and
- D. **WHEREAS**, the Parties desire to enter into this Addendum to comply with the provisions in the Privacy Rule requiring a business associate to provide adequate assurances to a covered entity with respect to the confidentiality of PHI.
- E. **NOW, THEREFORE**, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the Parties hereby agree as follows:

II. DEFINITIONS

- A. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR 164.501 and is limited to a group of records maintained by or for Covered Entity that includes: (a) enrollment, payment, and claims adjudication records of an Individual maintained by or for Covered Entity; or (b) other Protected Health Information used, in whole or in part, by or for Covered Entity to make coverage decisions about an Individual.
- B. "Electronic Protected Health Information" or "EPHI" shall have the same meaning as the term "electronic protected health information," at 45 CFR 160.103, and is limited to the electronic protected health information that is created, received, maintained, or transmitted to or on behalf of Covered Entity.
- C. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.
- D. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.
- E. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, found in the American Recovery and Reinvestment Act of 2009 at Division A, Title XIII and Division B, Title IV.
- F. "Individual" shall have the same meaning as the term "individual" in 45 CFR 160.103, and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
- G. "Minimum Necessary" shall have the meaning set forth in the Health Information Technology for Economic and Clinical Health Act, § 13405(b).
- H. "Participant" means any Individual who is eligible for benefits under Covered Entity's dental plan.
- I. "Privacy Rule" means the "Standards for Privacy of Individually Identifiable Health Information," at 45 CFR parts 160 and 164, subparts A and E, as promulgated pursuant to HIPAA.
- J. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR 160.103, and is limited to the information created, received, or accessed by Business Associate from or on behalf of Covered Entity.
- K. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.103.

- L. "Secretary" shall mean the Secretary of the Department of Health and Human Services, or his designee.
- M. "Security Rule" means the "Standards for the Security of Electronic Protected Health Information," at 45 CFR parts 160, 162 and 164, as promulgated pursuant to HIPAA.

III. AGREEMENTS

A. Obligations of Business Associate.

1. **Application of Security Rule and Privacy Rule to Business Associate.** The administrative, physical and technical safeguards set forth in the HIPAA Security Rule at 45 CFR 164.308, 164.310, 164.312, and 164.316, shall apply to Business Associate in the same manner that such sections apply to a covered entity. The additional requirements of Subtitle D of the HITECH Act (Sections 13400 through 13411) that relate to privacy or security and that are made applicable with respect to covered entities shall also be applicable to Business Associate and are hereby incorporated into this Agreement.
2. **Uses and Disclosures.** Business Associate shall not use or further disclose PHI other than (a) as permitted or required by this Agreement and Addendum, (b) as permitted or required by Covered Entity, (c) as permitted or required by the Privacy Rule, (d) as Required by Law, (e) in a manner that would be permissible if used or disclosed by Covered Entity, or (f) in a manner that would not violate the Privacy Rule or other applicable federal or state law or regulation. Business Associate may use and disclose PHI that Business Associate obtains or creates only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR 164.504(e).
3. **Minimum Necessary Standard.** Business Associate shall use and disclose PHI in a manner minimally necessary to accomplish the intended purpose of the use or disclosure.
4. **Security.** Business Associate agrees to: (a) implement safeguards in accordance with the Security Rule that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity; (b) ensure that any agents, including subcontractors, to whom Business Associate provides PHI agree to implement reasonable and appropriate safeguards in accordance with the Security Rule to protect the PHI; and (c) report to Covered Entity any violation of the Security Rule of which it becomes aware.
5. **Reporting and Mitigation of Unauthorized Access, Use or Disclosure of PHI.** Business Associate shall report to Covered Entity any use or disclosure of PHI not provided for under Section III.A.2 of this Addendum of which Business Associate becomes aware. Additionally, Business Associate agrees that, to the extent practicable, it shall mitigate any harmful effect of a use or disclosure of PHI of which it becomes aware that is in violation of the requirements of Section III.A.2 of this Addendum.
6. **Written Notification of Unauthorized Access, Use or Disclosure of Unsecured PHI.** Business Associate shall notify Covered Entity in writing of any unauthorized access, use or disclosure of unsecured PHI as soon as reasonably possible but no later than five (5) days following the date of discovery. Such notice shall include:
 - (a) a brief description of what happened, including the date of the breach and the date of the discovery,
 - (b) the name(s) of the Participant(s) whose PHI was used or disclosed,
 - (c) the identity(ies) of the entity(ies)/person(s) to whom the use or disclosure was made,
 - (d) description of the types of unsecured PHI that were disclosed,
 - (e) the steps taken by Business Associate to discontinue and minimize the impact of any inappropriate use or disclosure.
7. **Agents and Subcontractors.** Business Associate shall ensure that any subcontractors or agents to whom it provides PHI that has been created or received by Business Associate from or on behalf of Covered Entity agree to the same restrictions and conditions with respect to such PHI as are applicable to Business Associate as set forth herein.

8. **Requests for Information or Access.** Business Associate shall process any requests it receives from Individuals seeking access to or copies of PHI maintained by Business Associate for or on behalf of Covered Entity. Covered Entity hereby expressly delegates its authority regarding requests for access to Business Associate and agrees to abide by Business Associate's determinations to grant or deny access in accordance with the Privacy Rule.
 9. **Requests to Amend.** Business Associate shall make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR 164.526 at the request of Covered Entity or an Individual. The Business Associate shall make amendments as soon as administratively feasible.
 10. **Requests for Accounting.** Business Associate agrees to document disclosures of Protected Health Information, and information related to such disclosures, as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528 and any additional regulations promulgated by the Secretary pursuant to HITECH Act § 13405(c). Business Associate agrees to implement an appropriate record keeping process that will track, at a minimum, the following information: (i) the date of the disclosure; (ii) the name of the entity or person who received the Protected Health Information, and if known, the address of such entity or person; (iii) a brief description of the Protected Health Information disclosed; and (iv) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.
 11. **Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary for purposes of determining Covered Entity's compliance with HIPAA, the Privacy Rule, and other applicable federal and/or state law. Business Associate shall notify Covered Entity of any such requests and shall provide Covered Entity with a copy of the request and any documents or information provided in response to such requests.
 12. **Termination.** If either party knows or discovers a pattern of activity or practice of the other party that constitutes a material breach of the other party's obligations under this Agreement or under applicable federal standards, the discovering party agrees to immediately notify the other party in writing as to the nature and extent of such breach, and shall provide the other party a reasonable amount of time to cure such breach. A reasonable amount of time shall depend on the nature and extent of the breach, shall be clearly stated in the notice, but in no case shall the period for cure be less than five (5) business days. Notwithstanding the foregoing, should the discovering party determine that the breach is incurable, or that the other party has repeatedly engaged in such impermissible use or disclosure despite prior notice, the discovering party must terminate this Agreement, if feasible, upon written notice to the breaching party, without damages or liability thereto; or, if termination is not feasible, report the problem to the Secretary.
 13. **Return of PHI Upon Termination.** At termination of the Agreement, Business Associate shall return or destroy all PHI received from Covered Entity, or created by Business Associate on behalf of Covered Entity, that Business Associate maintains in any form. In the event the return or destruction of such PHI is infeasible, then Business Associate shall continue to extend the protections required hereunder to the PHI for as long as it maintains the PHI. Further, Business Associate shall limit any further use or disclosure of the PHI to those purposes that make its return or destruction infeasible. This provision shall survive the termination of this Agreement.
 14. **Prohibition against Sale or Marketing of PHI.** Except as otherwise provided in Section 13405 of the HITECH Act, Business Associate shall not (a) directly or indirectly receive remuneration in exchange for any PHI of a Participant; or (b) use or disclose PHI for any purpose related directly or indirectly to any marketing or marketing communication.
- B. **Additional Permissible Uses and Disclosures of PHI by Business Associate.** Subject to the foregoing provisions, and in addition to the use and disclosure by Business Associate of PHI authorized elsewhere in this Addendum, Business Associate may use and disclose PHI for the following additional purposes:
1. As necessary for data aggregation purposes relating to the health care operations of Covered Entity;
 2. As necessary for data aggregation purposes of Business Associate, but only if the PHI is de-identified pursuant to 45 CFR 164.514;

3. For the proper internal management and administration of Business Associate;
4. To carry out the legal responsibilities of Business Associate; and
5. To provide summary health information (as defined in 45 CFR 164.504) to Covered Entity for the purposes of administering its dental plan.

For purposes (3) and (4) above, Business Associate may disclose PHI to third parties only if the disclosure is either: (a) Required by Law; or (b) Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that such PHI will be held confidentially and used or further disclosed only for the purposes for which it was disclosed to the person and that any instances in which the confidentiality of such PHI is breached are immediately reported to the Business Associate.

C. Obligations of the Covered Entity.

1. **Communicate Changes in Permitted Uses and Disclosures.** Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individuals to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures of PHI.
 2. **Communication of Restrictions on Uses and Disclosures.** Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to.
 3. **Prohibition of Employment-Related Disclosures.** Covered Entity shall not use or disclose the PHI of any Participant for any employment-related purposes, nor shall it direct Business Associate to do so.
 4. **Limitation on Requests.** Covered Entity shall not ask Business Associate to use or disclose PHI in a manner that would not otherwise be permitted under the Privacy Rule if done by Covered Entity.
- D. Record Keeping.** Business Associate agrees to implement an appropriate record keeping process to enable it to comply with the HIPAA requirements applicable to it under this Addendum and the Privacy Rule.
- E. Confidential and Proprietary Information.** Business Associate may receive, create, or have access to confidential and/or proprietary information of Covered Entity concerning its business affairs, property, products, operations, computer systems, and strategies. Business Associate agrees to hold such confidential and/or proprietary information in strict confidence, to maintain and safeguard the confidentiality of such information, and to use such information solely to perform the Services as required by this Agreement.
- Likewise, Covered Entity may receive, create, or have access to confidential and/or proprietary information of Business Associate concerning its business affairs, property, operations, computer systems, dentists, providers, and strategies. Covered Entity agrees to hold such confidential and/or proprietary information in strict confidence, to maintain and safeguard the confidentiality of such information, and to use such information solely to perform its obligations as required by this Agreement.
- F. Amendment.** Upon enactment of any law or regulation affecting the use or disclosure of PHI, or the publication of any decision of a court of the State or the United States relating to any such law, or the publication of any interpretative policy or opinion of any government agency charged with the enforcement of any such law or regulation, Business Associate, may send written notice to Covered Entity requesting that this Addendum be amended as necessary to comply with such law or regulation. If, within thirty (30) days from the date of such notice, the Parties are unable to reach an agreement amending this Addendum, either Party may terminate the Agreement immediately upon written notice to the other Party.
- G. Binding Effect.** Except as otherwise provided herein, the terms and conditions of the Agreement shall remain in full force and effect. Additionally, the terms and conditions of this Addendum shall remain in full force and effect following termination of the Agreement.
- H. Indemnification by Covered Entity.** Covered Entity shall indemnify, defend, and hold harmless Business Associate, its board of directors, officers, members, agents, employees, subcontractors, and personnel from and against any and all claims, demands, suits, actions, losses, expenses, costs (including reasonable attorney fees), obligations, damages, deficiencies, causes of action, and liabilities (collectively, "Claims") incurred by Business Associate as a result of, or that are proximately caused by, (1) Covered Entity's breach of the terms of this agreement or; (2) Covered Entity's violation of HIPAA and any amendments thereto.

Business Associate shall provide prompt written notice of relevant information concerning the Claims to Covered Entity. Business Associate shall provide such reasonable assistance (at Covered Entity's expense) as may reasonably be requested by Covered Entity in connection with the defense of any Claim. Notwithstanding the foregoing: (1) Business Associate shall not settle any such Claim without the consent of Covered Entity, which consent shall not be unreasonably withheld, and (2) the indemnification obligations of Covered Entity hereunder shall not extend to Claims attributable solely to the gross negligence, intentional misconduct, or willful malfeasance of Business Associate.

- I. **Indemnification by Business Associate.** Business Associate hereby agrees to indemnify, defend, and hold harmless Covered Entity, its board of directors, officers, members, agents, employees, subcontractors, and personnel (the "Indemnities") from and against any and all claims, demands, suits, actions, losses, expenses, costs (including reasonable attorney fees), obligations, damages, deficiencies, causes of action, and liabilities (collectively, "Claims") incurred by the Indemnities as a result of, or that are proximately caused by, (1) Business Associate's breach of this Agreement; or (2) Business Associate's violation of HIPAA or any amendments thereto.

Covered Entity shall provide prompt written notice of relevant information concerning the Claims to Business Associate. Covered Entity shall provide such reasonable assistance (at Business Associate's expense), as may reasonably be requested by Business Associate, in connection with the defense of any Claim. Notwithstanding the foregoing: (1) Business Associate shall not settle any such Claim without the consent of Covered Entity, which consent shall not be unreasonably withheld, and (2) the indemnification obligations of Business Associate hereunder shall not extend to Claims attributable solely to the negligence, gross negligence, intentional misconduct, or willful malfeasance of Covered Entity.

- J. **Injunction.** The Parties acknowledge and agree that in the event of a breach or threatened breach by either Party, the non-breaching Party shall be irreparably and substantially harmed, and that remedies at law will not be an adequate remedy for such breach. Accordingly, in such event, non-breaching Party shall be entitled to seek injunctive relief against such breach or threatened breach. Such rights to injunctive relief shall be in addition to, and not in limitation of, any other legal and equitable relief available to either Party under applicable law.
- K. **Counterparts.** This Agreement may be executed in the original or by facsimile or other electronic means in any number of counterparts, each of which shall be deemed an original, and all of which together shall constitute one and the same instrument.



Delta Dental PPOSM

Our national PPO program

Welcome!

Your dental program is administered by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation doing business as Delta Dental of Michigan. Delta Dental of Michigan is the state's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at (800) 524-0149 or access our website at www.DeltaDentalMI.com.

You can easily verify your own benefit, claims and eligibility information online 24 hours a day, seven days a week by visiting www.DeltaDentalMI.com and selecting the link for our Consumer Toolkit. The Consumer Toolkit will also allow you to print claim forms and ID cards, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

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Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to This Plan and you should ignore the conflicting statement in this Certificate.



I. Delta Dental PPO Certificate

Delta Dental Plan of Michigan, Inc., referred to herein as Delta Dental, issues this Certificate to you, the Subscriber. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and your employer or organization.

The Benefits provided under This Plan may change if any state or federal laws change.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.



Laura L. Czelada, CPA
President and CEO
Delta Dental Plan of Michigan, Inc.

II. Definitions

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Benefit Year

The calendar year, unless your employer or organization elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.)

Benefits

Payment for the Covered Services that have been selected under This Plan.

Certificate

This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the contract between Delta Dental and your employer or organization.

Children or Child

Your natural Children, stepchildren, adopted Children, Children by virtue of legal guardianship, or Children who are residing with you during the waiting period for adoption or legal guardianship.

Completion Dates

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed.

Treatment is complete:

- ◆ For dentures and partial dentures, on the delivery dates;
- ◆ For crowns and bridgework, on the permanent cementation date;

- ◆ For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Control Plan (Delta Dental)

Delta Dental acts as the Control Plan for your contract. The Control Plan will provide all claims processing, service, and administration for your group. The Control Plan is referred to as Delta Dental in this document.

Copayment

The percentage of the charge, if any, that you must pay for Covered Services.

Covered Services

The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible

The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental

Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation providing dental benefits. Delta Dental is not an insurance company.

Delta Dental Plan

An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental PPO

Delta Dental's national preferred provider organization program that can reduce your out-of-pocket expenses if you receive care from a Delta Dental PPO Dentist.

Delta Dental Premier®

Delta Dental's national managed fee-for-service dental benefits program.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- ◆ **Delta Dental PPO Dentist ("PPO Dentist")** – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental PPO.
- ◆ **Delta Dental Premier Dentist ("Premier Dentist")** – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental Premier.
- ◆ **Nonparticipating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Plan to participate in Delta Dental PPO or Delta Dental Premier.
- ◆ **Out-of-Country Dentist** – A Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Premier Dentists are sometimes collectively referred to herein as **“Participating Dentists.”** Wherever a definition or provision of this Certificate differs from another state’s Delta Dental Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as **“Non-PPO Dentists.”**

Eligible Dependent(s)

The Summary of Dental Plan Benefits will have specific information about This Plan’s rules for dependent eligibility, but generally, your Eligible Dependents are:

- ◆ Your legal spouse
- ◆ Your unmarried Children who have not yet reached the dependent age limit stated in the Summary of Dental Plan Benefits
- ◆ Your unmarried Children who have reached the dependent age limit stated in the Summary of Dental Plan Benefits, but are eligible to be claimed by you as dependents under the U.S. Internal Revenue Code during the current calendar year
- ◆ Any unmarried Children for whom you or your legal spouse are financially responsible for the medical, health, or dental care under the terms of a court decree or who have been named as alternate recipients under a qualified medical child support order
- ◆ Your Children who have reached the dependent age limit stated in the Summary of Dental Plan Benefits, but who were at that time (and continue to be) totally and permanently disabled by a physical or mental condition. Those Children must also be eligible to be claimed by you or your legal spouse as dependents under the U.S. Internal Revenue Code during the current calendar year. If Delta Dental asks you to do so, you must submit medical reports confirming the Child’s initial or continuing total disability.

Eligible Person(s)

Any Subscriber or Eligible Dependent with coverage under This Plan.

Maximum Approved Fee

A system used by Delta Dental to determine the approved fee for a given procedure for a given Participating Dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

- ◆ The Submitted Amount
- ◆ The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist’s contractual agreement with another dental benefits organization.
- ◆ The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstances, based upon applicable Participating Dentist schedules and internal procedures.

Delta Dental may also approve a fee under unusual circumstances.

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In

all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. (See the Summary of Dental Plan Benefits.)

Nonparticipating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

Open Enrollment Period

The period of time, as determined by your employer or organization, during which an Eligible Person may enroll or be enrolled for Benefits.

Out-of-Country Dentist Fee

The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

Post-Service Claims

Claims for Benefits that are not conditioned on your seeking advance approval, certification, or authorization to receive the full amount for any Covered Services. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for Benefits.

PPO Dentist Schedule

The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist’s local Delta Dental Plan.

Premier Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist’s local Delta Dental Plan.

Pre-Treatment Estimate

A voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan’s limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is

not a claim for Benefits or a preauthorization, precertification or other reservation of future Benefits.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of claims. The Processing Policies may be amended from time to time.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Eligible Dependents for the difference between this amount and the amount Delta Dental approves for the treatment.

Subscriber

You, when your employer or organization notifies Delta Dental that you are eligible to receive Benefits under This Plan.

Summary of Dental Plan Benefits

A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for Eligible Persons pursuant to this Certificate.

III. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental Participating Dentist.

To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at www.DeltaDentalMI.com or call (800) 524-0149.

IV. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 9089, Farmington Hills, Michigan 48333-9089, or calling the toll-free number at (800) 524-0149.
3. After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:
 - a. The Subscriber's full name and address
 - b. The Subscriber's Member ID number
 - c. The name and date of birth of the person receiving dental care
 - d. The group's name and number

Notice of Claim Forms

Delta Dental does not require special claim forms. However, most dental offices have claim forms available. Participating Dentists will fill out and submit your dental claims for you.

Mail claims and completed information requests to:

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

Pre-Treatment Estimate

A Pre-Treatment Estimate is not required to receive payment, but it allows claims to be processed more efficiently and allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Pre-Treatment Estimate Notice before treatment. Once treatment is complete, the dental office will submit a claim to Delta Dental for payment.

Written Notice of Claim and Time of Payment

Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all claims under This Plan are Post-Service Claims. All claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a claim is filed, Delta Dental will decide it within 30 days of receiving it. If there is not enough information to decide your claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) inform you or your Dentist that the information must be received within 45 days or your claim will be denied. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it has 15 days to decide your claim. If you or your Dentist does not supply the requested information, Delta Dental will have no choice but to deny your claim. Once Delta Dental decides your claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see the Claims Appeal Procedure section). You should contact your Human Resources department, call Delta Dental's Customer Service department, toll-free, at (800) 524-0149, or write them at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089, to request a form to designate the person you wish to appoint as your representative. While in some circumstances your Dentist is treated as your authorized representative, generally Delta Dental only recognizes the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate directly with you.

Questions and Assistance

Questions regarding your coverage should be directed to your Human Resources department or call Delta Dental's Customer Service department, toll-free, at (800) 524-0149. You may also write to Delta Dental's Customer Service department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When writing to Delta Dental, please include your name, the group's name and number, the Subscriber's Member ID number, and your daytime telephone number.

V. How Payment is Made

Delta Dental shall make payments for covered services in accordance with the plan selected by your employer or organization. Your Plan will be identified on your Summary of Dental Plan Benefits.

Delta Dental PPO (Point-of-Service)

If your Dentist is a Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

If your Dentist is a Nonparticipating Dentist, Delta Dental will base payment on the Nonparticipating Dentist Fee for Covered Services.

If your Dentist is an Out-of-Country Dentist, Delta Dental will base payment on the Out-of-Country Dentist Fee for Covered Services.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will usually send payment to you, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Delta Dental PPO (Standard)

Whether your Dentist is a PPO Dentist or not, Delta Dental will base its payment on the lesser of the Submitted Amount or the PPO Dentist Schedule.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments or Deductibles. If your Dentist is not a PPO Dentist, but is a Premier Dentist, you will also be responsible for any difference between the PPO Dentist Schedule and the Premier Dentist Schedule for Covered Services, in addition to Copayments or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will usually send payment to you, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

VI. Benefit Categories

Important

A description of various dental services that can be selected for dental benefits is included below. **ONLY the dental services listed in your Summary of Dental Plan Benefits are covered by This Plan.**

Covered Services are also subject to exclusions and limitations. You will want to review this section of this Certificate carefully.

Diagnostic & Preventive

Diagnostic and Preventive Services

Services and procedures to determine your dental health or to prevent or reduce dental disease. These services include examinations, evaluations, prophylaxes (cleanings), space maintainers, and fluoride treatments.

Brush Biopsy

Oral brush biopsy procedure and laboratory analysis used to detect oral cancer. Using this diagnostic procedure, Dentists can identify and treat abnormal cells that could become cancerous, or they can detect the disease in its earliest and most treatable stage.

Radiographs

X-rays as required for routine care or as needed to diagnose the condition of your teeth.

Emergency Palliative Treatment

Emergency treatment to temporarily relieve pain.

Basic Services

Oral Surgery Services

Extractions and dental surgery, including pre-operative and post-operative care.

Endodontic Services

The treatment of teeth with diseased or damaged nerves (for example, root canals).

Periodontic Services

The treatment of diseases of the gums and supporting structures of the teeth, including periodontal maintenance following periodontal therapy (periodontal cleanings).

Relines and Repairs

Relines and repairs to partial dentures and complete dentures, and repairs to bridges.

Restorative Services

Services to rebuild and repair your teeth damaged by disease, decay, fracture, or injury.

Restorative services include:

- ◆ Minor restorative services, such as amalgam (silver) fillings and composite resin (white) fillings.
- ◆ Major restorative services, such as crowns, used when teeth cannot be restored with another filling material.

Major Services

Prosthodontic Services

Services and appliances that replace missing natural teeth (such as bridges, endosteal implants, partial dentures, and complete dentures).

Orthodontic Services

Services, treatment, and procedures to correct malposed or misaligned teeth (such as braces).

Other Benefits

The Summary of Dental Plan Benefits lists any other Benefits that may have been selected.

VII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the same will be your responsibility (though your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible):

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX of the Social Security Act; that is, Medicaid.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services started or appliances started before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, and histopathological examinations.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized techniques.
12. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
13. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental, under the scope of his or her license as permitted by applicable state law.
14. Services or supplies excluded by the policies and procedures of Delta Dental, including the Processing Policies.
15. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
16. Services or supplies received due to an act of war, declared or undeclared.
17. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
18. Services or supplies that are not within the categories of Benefits selected by your employer or organization and that are not covered under the terms of this Certificate.
19. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
20. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
21. Sealants.
22. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
23. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
24. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
25. Veneers.
26. Prefabricated crowns used as final restorations on permanent teeth.
27. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the contract between Delta Dental and your employer or organization.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.
31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.

34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch.
37. Precision attachments and stress breakers.
38. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
39. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
40. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
41. Myofunctional therapy.
42. Mounted case analyses.

Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Eligible Persons for these services or supplies. All charges from Nonparticipating Dentists for the following are your responsibility:

1. The completion of forms or submission of claims.
2. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
3. Local anesthesia.
4. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
5. Infection control.
6. Temporary, interim, or provisional crowns.
7. Gingivectomy as an aid to the placement of a restoration.
8. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
9. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
10. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
11. Post-operative X-rays, when done following any completed service or procedure.
12. Periodontal charting.
13. Pins and preformed posts, when done with core buildups for crowns, onlays, or inlays.
14. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
15. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
16. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
17. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
18. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling and root planing.
19. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
20. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
21. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or, at the request of your group, any dental plan:

1. Bitewing X-rays are payable once per calendar year. Panoramic or full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
2. Any combination of teeth cleanings (prophylaxes, full mouth debridement and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable only once in a lifetime.
3. Oral examinations and evaluations are only payable twice per calendar year, regardless of the Dentist's specialty.
4. Patient screening is payable once per calendar year.
5. Preventive fluoride treatments are payable twice per calendar year for people under age 19.
6. Space maintainers are payable for people under age 14.
7. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth.
8. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture.
9. Individual crowns over implants are payable at the prosthodontic benefit level.
10. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.
11. An occlusal guard is payable once in a lifetime.
12. An interim partial denture is payable only for the replacement of permanent anterior teeth for people under age 17 or during the healing period for people age 17 and over.
13. Prosthodontic Services limitations:
 - a. One complete upper and one complete lower denture are payable once in any five-year period.

- b. A removable partial denture, implant, or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
- c. Fixed bridges and removable partial dentures are not payable for people under age 16.
- d. A relined or the complete replacement of denture base material is payable once in any three-year period per appliance.
- e. Implant removal is payable once per lifetime per tooth or area.
- f. Implant maintenance is payable once per calendar year.

14. Orthodontic Services limitations:

- a. Orthodontic Services are payable for Eligible Persons under age 19.
- b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
- c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.

15. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a claim for those services within one year of the date of service.

16. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each Dentist.

17. Care terminated due to the death of an Eligible Person will be paid to the limit of Delta Dental's liability for the services completed or in progress.

18. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

- a. Plastic, resin, porcelain fused to metal, and porcelain crowns on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.
- b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
- c. Plastic, resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.
- d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.

- e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
- f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
- g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
- h. Stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.

19. Maximum Payment:

- a. The maximum Benefits payable in any one Benefit Year will be limited to the Maximum Payment stated in the Summary of Dental Plan Benefits.
- b. Delta Dental's payment for Orthodontic Services will be limited to the annual or lifetime Maximum Payment stated in the Summary of Dental Plan Benefits.

20. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.

21. Processing Policies may limit Delta Dental's payment for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Eligible Persons for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or, at the request of your group, any dental plan:

- 1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
- 2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
- 3. Recementation of a crown, onlay, inlay, space maintainer, or bridge within six months of the seating date.
- 4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
- 5. Root planing is payable once in any two-year period.
- 6. Periodontal surgery is payable once in any three-year period.
- 7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.

8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including relining or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Processing Policies may limit Delta Dental's payment for services or supplies.

VIII. Coordination of Benefits

Coordination of Benefits ("COB") applies to This Plan when an Eligible Person has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether This Plan's Benefits are determined before or after another plan's benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Which Plan is Primary?

To decide which plan is primary, Delta Dental will consider both the COB provisions of the other plan and the relationship of the Eligible Person to This Plan's Subscriber, as well as other factors. The primary plan is determined by the first of the following rules that applies:

1. Non-coordinating Plan

If you have another plan that does not coordinate benefits, it will always be primary.

2. Employee or Subscriber

The plan that covers the Eligible Person other than as an Eligible Dependent. For example, the plan that covers you as the employee, neither laid off nor retired, or Subscriber is usually primary. However, if the Eligible Person is a Medicare beneficiary, federal law may reverse this order.

3. Children (Parents Divorced or Separated)

If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the Child's health care expenses, Delta Dental follows the birthday rule (see rule 4 below).

If neither of these rules applies, the order will be determined as follows:

- a. First, the plan of the parent with custody of the Child;
- b. Then, the plan of the spouse of the parent with custody of the Child;
- c. Next, the plan of the parent without custody of the Child; and
- d. Last, the plan of the spouse of the parent without custody of the Child.

4. Children and the Birthday Rule

The plan of the parent whose birthday is earliest in the calendar year is always primary for Children. For example, if your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your Children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

5. Laid Off or Retired Employees

The plan that covers the Eligible Person as a laid off or retired employee or as a dependent of a laid off or retired employee.

6. COBRA Coverage

The plan that is provided under a right of continuation pursuant to federal law or a similar state law (that is, COBRA).

7. Other Plans

If none of the rules above determines the order of benefits, the plan that has covered the Eligible Person for the longer period will be primary.

If the other plan does not have rule 5 and/or rule 6 (above) and decides the order of benefits differently from This Plan, This Plan may ignore either of those rules.

In the event that these rules do not determine how Delta Dental should coordinate benefits with another plan, Delta Dental will follow its internal policies and procedures, unless prohibited by applicable law.

How Delta Dental Pays as Primary Plan

When Delta Dental is the primary plan, it will pay for Covered Services as if you had no other coverage.

How Delta Dental Pays as Secondary Plan

When Delta Dental is the secondary plan, it will pay for Covered Services based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan. However, Delta Dental may pay less than it would have paid as the primary plan.

When Benefits are reduced as described above, each Benefit is reduced in proportion. Benefits are then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Delta Dental need not tell or get the consent of any person to do this. Each person claiming Benefits under This Plan must give Delta Dental any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, Delta Dental may pay that amount to the organization that made the payment.

That amount will then be treated as though it were a Benefit paid under This Plan, and Delta Dental will not have to pay

that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If Delta Dental pays more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The people it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

Payment includes the reasonable cash value of any benefits provided in the form of services.

IX. Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your claim, you or your Dentist should contact Delta Dental's Customer Service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, (800) 524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems, or submit an explanation or additional information that might indicate your claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to recheck its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your authorized representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination.

To request a formal review of your claim, send your request in writing to:

**Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916**

Please include your name and address, the Subscriber's Member ID, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the contract between Delta Dental and your employer or organization and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the

information, including any additional information that you have provided, as if he or she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination.

The reviewer will make a determination within 60 days of receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reason(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your claim free of charge. This notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

X. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- ◆ When your employer or organization advises Delta Dental to terminate your coverage.
- ◆ On the first day of the month for which your employer or organization has failed to pay Delta Dental.
- ◆ For fraud or misrepresentation in the submission of any claim.
- ◆ For your Children, when they no longer qualify as an Eligible Dependent.
- ◆ For any other reason stated in the contract between Delta Dental and your employer or organization.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by your employer or organization. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 or comparable, non-preempted state law ("COBRA").

XI. Continuation of Coverage

If your employer or organization is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your dental coverage would otherwise end, you and your Eligible Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Eligible Dependent's coverage would end because:

1. Your employment ends for any reason other than your gross misconduct.
2. Your hours of work are reduced so that you are no longer a full-time employee.
3. You are divorced or legally separated.
4. You die.
5. Your Child is no longer an Eligible Dependent (for example, because he or she turns 19).
6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact your employer or organization to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

XII. General Conditions

Assignment

Services and Benefits are for the personal benefit of Eligible Persons and cannot be transferred or assigned, other than to pay Participating Dentists directly.

Subrogation and Right of Reimbursement

If Delta Dental provides Benefits under this Certificate and you have a right to recover damages from another, Delta Dental is subrogated to that right.

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you or your Eligible Dependent has to recover from another, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions. You or your legal representative must do whatever is necessary to enable Delta Dental to exercise its rights and do nothing to prejudice them.

If you or your Eligible Dependent recovers damages from any party or through any coverage named above, you must reimburse Delta Dental from that recovery to the extent of payments made under This Plan.

Obligation to Assist in Delta Dental's Reimbursement Activities

If you are involved in an automobile accident or require Covered Services that may entitle you to recover from a third party and Delta Dental advances payment to prevent any financial hardship to you or your family, you and your Eligible Dependents have an obligation to help Delta Dental obtain reimbursement for the amount of the payments advanced for which another source was also responsible for making payment. You and your Eligible Dependents are required to provide Delta Dental with any information about any other insurance coverage (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another group health plan), and the identity of any other person or entity, and his or her insurers (if known), that may be obligated to provide payments or benefits for the same Covered Services that Delta Dental already paid.

Eligible Persons must:

1. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
2. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),
3. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
4. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by an Eligible Person to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to that person under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information

While you are an Eligible Person, you agree to provide Delta Dental with any information it needs to process your claims and administer your Benefits. This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Eligible Persons are free to choose any Dentist. Each Dentist maintains the dentist-patient relationship and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment

If an Eligible Person loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by

Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a claim for such has not been received by Delta Dental within one year following the date the services or supplies were completed.

Change of Certificate or Contract

No agent has the authority to change any provisions in this Certificate or the provisions of the contract on which it is based. No changes to this Certificate or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

No action on a legal claim arising out of or related to this Certificate will be brought within 60 days after notice of the legal claim has been given to Delta Dental, unless prohibited by applicable state law. In addition, no action can be brought more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, if longer. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status

You must notify Delta Dental, through your employer or organization, of any event that changes the status of an Eligible Dependent. Events that can affect the status of an Eligible Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law

This Certificate and the underlying group contract will be governed by and interpreted under the laws of the state of Michigan.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to your acts or acts of your Eligible Dependents, it may recover that payment from you or your Eligible Dependents. You and your Eligible Dependents authorize Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Eligible Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Eligible Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

(800) 524-0147



**Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 1535-0003, 9903
City of Novi**

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	75%	75%	75%
Emergency Palliative Treatment – to temporarily relieve pain	75%	75%	75%
Brush Biopsy – to detect oral cancer	75%	75%	75%
Radiographs – X-rays	75%	75%	75%
Basic Services			
Minor Restorative Services – fillings and crown repair	75%	75%	75%
Endodontic Services – root canals	75%	75%	75%
Periodontic Services – to treat gum disease	75%	75%	75%
Oral Surgery Services – extractions and dental surgery	75%	75%	75%
Major Restorative Services – crowns	75%	75%	75%
Other Basic Services – misc. services	75%	75%	75%
Relines and Repairs – to bridges, implants, and dentures	75%	75%	75%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Up to age 19	Up to age 19	Up to age 19

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,000 per person total per Benefit Year on all services except orthodontics. \$1,500 per person total per lifetime on orthodontic services.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered on the date of hire.

Eligible People – All command officers of the Contractor (0003) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (9903). The Contractor pays the full cost of this plan.

Also eligible are your legal spouse, your dependent children to the end of the calendar year in which they attain the age of 19, and your dependent unmarried children who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year.

If you and your spouse are both eligible for coverage under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Your dependent children may only be enrolled on one application. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Contract. Also eligible at your option are your legal spouse, your dependent children to the end of the calendar year in which they turn 19, and your dependent unmarried children to the end of the calendar year in which they turn 25 if a full-time student and eligible to be claimed by you as a dependent under the U.S. Internal Revenue Code during the current calendar year.

Benefits will cease on the last day of the month in which the employee is terminated.

Section 3: What BCBSM Pays For

Temporary Benefits for Out-of-network Hospital Services (continued)

Payable Services (continued)

Payment will be subject to the following provisions:

Inpatient Services

If you require inpatient services from an out-of-area hospital, we will pay up to \$250 per day for the reasonable and necessary cost of travel and lodging up to a maximum of \$5,000 per admission. These maximums apply to the combined expenses for you and the person(s) eligible to accompany you. Our payment will be the lesser of your actual expenses or the \$250 or \$5,000 maximums.

Coverage will begin on the day before your admission and end on your date of discharge. We 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 require outpatient services from an out-of-area hospital or from a physician, we will pay up to \$125 for travel and lodging each time you require these services. Physician services must be directly related to an admission to an out-of-area hospital.

Limitations and Exclusions

- We do not pay for 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.
- We do not pay for travel and lodging beyond the maximums stated above.
- We will not pay for items that we do not consider directly related to travel and lodging, such as: dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, household utilities (including cellular telephones), maids, babysitters or daycare services and entertainment such as cable television, books, magazines, movie rentals or charges for hospital services that are not covered (telephone, television, private room).
- Deductibles, copayments or coinsurances required under your certificate will not apply to travel and lodging.

Remember, your temporary benefits will end **six months** from the date a noncontracted hospital terminated its participating contract with BCBSM.

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Transplant Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For general surgery services, see Page 100.
For oncology clinical trials, see Page 64.

Locations: Kidney, cornea, skin and bone marrow transplants are payable when performed in a **participating** hospital (inpatient or outpatient) or **participating** ambulatory surgery facility. Transplants for specified organs such as heart or liver (complete list on Page 112) are **only** covered when performed in a "designated facility" (see definition on Page 148). Payment for transplants are subject to the conditions described below:

We pay for:

Organ transplants

We pay for services performed to obtain, test, store and transplant the following human tissues and organs:

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

Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

NOTE

The immunization benefit does not apply to cornea and skin transplants.

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

Bone Marrow Transplants

When directly related to two tandem transplants, two single transplants or a single and a tandem transplant per member, per condition, we pay for the following services:

- Allogeneic Transplants
 - Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)

Section 3: What BCBSM Pays For

Transplant Services (continued)

We pay for: (continued)

Bone Marrow Transplants (continued)

Allogeneic Transplants (continued)

- 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.)



Harvesting and storage will be covered if it is not covered by the donor's insurance but only when the recipient of harvested material is a BCBSM member. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.

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

Transplant Services (continued)

We pay for: (continued)

Bone Marrow Transplants (continued)

- 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



A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma. We pay for up to two tandem transplants or a single and a tandem transplant per patient for this condition. Refer to the definition of "Tandem Transplant" in Section 7.

Allogeneic transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute myelogenous leukemia
- Aplastic anemia (acquired or congenital, e.g., Fanconi's anemia or Diamond-Black fan syndrome)
- Beta Thalassemia
- Chronic myeloid leukemia
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Myelodysplastic syndromes
- Neuroblastoma (stage III or IV)

Section 3: What BCBSM Pays For

Transplant Services (continued)

We pay for: (continued)

Bone Marrow Transplants (continued)

Allogeneic transplants are covered to treat the following conditions (continued)

- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency disease
- Wiskott-Aldrich syndrome
- Sickle Cell Anemia (ss or sc)
- Myelofibrosis
- Multiple myeloma
- Primary amyloidosis (AL)
- Glanzmann thrombasthenia
- Paroxysmal nocturnal hemoglobinuria
- Kostmann's syndrome
- Leukocyte adhesion deficiencies
- X-linked lymphoproliferative syndrome
- Primary, secondary and unspecified thrombocytopenia (e.g., megakaryocytic thrombocytopenia)
- Mantle cell lymphoma
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Chronic lymphocytic leukemia
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- Mucopolipidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact
- Renal cell CA
- Plasmacytomas

Transplant Services (continued)

We pay for: (continued)

Bone Marrow Transplants (continued)

Autologous transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Multiple myeloma
- Primitive neuroectodermal tumors
- Ewing's sarcoma
- Medulloblastoma
- Wilms' tumor
- Primary amyloidosis
- Rhabdomyosarcoma
- Mantle cell lymphoma

Additional services for bone marrow transplants:

In addition to the conditions listed above, we will pay for services related to, or for high-dose chemotherapy, total body irradiation, and allogeneic or autologous transplants to treat conditions that are not experimental. This does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

We do not pay the following for bone marrow transplants:

- Services that are not medically necessary (see Section 7 for the definition of medically necessary)
- Services rendered in a facility that does not participate with BCBSM
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Services rendered to 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

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Section 3: What BCBSM Pays For

Transplant Services (continued)

Bone Marrow Transplants (continued)

We do not pay the following for bone marrow transplants: (continued)

- Services rendered 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

When performed in a designated facility (see definition on Page 148), **we pay for** transplantation of the following organs. **We also pay for** the cost of obtaining, preserving and storing human skin, bone, blood, and bone marrow to be used for medically necessary covered services.

- Combined small intestine-liver
- Heart
- Heart-lung(s)
- Liver
- Lobar lung
- Lung(s)
- Pancreas

Transplant Services (continued)

Specified Human Organ Transplants (continued)

- Partial liver
- Kidney-liver
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Multivisceral transplants (as determined by BCBSM)

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

When directly related to the transplant, we pay for:

- Facility and professional services
- Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed. Payment will be based on BCBSM's approved amount.
- Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).
- 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

NOTE

We will pay for any service needed to treat a condition as a direct result of the organ transplant surgery if it is a benefit under any of our certificates.

We also pay for the following:

- Up to \$10,000 for eligible travel and lodging during the initial transplant surgery. This includes:

Section 3: What BCBSM Pays For

Transplant Services (continued)

Specified Human Organ Transplants (continued)

We also pay for the following: (continued)

- 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)



In certain limited cases, we may consider return travel needed for an acute rejection episode to the original transplant facility. The condition must be emergent and must fall within the benefit period. The cost of the travel must still fall under the \$10,000 maximum for travel and lodging.

- 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



We will pay the BCBSM approved amount for the cost of acquiring the organ.

Transplant Services (continued)

Specified Organ Transplants (continued)

Limitations and Exclusions

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

We do not pay for the following for specified human organ transplants:

- Services that are not BCBSM benefits
- Services rendered 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. You must pay for the transplant surgery and related services you receive in a nondesignated facility unless medically necessary and approved by the BCBSM medical director
- Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
- Items that are not considered directly related to travel and lodging (examples include, but are not limited to the following: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitters or daycare services, services provided by family members, reimbursement of food stamps, mail/UPS services, Internet service, and entertainment (such as cable television, books, magazines and movie rentals))
- 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. See the "General Conditions of Your Contract" section for guidelines related to experimental treatment.

Section 3: What BCBSM Pays For

Urgent Care Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

We pay for physician services provided at an urgent care facility.

Section 4: How Providers Are Paid

This section describes how BCBSM pays its providers. This includes physicians and other professional providers and hospitals, facilities and alternative to hospital care providers. Our basic payment policy is illustrated in the chart below and explained in more detail in the pages that follow.

PPO In-network Providers	BCBSM sends payment directly to in-network providers. They accept this payment, which is our approved amount, as payment in full for covered services.
PPO Out-of-Network Providers	<p>Your care is considered out-of-network, unless you have a referral from a PPO network provider. Not all services are covered out-of-network.</p> <p>When using out-of-network providers you will need to find out if the provider is participating or nonparticipating with BCBSM.</p> <p><u>Here's why:</u></p> <ul style="list-style-type: none">• Participating providers — BCBSM sends payment directly to participating providers. They accept BCBSM's approved amount as payment in full.• Nonparticipating physicians and other professional providers — BCBSM sends payment directly to you and you must pay the provider.• Nonparticipating hospitals, facilities and alternative to hospital care providers * — BCBSM does not pay for services received at nonparticipating hospitals except for services to treat accidental injuries or medical emergencies. You will need to pay most of the charges yourself.

* An alternative to hospital may include home health care, home infusion therapy, hospice care, and care in a skilled nursing facility.

This section will help you understand BCBSM's relationship with providers by describing our payment practices when you receive services from:

- **PPO In-network Providers**
- **PPO Out-of-Network Providers**
- **Emergency Services at a Nonparticipating Hospital**
- **Hospital Services that You Must Pay**
- **Out-of-Area Services**
- **BlueCard® PPO Program**
- **Negotiated (non-BlueCard Program) National Account Arrangements**
- **BlueCard Worldwide® Program**

Section 4: How Providers Are Paid

PPO In-network Providers

When you receive covered services from an in-network provider (see definition of "In-network Providers" on Page 153), we will pay our approved amount for covered services directly to the provider. You are responsible only for the deductible, copayments, and coinsurances described in this certificate (see Section 2: "What You Must Pay").

In-Network Providers

Provider Status	Type of Provider	COVERED SERVICES			
		BCBSM Pays		You Pay	
		Amount	Whom	Amount	Whom
PPO In-Network	Professionals, Hospitals and Facilities	BCBSM's approved amount minus what you must pay	Provider*	<u>In-Network</u> <ul style="list-style-type: none"> • Deductible • Coinsurance • Copayments (See Section 2) 	Provider
		NON-COVERED SERVICES			
		You may be billed for:		You may NOT be billed for:	
		<ul style="list-style-type: none"> • Services not covered by your contract. • Services determined by BCBSM to be medically unnecessary or experimental. You may be billed only if: <ul style="list-style-type: none"> – You acknowledge in writing before you receive the service that we will not cover it because it is medically unnecessary or experimental and you agree to receive the service and pay for it, and – The provider gives you an estimate of what the services will cost you. • Your failure to provide the required identifying information in a timely manner for the provider to file a claim**. 		<ul style="list-style-type: none"> • Services that are not covered because BCBSM determined that the provider lacked the appropriate credentials or privileges needed to perform the service, or the provider failed to comply with BCBSM policies when rendering the services. • An overpayment made to the provider which BCBSM later requires the provider to repay to BCBSM. • Balances in excess of our approved amounts. 	

* If you need to know what providers are paid directly, call us at one of the numbers listed in Section 8: "How to Reach Us".

** A provider may bill you only if a claim was submitted within three months after the provider obtained the necessary information. BCBSM may deny a claim from a participating provider that was submitted more than two years after the service because you did not furnish needed information.

Section 4: How Providers Are Paid

PPO Out-of-Network Providers

When you receive covered services from an out-of-network provider, BCBSM's payment to the provider and your payment responsibilities will be determined by whether the provider is participating or nonparticipating with BCBSM.

Out-of-Network Participating Providers

Provider Status	Type of Provider	COVERED SERVICES			
		BCBSM Pays		You Pay	
		Amount	Whom	Amount	Whom
Out-of-Network Participating Provider	Professionals, Hospitals and Facilities	BCBSM's approved amount minus what you must pay	Provider	<u>Out-of-Network</u> <ul style="list-style-type: none"> • Deductible • Coinsurance • Copayments (see Section 2) <p>Out-of-network deductibles, coinsurances and copayments are not applied to:</p> <ul style="list-style-type: none"> • 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" by BCBSM for that particular provider specialty 	Provider

In limited instances, out-of-network deductible, copayment, and coinsurance requirements may not be imposed 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. You may contact BCBSM for information regarding these professional services.
- 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.



While the out-of-network deductible, copayment and coinsurance requirements may not be imposed, covered services will be subject to applicable in-network deductible (if any), copayment and coinsurance requirements.

If you need to know when your out-of-network cost share will not be imposed, call us at one of the numbers listed in Section 8: "How to Reach Us".

Section 4: How Providers Are Paid

Out-of-Network Participating Providers (continued)

If you receive services from an out-of-network provider, BCBSM's payment to the provider and your payment responsibilities will be determined by the out-of-network provider's participation or nonparticipation status with BCBSM, as explained on the following pages.

When Out-of-Network Participating Providers May or May Not Bill You

Provider Status	Type of Provider	NON-COVERED SERVICES	
		You may be billed for:	You may NOT be billed for:
Out-of-Network Participating Provider	Professionals Hospitals and Facilities	<ul style="list-style-type: none">• Services not covered by your contract.• Services determined by BCBSM to be medically unnecessary or experimental. You may be billed only if:<ul style="list-style-type: none">– You acknowledge in writing before you receive the service that we will not cover it because it is medically unnecessary or experimental and you agree to receive the service and pay for it, and– The provider gives you an estimate of what the services will cost you.• Your failure to provide the required identifying information in a timely manner for the provider to file a claim.*	<ul style="list-style-type: none">• Services that are not covered because BCBSM determined that the provider lacked the appropriate credentials or privileges needed to perform the service, or the provider failed to comply with BCBSM policies when rendering the services.• An overpayment made to the provider which BCBSM later requires the provider to repay to BCBSM.• A balance in excess of our approved amount

* A provider may bill you only if a claim was submitted within three months after the provider obtained the necessary information. BCBSM may deny a claim from a participating provider that was submitted more than two years after the service because you did not furnish needed information.

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Out-of-Network Providers (continued)**Nonparticipating Physicians and Other Providers**Out-of-Network Nonparticipating Providers

If the out-of-network provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. After paying the provider, you should submit a claim to us. If we approve the claim, we will send payment to the member.

Out-of-Network Nonparticipating Providers

Provider Status	Type of Provider	COVERED SERVICES			
		BCBSM Pays		You Pay	
		Amount	Whom	Amount	Whom
Out-of-Network Nonparticipating Provider*	Professional	BCBSM's approved amount minus what you must pay	Member	<u>Out-of-Network</u> <ul style="list-style-type: none"> • Deductible • Coinsurance • Copayments AND The difference between BCBSM's approved amount and the amount charged by the nonparticipating provider	Provider
	Hospital and Facilities	<ul style="list-style-type: none"> • Coverage is limited to treatment an accidental injury or medical emergency BCBSM's payment for these services is limited (see Page 109)	Member	<u>In-Network</u> <ul style="list-style-type: none"> • Deductible • Coinsurance • Copayments AND The difference between BCBSM's payment and the amount charged by the nonparticipating provider	Provider

To receive payment for covered services provided by a nonparticipating provider, you will need to send us a claim. Call your customer service representative (see Section 8: "How to Reach Us") for information on filing claims.

* Nonparticipating professional providers, except independent physical therapists, certified nurse practitioners, independent occupational therapists, independent speech-language pathologists and audiologists, may agree to participate on a per claim basis. This means that they will accept the approved amount (less applicable deductible, copayments and coinsurances) as payment in full for a

Section 4: How Providers Are Paid

specific service. The provider will submit a claim to us and we will send payment to the nonparticipating provider.

Out-of-Network Providers (continued)

Nonparticipating Hospitals, Facilities and Alternative to Hospital Care Providers (continued)

BCBSM does not pay for services at nonparticipating:

- Outpatient physical therapy facilities
- Mental health or substance abuse treatment facilities
- Freestanding ambulatory surgery facilities
- Freestanding ESRD facilities
- Home health care agencies
- Hospice programs
- Long-term Acute Care Hospitals
- Skilled nursing facilities, or
- Ambulatory infusion centers.

If you need to know if a provider participates, ask your doctor, the provider's admitting staff, or call us. (Use the numbers listed in Section 8: "How to Reach Us".)

BlueCard® PPO Program

We participate with other Blue Cross and/or Blue Shield plans in the BlueCard PPO Program. This Program offers members of Blue Cross and/or Blue Shield plans medical benefits when they receive health care from BlueCard PPO providers outside the area their local plan services. When you receive covered services in the area served by a Host Plan, we will pay for covered services. However, the Host Plan is responsible for contracting with and generally handling all interactions with its participating providers.

BlueCard PPO Network Providers

If you receive covered services from an out-of-area PPO network provider:

- The provider will file your claim with the Host Plan
- The Host Plan will pay the provider and **not** reduce its payment by the amount specified under this certificate for services provided by an out-of-network provider.

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BlueCard PPO Program (continued)

Network status is not based on provider participation with BCBSM but with the plan where the services are rendered.

When you receive covered services outside our service area and the claim is processed through the BlueCard Program, your deductible, copayment and coinsurance will be based on the lower of:

- The billed charges for your covered services; or
- The negotiated price that the Host Plan makes available to us.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your provider. Sometimes it is an estimated price that takes into account special arrangements with your provider or provider group that may include settlements, incentive payments, and/or other credits or charges. Occasionally it may be an average price based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in other states may require the Host Plan to add a surcharge to your claim. If any state laws mandate other liability calculation methods, including a surcharge, we will calculate your liability for any covered services according to applicable law.

BlueCard PPO Out-of-Network Providers

If the provider is not a PPO network provider, we will notify the Host Plan to reduce its payment to the amount specified under this certificate for services provided by an out-of-network provider, unless:

- You were referred to that provider by a PPO network provider (You must obtain the referral before receiving the referred service or the service will be subject to the out-of-network deductible requirements) or
- You needed care for an accidental injury or a medical emergency (see Emergency Services, Page 41).

BlueCard PPO providers may not be available in some areas. In areas where they are not available, you can still receive BlueCard PPO benefits if you receive services from a BlueCard participating provider. The Host Plan must notify BCBSM of the provider's status.

Section 4: How Providers Are Paid

BlueCard PPO Program (continued)

Nonparticipating Providers Outside Our Service Area

An out-of-area provider that does not participate with BCBSM or the local Host Plan may require you to pay for services at the time they are provided. If so:

- Submit an itemized statement to us for the services. Call your customer service representative (see Section 8) for information on filing claims.
- We will pay you the amount specified under this certificate for covered services provided by a nonparticipating provider. (We do not pay for services of nonparticipating facility providers listed on Page 122 and provide very limited coverage for services of nonparticipating hospitals.)

In all cases, you are also responsible for the out-of-network deductible, copayment and/or coinsurance required under this certificate.

To find out if an out of area provider is a BlueCard or BCBSM PPO provider please call 1-800-810-BLUE (2583).

You may also visit the BlueCard Doctor and Hospital Finder website at www.bcbs.com for a listing of participating providers.

Subscriber Liability Calculation

When covered services are provided outside of our service area by nonparticipating providers, the amount you pay for such services will generally be based on either the Host Plan's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the covered services as set forth in this paragraph.

Exceptions:

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the services had been obtained within our service area, or a special negotiated payment, as permitted under interplan programs policies, to determine the amount we will pay for services rendered by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered services as set forth in this paragraph.

Specialty Providers in the BlueCard Program

The Host Plan can pay provider specialties recognized within the Host Plan's area (even if BCBSM does not contract with the particular provider specialty). If the Host Plan contracts with a provider specialty and the services being performed by this provider are covered under the terms of the BCBSM policy, then this provider's services can be paid.

BlueCard PPO Program (continued)

BlueCard PPO Program Exceptions

The BlueCard PPO Program will not apply if:

- The services are not a benefit under this certificate
- This certificate excludes coverage for services performed outside of Michigan
- The Blue Cross and/or Blue Shield plan does not participate in the BlueCard PPO Program
- You require the services of a provider whose specialty is not part of the BlueCard PPO Program or
- The services are performed by a vendor or provider who has a contract with BCBSM for those services.

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered services may be processed through a negotiated national account arrangement with a Host Plan.

The amount you pay for covered services under this arrangement will be calculated based on the negotiated price or lower of either the billed charges or negotiated price made available to us by the Host Plan.

BlueCard Worldwide® Program

The BlueCard Worldwide Program assists BCBSM members traveling or living outside of the United States in obtaining medical care services; provides access to a worldwide network of health care providers; and includes claims support services.



A PPO network is not available outside the United States.

In this BlueCard Worldwide Program section, when we refer to participating or nonparticipating hospitals or physicians, we mean participating or nonparticipating in the BlueCard Worldwide Program.

Medical Assistance Services

If subscribers need medical services while traveling or living outside of the United States, they are responsible for contacting the BlueCard Worldwide Service Center at 1-800-810-BLUE (or call collect at 804-673-1177 if they are calling from outside the United States) to assist them with information on participating hospitals and physicians and by providing medical assistance services. Failure to contact the BlueCard Worldwide Service Center could result in payment reductions or non-payment of services.

Section 4: How Providers Are Paid

BlueCard Worldwide Program (continued)

Coverage for BlueCard Worldwide Participating Hospitals

Inpatient Hospital Services

- Subscribers are responsible for calling the BlueCard Worldwide Service Center to arrange cashless access with a participating hospital if an inpatient admission is necessary. Cashless access means that the subscriber is only required to pay applicable in-network deductible(s) and copayment(s) at the time of the admission for all covered services. The hospital will file the claim for the subscriber.
- Subscribers are responsible for in-network deductible(s), copayment(s) and coinsurances.
- Subscribers are responsible for the payment of noncovered services.
- Providers are responsible for contacting BCBSM for preauthorization. Call the customer service number listed on the back of your BCBSM ID card.

Outpatient Hospital Services

- Subscribers are responsible for payment of all outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Coverage for Nonparticipating Hospitals

Inpatient Hospital Services

- If subscribers are admitted to a nonparticipating hospital, they are responsible for calling the BlueCard Worldwide Service Center to try to arrange a referral for cashless access and approval from BCBSM. Cashless access means that the subscriber is only required to pay applicable out-of-network deductible(s) and copayment(s) at the time of the admission for all covered services. If approved, the claim will be considered a participating provider payable claim. The hospital will file the claim for the subscriber.
- If cashless access is arranged, the subscriber will be responsible for the out-of-network deductible(s) and copayment(s) and non-covered services.
- A subscriber who does not contact the Service Center to arrange cashless access and approval from BCBSM may be responsible for paying the entire admission.

BlueCard Worldwide Program (continued)

Outpatient Hospital Services

- Subscribers are responsible for payment of all outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Emergency Services at Participating or Nonparticipating Hospitals

- In the case of an emergency, subscribers are advised to go to the nearest hospital.
- If hospitalized, subscribers are advised to follow the process for inpatient hospital services.
- If subscribers are not hospitalized, they are responsible for payment of all professional and outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

BlueCard Worldwide Professional Services

- Subscribers are responsible for payment of all professional services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Section 5: General Services We Do Not Pay For

We do not pay for services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan.

The services listed in this section are in addition to all other **nonpayable** services stated in this certificate.

Noncontractual services described in your case management treatment plan when such services have not been approved by BCBSM

- **Elective Abortions:** Services, devices, drugs or other substances provided by any provider in any location that are intended to terminate a woman's pregnancy for a purpose other than to: increase the probability of a live birth; preserve the life or health of the child after a live birth; or remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman. Any service, device, drug or other substance related to an elective abortion is also excluded.



Elective abortions do not include: a prescription drug or device intended as a contraceptive; services, devices, drugs or other substances provided by a physician to terminate a woman's pregnancy because her physical condition, in the physician's reasonable medical judgment, requires that her pregnancy be terminated to avert her death; and treatment of a woman experiencing a miscarriage or who has been diagnosed with an ectopic pregnancy.

Hospital admissions that we do not pay for:

- Those for care that is not considered acute, such as:
 - Observation
 - Diagnostic evaluations
 - Dental treatment, including extraction of teeth, except as otherwise noted in this certificate
 - Lab exams
 - Electrocardiography
 - Weight reduction
 - X-ray, exams or therapy
 - Cobalt or ultrasound studies
 - Basal metabolism tests
 - Convalescence, rest care or convenience
- Those mainly for physical therapy, speech and language pathology services or occupational therapy
- Services that may be medically necessary but can be provided safely in an outpatient or office location
- Custodial care or rest therapy
- Psychological tests if used as part of, or in connection with, vocational guidance training or counseling
- Outpatient inhalation therapy
- Sports medicine, patient education or home exercise programs

General Services We Do Not Pay For (continued)

Alternative facility services that we do not pay for:

- We do not pay for any facility services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution.



If a nursing home is your primary residence, then we 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.

Professional provider services that we do not pay for:

- Services, care, supplies or devices not prescribed by a physician
- Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or children
- Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed on Page 101
- Weight loss programs
- Services provided during nonemergency medical transport
- Experimental treatment
- Hearing aids or services to examine, prepare, fit or obtain hearing aids
- Health care services provided by persons who are not eligible for payment or appropriately credentialed or privileged (as determined by BCBSM) or providers who are not legally authorized or licensed to order or provide such services



If BCBSM has not credentialed or privileged a participating/PPO in-network provider to perform a service, the provider will be financially responsible for the entire cost of the service and cannot bill you for it. This includes the charge for the service and any copayments, deductibles or other cost-sharing amounts. If you receive services from a nonparticipating/ out-of-network provider who is not credentialed or privileged to perform a service, you will have to pay for the entire cost of the service.

Section 6: General Conditions Of Your Contract

Professional provider services that we do not pay for: (continued)

- Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
- Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)
- Infertility services that do not treat a medical condition other than infertility. This can include services such as:
 - Sperm washing
 - Post-coital test
 - Monitoring of ovarian response to ovulatory stimulants
 - In vitro fertilization
 - Ovarian wedge resection or ovarian drilling
 - Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
 - Diagnostic studies done for the sole purpose of infertility assessment
 - Any procedure done to enhance reproductive capacity or fertility

NOTE

You or your physician can call us to determine if other proposed services are a covered benefit under your certificate.

- Sports medicine, patient education (except as otherwise specified) or home exercise programs
- Screening services (except as otherwise stated)
- 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

NOTE

If a nursing home is your primary residence, then we 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.

Section 6: General Conditions of Your Contract

This section lists and explains certain general conditions that apply to your contract. These conditions may make a difference in how, where and when benefits are available to you.

Assignment

The services provided under this certificate are for your personal benefit and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all your rights under it. No right to payment from us, claim or cause of action against us may be assigned by you to any provider. We will not pay any provider except under the terms of this contract.

Care and Services That are Not Payable

We do not pay for the following care and services:

- Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under this certificate
- Those available in a hospital maintained by the state or federal government, unless payment is required by law
- Those payable by government-sponsored health care programs, such as Medicare, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal laws require the government-sponsored program to be secondary to this coverage.
- Any services not listed in this certificate as being payable

Changes in Your Family

We must be notified by your group of any changes in your family. This requires you to complete an enrollment/change of status form with your group. Any coverage changes will then take effect as of the date of the event. Changes include marriage, divorce, birth, death, adoption, or the start of military service. An enrollment/change of status form should be completed when you have a change of address.

Changes to Your Certificate

BCBSM employees, agents or representatives cannot agree to change or add to the benefits described in this certificate.

- Any changes must be in writing and approved by BCBSM and the Director of the Michigan Department of Insurance and Financial Services.
- We may add, limit, delete or clarify benefits by issuing a rider. Keep any riders you receive with this certificate.

Section 6: General Conditions Of Your Contract

Claim Forms

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Coordination of Benefits

We will coordinate the benefits payable under this certificate pursuant to the Coordination of Benefits Act, Public Act No. 64 of 1984 (starting at MCLA 550.251). To the extent that the services covered under this certificate are also covered and payable under another group health care plan, we will combine our payment with that of the other plan to pay the maximum amount we would routinely pay for the covered services.

Coverage for Drugs and Devices

We do not pay for any drug or device prescribed for uses or in dosages other than those specifically approved by the Federal Food and Drug Administration. (This is often referred to as the off-label use of a drug or device.) However, we will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescribing M.D. or D.O. can substantiate that the drug is recognized for treatment of the condition for which it is prescribed by one of the following:

- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

NOTE

Chemotherapeutic drugs are not subject to this general condition.

Deductibles, Coinsurance and Copayments Paid Under Other Certificates

We do not pay deductibles, coinsurance or copayments that you were required to pay under any other certificate subject to coordination of benefits requirements.

Entire Contract; Changes

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Experimental Treatment

Services That Are Not Payable

We do not pay for experimental treatment (including experimental drugs or devices) or services related to experimental treatment, except as explained under "Clinical Trials (Routine Patient Costs)", "Oncology Clinical Trials" in Section 3 and "Services That Are Payable" below. In addition, we do not pay for administrative costs related to experimental treatment or for research management.



This certificate does not limit or preclude the use of chemotherapeutic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

How BCBSM Determines If a Treatment Is Experimental

If a treatment, including items and services, is not covered under "Clinical Trials (Routine Patient Costs)" or "Oncology Clinical Trials" in Section 3, BCBSM's medical director will determine whether it is experimental. For example, a treatment, item or service may be determined to be experimental when:

- Medical literature or clinical experience is inconclusive as to whether the service is safe or effective for treatment of any condition, or
- It has been shown to be safe and effective treatment for some conditions, but there is inadequate medical literature or clinical experience to support its use in treating the patient's condition, or
- Medical literature or clinical experience has shown the service to be unsafe or ineffective for treatment of any condition, or
- There is a written experimental or investigational plan by the attending provider or another provider studying the same service, or
- It is being studied in an on-going clinical trial, or
- There is a written informed consent used by the treating provider in which the service is referred to as experimental or investigational or other than conventional or standard treatment.



The medical director may consider other factors.

When available, the following sources will be considered in evaluating whether a treatment is experimental under the above criteria:

- Scientific data, such as controlled studies in peer-reviewed journals or medical literature
- Information from the Blue Cross and Blue Shield Association or other local or national bodies
- Information from independent, nongovernmental, technology assessment and medical review organizations

Section 6: General Conditions Of Your Contract

Experimental Treatment (continued)

- Information from local and national medical societies, other appropriate professional societies, organizations, committees or governmental bodies
- Approval, when applicable, by the Federal Food and Drug Administration (FDA), the Office of Health Technology Assessment (OHTA) and other governmental agencies
- Accepted national standards of practice in the medical profession
- Approval by the Institutional Review Board of the hospital or medical center

NOTE

The medical director may consider other sources.

Services That Are Payable

We do pay for experimental treatment and services related to experimental treatment when all of the following are met:

- BCBSM considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).
- The treatment is covered under your certificates when it is provided as conventional treatment.
- The services related to the experimental treatment are covered under your certificates when they are related to conventional treatment.
- The experimental treatment and related services are provided during a BCBSM-approved oncology clinical trial (check with your provider to determine whether a clinical trial is approved by BCBSM) or the related items or services are routine patient costs that are covered under "Clinical Trials (Routine Patient Costs)" in Section 3.

NOTE

This certificate does not limit or preclude the use of chemotherapeutic off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Limitations and Exclusions

- This section of your certificate does not provide coverage for services not otherwise covered under your certificates.
- Drugs or devices provided to you during a BCBSM-approved oncology clinical trial will be covered only if they have been approved by the FDA, regardless of whether the approval is for treatment of the member's condition, and to the extent they are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.

Grace Period

A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

Illness or Injuries Resulting from War

Services are not payable for the treatment of illness or injuries resulting from declared or undeclared military acts of war.

Improper Use of Contract

If you allow any ineligible person to receive benefits (or try to receive benefits) under your contract, we may:

- Refuse to pay benefits
- Cancel your contract
- Begin legal action against you
- Refuse to cover your health care services at a later date

Individual Coverage

If you choose not to enroll in COBRA, or if your COBRA coverage period ends, coverage may be available through a BCBSM individual plan. Contact BCBSM Customer Service for information about what plan best meets your needs.

Notice of Claim

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Notification

When we need to notify you, we mail the notice to you or remitting agent or to your most recent address we have in our records, as applicable. This fulfills our obligation to notify you.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation.

Payment of Covered Services

The covered services described in this certificate, such as multiple surgeries or a series of services such as laboratory tests, are combined and paid according to payment policies adopted by BCBSM.

Section 6: General Conditions Of Your Contract

Personal Costs

We will not pay for:

- Transportation and travel, even if prescribed by a physician, except as provided in this certificate
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

Pharmacy Fraud, Waste, and Abuse

We do not pay for the following:

- Prescription drugs that are not medically necessary; may cause significant patient harm; or are not appropriate for the patient's documented medical condition;
- Drugs prescribed by a prescriber who is sanctioned at the time the prescription is dispensed.



Sanctioned prescribers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

BCBSM will notify you if any prescriber you have received services from during the previous 12 months has been sanctioned. You will be given 30 days notice, after which we will not pay for prescriptions written by the sanctioned prescriber.

Physician of Choice

You may continue to receive services from the physician of your choice. However, you should receive services from an in-network physician in order to avoid out-of-network costs to you.

Proofs of Loss

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

A handwritten signature in black ink, located at the bottom right of the page.

Refunds of Premium

If we determine that we must refund a premium, we will refund up to a maximum of two years of payments.

Reinstatement

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: Provided, however, That if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Release of Information

You agree to permit providers to release information to us. This can include medical records and claims information related to services you may receive or have received.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

Reliance on Verbal Communications

Verbal verification of a member's eligibility for coverage or availability of benefits is not a guarantee of payment of claims. All claims are subject to a review of the diagnosis reported, medical necessity verification, and the availability of benefits at the time the claim is processed, as well as to the conditions, limitations, exclusions, maximums, deductibles and copayments under your coverage.

Right to Interpret Contract

During claims processing and internal grievances, BCBSM reserves the right to interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances are subject to your right to appeal under applicable law.

Semiprivate Room Availability

If a semiprivate room is not available when you are admitted to a participating hospital, you may be placed in a room with more than two beds. When a semiprivate room is available, you will be placed in it. You may select a private room; however, you will be responsible for any additional cost. BCBSM will not pay the difference between the cost of hospital rooms covered by your certificate and more expensive rooms.

Section 6: General Conditions Of Your Contract

Services Before Coverage Begins or After Coverage Ends

Unless otherwise stated in this certificate, we will not pay for any services, treatment, care or supplies provided before your coverage under this certificate becomes effective or after your coverage ends. If your coverage begins or ends while you are an inpatient at an acute care hospital, our payment will be based on the hospital's contract with us. Our payment may cover:

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

Our payment will cover only the services, treatment, care or supplies you receive while your coverage is in effect if your coverage begins or ends while you are:

- An inpatient in a facility such as: hospice, long-term acute care facility, rehabilitation hospital, psychiatric hospital, skilled nursing facility or other facility identified by BCBSM, or
- Under a course of treatment for an episode of illness from a home health agency, ESRD facility or outpatient hospital physical/occupational/speech therapy unit or other facility identified by BCBSM.

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

Subscriber Liability

At the discretion of your provider, certain technical enhancements may be employed to complement a medical procedure. These enhancements may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered by this certificate. Your provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

Time Limit for Filing Claims

We will not pay for claims for drugs that are not filed within the following time limits from the date of service:

- 60 days for pay-provider claims
- One year for pay-subscriber claims

Time Limit for Legal Action

Legal action against us may not begin later than three years after we have received a complete claim for services. No action or lawsuit may be started until 30 days after you notify us that our decision under the claim review procedure is unacceptable.

Time Limit on Certain Defenses

- After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2-year period.
- No claim for loss incurred or disability commencing after 2 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

Time of Payment of Claims

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

Unlicensed and Unauthorized Providers

Benefits are not payable for health care services provided by persons who are not appropriately credentialed or privileged (as determined by BCBSM), or legally authorized or licensed to order or provide such services.

What Laws Apply

This certificate will be interpreted under the laws of the state of Michigan and federal law where applicable.

When Others are Responsible for Illness or Injury (Subrogation)

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we paid benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

Section 6: General Conditions Of Your Contract

When Others are Responsible for Illness or Injury (continued)

- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

NOTE

We will pay the costs of any covered services you receive that are in excess of any recoveries made.

Our rights of recovery and subrogation as described in this Section may be enforced by BCBSM or by any Local Plan that administered the benefits paid in connection with the injury or illness at issue, or by any combination of these entities.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When a third party injures you, for example, through medical malpractice;
- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
 - Medical reimbursement coverage

Contact us if you need more information about subrogation.

Workers Compensation

We do not pay for the treatment of work-related injuries covered by workers compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by an employer.

Section 7: Definitions

This section explains the terms used in your certificate. The terms are listed in alphabetical order.

Accidental Injury

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
- Attempted suicide
- A dental accidental injury occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

Acute Care

Medical care that requires a wide range of medical, surgical, obstetrical and/or pediatric services. It generally requires a hospital stay of less than 30 days.

Acute Care Facility

A facility that provides acute care. This facility primarily treats patients with conditions that require a hospital stay of less than 30 days. The facility is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care
- Care of the aged or substance abusers
- Skilled nursing or other nursing care

Administrative Costs

Costs incurred by the organization sponsoring an approved oncology clinical trial. They may include, but are not limited to, the costs of gathering data, conducting statistical studies, meeting regulatory or contractual requirements, attending meetings or travel.

Affiliate Cancer Center

A health care provider that has contracted with an NCI-approved cancer center to provide treatment.

Section 7: Definitions

Allogeneic (Allogenic) Transplant

A procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord to transplant into the patient. This includes syngeneic transplants.

Ambulatory Infusion Center

A freestanding outpatient facility that provides infusion therapy and select injections that can be safely performed in this setting.

Ambulatory Surgery

Elective surgery that does not require the use of extensive hospital facilities and support systems, but is not usually performed in a physician's office. Only surgical procedures identified by BCBSM as ambulatory surgery are covered.

Ambulatory Surgery Facility

A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient hospital care. It is not an office of a physician or other private practice office.

Ancillary Services

Services such as drugs, dressings, laboratory services, physical therapy or other care that supplements the primary care the patient receives. They do not include room, board and nursing care.

Approved Amount

The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Approved Clinical Trial means a Phase I, II, III or IV clinical trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:

- A federally-funded trial, as described in the Patient Protection and Affordable Care Act
- A trial conducted under an investigational new drug application reviewed by the Federal Drug Administration
- A drug trial that is exempt from having an investigational new drug application
- A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the Patient Protection and Affordable Act

Arthrocentesis

Surgical puncture of a joint to inject and/or withdraw fluid. When performed for temporomandibular joint (jaw joint) dysfunction, this surgery may be performed for reversible, irreversible or diagnostic purposes.

Attending Physician

The physician in charge of a case who exercises overall responsibility for the patient's care:

- Within a facility (such as a hospital and other inpatient facility)
- As part of a treatment program
- In a clinic or private office setting

The attending physician may be responsible for coordination of care delivery by other physicians and/or ancillary staff.

Audiologist

A professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems.

Autism Diagnostic Observation Schedule

The protocol available through western psychological services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the Michigan Department of Insurance and Financial Services, if the Director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

Autism Evaluation Center

An academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the autism spectrum disorders. The autism evaluation center must be approved by BCBSM to:

- Evaluate and diagnose the member as having one of the covered autism spectrum disorders and
- Recommend an initial high-level treatment plan for member's with autism spectrum disorders.

Autism Spectrum Disorders

Autism spectrum disorders include Autism Disorder, Autism Pervasive Developmental Disorder Not Otherwise Specified, or Asperger's Disorder, as defined in the most current American Psychiatric Association Diagnostic and Statistical Manual.

Autologous Transplant

A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.

BCBSM

Blue Cross Blue Shield of Michigan.

Section 7: Definitions

Behavioral Health Treatment

Evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

Benefit Period

The period of time that begins five days before, and ends one year after, the organ transplant. All payable human organ transplant services, except anti-rejection drugs and other transplant related prescription drugs, must be provided during this period of time.

Biological

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or similar product, used for the prevention, treatment, or cure of a disease or condition of human beings. FDA regulations and policies have established that biological products include blood-derived products, vaccines in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products.

Birth Year

A 12-month period of time beginning with a child's month and day of birth.

BlueCard PPO® Program

A program that allows Blue Cross Blue Shield PPO members to receive health care services in other states and have claims processed by the Host Plan, subject to Blue Cross and Blue Shield Association policies.

BlueCard Worldwide® Program

A program that provides access to a network of inpatient facilities and medical assistance services worldwide including referrals to professional providers for all Blue Cross Blue Shield of Michigan members whose claims are eligible for processing through the BlueCard Program.

Blue Cross Plan

Any hospital service plan approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.

Blue Shield Plan

Any medical service plan approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.

Board Certified Behavior Analyst

An analyst certified by the Behavior Analyst Certification Board (BACB) at the time services are rendered.



Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.

Calendar Year

A period of time beginning January 1 and ending December 31 of the same year.

Carrier

An insurance company providing a health care plan for its members.

Certificate

This book, which describes your benefit plan, and any riders that amend this certificate.

Certified Nurse Midwife

A nurse who provides some maternity, contraceptive, and other services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a nurse midwife by the Michigan Board of Nursing
- Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing

Certified Nurse Practitioner

A nurse who provides some medical services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified nurse practitioner by the Michigan Board of Nursing
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed

Certified Registered Nurse Anesthetist

A nurse who provides anesthesiology services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified registered nurse anesthetist by the Michigan Board of Nursing
- Meets BCBSM qualification standards
- When outside of the state of Michigan, is legally qualified to perform anesthesiology services in the state where the services are performed

Section 7: Definitions

Chronic Condition

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.

Claim for Damages

A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

Clinical Licensed Master's Social Worker

A clinical licensed master's social worker who provides some mental health services and who:

- Is licensed as a clinical social worker by the state of Michigan.
- Meets BCBSM qualification standards.
- When outside of the state of Michigan, is legally qualified to perform services in the state where services are performed.

Clinical Trial

A study conducted on a group of patients to determine the effect of a treatment. For purposes of this certificate, clinical trials include:

- Phase II - a study conducted on a number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.
- Phase III - a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Coinsurance

The portion of the approved amount that you must pay for a covered drug or service. Your coinsurance is not altered by an audit, adjustment, or recovery. For prescription drugs, your coinsurance is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Colony Stimulating Growth Factors

Factors that stimulate the multiplication of very young blood cells.

Congenital Condition

A condition that exists at birth.

Contraceptive Device

A device such as, but not limited to, a diaphragm, intrauterine device or contraceptive implant designed to prevent pregnancy.

Contraceptive Medication

Any drug used for the express purpose of preventing pregnancy at the time of its administration.

Contract

This certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Contracted Area Hospital

A BCBSM participating or in-network hospital located in the same area as a noncontracted area hospital.

Conventional Treatment

Treatment that has been scientifically proven to be safe and effective for treatment of the patient's condition.

Coordination Period

A period of time, defined by Medicare, that begins in the first month of Medicare entitlement due to ESRD and lasts for 30 months.

Copayment

The dollar amount that you must pay for a covered drug or service. Your copayment is not altered by an audit, adjustment, or recovery. For prescription drugs, your copayment is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Covered Services

A health care service that is identified as payable in this certificate. Such services must be medically necessary, as defined in this certificate, 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.

Custodial Care

Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, and bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

Deductible

The amount that you must pay for covered services, under any certificate, before benefits are payable.

Dental Care

Care given to diagnose, treat, restore, fill, remove or replace teeth or the structures supporting the teeth, including changing the bite or position of the teeth.

Designated Cancer Center

A site approved by the National Cancer Institute as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request.

Section 7: Definitions

Designated Facility

To be a covered benefit, human organ transplants must take place in a "BCBSM-designated" facility. A **designated facility** is one that BCBSM determines to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to you and your physician upon request.

Designated Services

Services that BCBSM determines only a noncontracted area hospital is equipped to provide.

Detoxification

The medical process of removing an intoxicating or addictive substance from the body of a person who is dependent on that substance.

Developmental Condition

A condition that can delay or completely stop the normal progression of speech development. Speech therapy may not help these conditions.

Diagnostic Agents

Substances used to diagnose rather than treat a condition or disease.

Dialysis

The process of cleaning wastes from the blood artificially. This job is normally done by the kidneys. If the kidneys fail, the blood must be cleaned artificially with special equipment. The two major forms of dialysis are hemodialysis and peritoneal dialysis.

Direct Supervision

The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.

Diversional Therapy

Planned recreational activities, such as hobbies, arts and crafts, etc., not directly related to functional therapy for a medical condition.

Dual Entitlement

When an individual is entitled to Medicare on the basis of both ESRD and age or disability.

Durable Medical Equipment

Equipment that can withstand repeated use and that is used for a medical purpose by a patient who is ill or injured. It may be used in the home.

Effective Date

The date your coverage begins under this contract. This date is established by BCBSM.

Eligibility

As used in Section 1 of this certificate under **End Stage Renal Disease**, eligibility means the member's right to Medicare coverage under Title XVIII of the Social Security Act, as amended. Otherwise, eligibility means the member's right to coverage under this certificate.

Emergency Care

Care to treat an accidental injury or medical emergency.

Emergency Medical Condition

Emergency Medical Condition is 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 delivery or the transfer may pose a threat to the health and safety of the woman or unborn child)

Emergency Services

Emergency Services include medical screening exams (as required under Section 1167 of the Social Security Act) that are within the capability of an emergency room department of a hospital, and include ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. They also include, within the capabilities of the staff and facilities available at the hospital, additional medical exams and treatment (as required under Section 1867 of the Social Security Act) to stabilize the patient.

End Stage Renal Disease (ESRD)

Chronic, irreversible kidney failure that requires a regular course of dialysis or a kidney transplant as verified by a medical evidence report (defined in this section) or a provider bill that contains a diagnosis of chronic renal (kidney) failure.

Enrollment Date

The first date of coverage or, if there is a new hire waiting period, the first day of the waiting period.

Entitlement (or Entitled)

The member's right to receive Medicare benefits once the member has met the eligibility requirements to qualify for Medicare coverage, has filed a valid application for benefits, and has met any applicable waiting period requirements.

Evaluation

An evaluation must include a review of the member's clinical history and examination of the member. Based on the member's needs, as determined by the BCBSM-approved treatment center, an evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening.

Exclusions

Situations, conditions, or services that are not covered by the subscriber's contract.

Section 7: Definitions

Experimental Treatment

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."

Facility

A hospital or clinic that offers acute care or specialized treatment, such as substance abuse treatment, rehabilitation treatment, skilled nursing care or physical therapy.

Fecal Occult Blood Screening

A laboratory test to detect blood in feces or stool.

Federal Food and Drug Administration (FDA)

An agency of the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

First Degree Relative

An immediate family member who is directly related to the patient: either a parent, sibling or child.

First Priority Security Interest

The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Flexible Sigmoidoscopy

A visual examination of the lower portion of the colon through the rectum, using a flexible instrument called a sigmoidoscope.

Freestanding Outpatient Physical Therapy Facility

An independently owned and operated facility, separate from a hospital, which provides outpatient physical therapy services and occupational therapy or speech and language pathology services.

Group

A collection of subscribers under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

Gynecological Examination

A history and physical examination of the female genital tract.

Hazardous Medical Condition

The dangerous state of health of a patient who is at risk for loss, harm, injury or death.

Health Maintenance Examination

A comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

Hematopoietic Transplant

A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.

Hemodialysis

The use of a machine to clean wastes from the blood after the kidneys have failed.

High-Dose Chemotherapy

A procedure in which patients are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.

High-Risk Patient

An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

HLA Genetic Markers

Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

Home Health Care Agency

An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home.

Section 7: Definitions

Hospice

A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

Hospital

A facility that:

- Provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis 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.



A facility that provides specialized services that does not meet all of the above requirements does not qualify as a hospital under this certificate, regardless of its affiliation with any hospital that does meet the above requirements. Such facilities include but are not limited to the following:

- Facilities that provide custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care
- Facilities that serve as institutions for exceptional children or for the treatment of the aged or of substance abusers
- Skilled nursing facilities or other nursing care facilities

Hospital privileges

Permission granted by a hospital to allow accredited professional providers on the hospital's medical staff to perform certain services at that hospital.

Host Blue

See definition of "Host Plan."

Host Plan

A Blue Cross and/or Blue Shield plan outside of Michigan that participates in the BlueCard PPO Program and processes claims for services that you receive in that state. Sometimes referred to as Host Blue.

Independent Occupational Therapist

An occupational therapist who provides some occupational therapy services and who:

- Is licensed as an occupational therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

In-network Providers

Hospitals, physicians and other licensed facilities or health care professionals who provide services through this PPO program. In-network providers have agreed to accept BCBSM's approved amount as payment in full for covered services provided under this PPO program.

Independent Physical Therapist

A physical therapist who provides some physical therapy services and who:

- Is licensed as a physical therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Independent Speech-Language Pathologist

A speech-language pathologist who provides some speech-language therapy services and who:

- Is licensed as a speech-language pathologist by the state of Michigan. If the state of Michigan has not released license applications or has not issued licenses, then a Certificate of Clinical Competence from the American Speech and Hearing Association is an acceptable alternative until the state issues licenses.
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Infusion Therapy

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

BDV

Section 7: Definitions

Injectable Drugs

Payable drugs that are ordered or furnished by a physician and administered by the physician or under the physician's supervision.

Irreversible Treatment

Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- The treatment is intended to cause permanent change to a person's bite or position of the jaws.
- The treatment includes, but is not limited to:
 - Crowns, inlays, caps, restorations and grinding
 - Orthodontics, such as braces, orthopedic repositioning and traction
 - Installation of removable or fixed appliances such as dentures, partial dentures or bridges
 - Surgery directly to the jaw joint and related anesthesia services
 - Arthrocentesis

Jaw Joint Disorders

These include, but are not limited to:

- Skeletal defects of the jaws or problems with the bite that cause pain and inability to move the jaw properly
- Muscle tension, muscle spasms, or problems with the nerves, blood vessels or tissues related to the jaw joint that cause pain and inability to move the jaw properly
- Defects within the temporomandibular joint (jaw joint) that cause pain and an inability to move the jaw properly

Lien

A first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid as a result of the plaintiff's injuries.

Life-threatening Condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Line Therapy

Tutoring or other activities performed one-on-one with a person diagnosed with an Autism Spectrum Disorder. Line therapy must be performed in accordance with a treatment plan that has been designed by a BCBSM-approved autism evaluation center and a board-certified behavior analyst.

Lobar Lung

A portion of a lung from a cadaver or living donor.

Long-Term Acute Care Hospital

A specialty hospital that focuses on treating patients requiring extended intensive care; meets BCBSM qualification standards and is certified by Medicare as an LTACH.

Mammogram

A low dose X-ray of the breast, two views per breast. The radiation machine must be state-authorized and specifically designed and used to perform mammography.

Mandibular Orthotic Reposition Device

An appliance used in the treatment of temporomandibular joint dysfunction.

Maternity Care

Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.

Maxillofacial Prosthesis

A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

Medical Emergency

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

Medical Evidence Report

A form required by the Centers for Medicare and Medicaid Services that a physician must complete and submit for each ESRD patient beginning dialysis.

Medically Necessary

A service must be medically necessary to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and LTACHs; and a third applies to other providers.

Medical necessity for payment of professional provider services:

Health care services that a professional 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.

Section 7: Definitions

Medically Necessary (continued)

NOTE

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

- **Medical necessity for payment of services of other providers:**

Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type or medical specialty, that:

- The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician.
- In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

NOTE

In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.

- **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 Quality and Health Management Programs (applies only to hospitals, not to LTACHs).

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Member

Any person eligible for health care services under this certificate on the date the services are rendered. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered drugs or services.

Network Providers

Also called "in-network providers" See the definition of "In-network Providers" on Page 153.

Noncontracted Area Hospital

A BCBSM nonparticipating and out-of-network hospital located in an area defined by BCBSM.

Nonparticipating Hospital

A hospital that has not signed a participation agreement with BCBSM to accept our approved amount as payment in full.

Nonparticipating Providers

Physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Some nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

Occupational Therapy

A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

- Develop, improve, 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)

Off-Label

The use of a drug or device for clinical indications other than those stated in the labeling approved by the Federal Food and Drug Administration.

Orthopedic Shoes

Orthopedic shoes are prescribed by a physician or certified nurse practitioner to support or correct the bones, joints, muscles, tendons and ligaments of a weak or deformed foot.

ADK

Section 7: Definitions

Orthotic Device

An appliance worn outside the body to correct a body defect of form or function.

Out-of-Area Hospital

A BCBSM in-network or participating hospital that is more than 75 miles from a noncontracted area hospital. It is not in the same area as a contracted or noncontracted area hospital.

Out-of-Area Services

Services available to members living or traveling outside a health plan's service area.

Out-of-network Providers

Hospitals, physicians and other licensed facilities or health care professionals who have not signed an agreement to provide services under this PPO program.

Outpatient Mental Health Facility

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.

Outpatient Substance Abuse Treatment Program

A program that provides medical and other services on an outpatient basis specifically for substance abusers.

Pap Smear

A method used to detect abnormal conditions, including cancer of the female genital tract.

Partial Liver

A portion of the liver taken from a cadaver or living donor.

Participating Hospital

A hospital that has signed a participation agreement with BCBSM to accept our approved amount as payment in full. Copayments or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Participating PPO Provider

A provider who participates with the Host Plan's PPO.

Participating Providers

Physicians and other health care professionals, or hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Patient

The subscriber or eligible dependent that is awaiting or receiving medical care, treatment or covered drugs.

Per Claim Participation

Available to some nonparticipating providers when they elect to accept the approved amount for specific covered services as payment in full.

Period of Crisis

A period during which a patient requires continuous care (primarily nursing care) to alleviate or manage acute medical symptoms.

Peripheral Blood Stem Cell Transplant

A procedure in which blood stem cells are obtained by pheresis and infused into the patient's circulation.

Peritoneal Dialysis

Removal of wastes from the body by perfusion of a chemical solution through the abdomen.

Pheresis

Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets and stem cells).

Physical Therapist

A physical therapist who provides some physical therapy services and who is licensed as a physical therapist by the state of Michigan.

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
- General mobility

Physician

A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as "practitioners."

Plaintiff

The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Section 7: Definitions

Practitioner

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 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.

Preapproval

A process that allows you or your provider to know if we will cover proposed services before you receive them. If preapproval is not obtained **before** you receive certain services described in this rider, they will not be covered.

Preferred Provider Organization (PPO)

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.

Presurgical Consultation

A consultation that allows a member to get an additional opinion from a physician who is a **doctor of medicine, osteopathy, podiatry or an oral surgeon** when surgery is recommended.

Primary Payer

The health care coverage plan that pays first when you are provided benefits by more than one carrier. (For example, you may have BCBSM group coverage and Medicare.)

Primary Plan

The health care plan obligated to pay for services before any other health care plan that covers the member or patient.

Prior Authorization Process

A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves all applied behavior analysis services. A request for continued services will be authorized contingent on the member meeting a mutually agreed upon (between BCBSM and the board certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at three, six, or nine month intervals or at other mutually agreed upon intervals after the onset of treatment.

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Professional Provider

One of the following:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist
- Chiropractor
- Fully licensed psychologist
- Clinical licensed master's social worker
- Oral surgeon
- Board certified behavior analyst
- Other providers as identified by BCBSM

Professional providers may also be referred to as "practitioners."

Prosthetic Device

An artificial appliance that:

- Replaces all or part of a body part or
- Replaces all or part of the functions of a permanently disabled or poorly functioning body organ

Provider

A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care or a pharmacy legally licensed to dispense drugs.

Provider-Delivered Care Management (PDCM)

A program that enables patients to receive care management from a trained clinical care manager in collaboration with, and coordinated by, your primary care physician.

Psychiatric Day Treatment

Treatment for mental or emotional disorders given to a patient who lives at home and goes to a facility for each day of treatment.

Psychiatric Night Treatment

Treatment for mental or emotional disorders given to a patient who lives at home, but goes to a facility at night for treatment and is given meals and a bed.

Psychologist

A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.

Section 7: Definitions

Purging

A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.

Qualified Beneficiary

Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).

Qualified Individual

An individual eligible for coverage under this certificate who participates in an approved clinical trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

- The referring provider participates in the trial and has concluded that the individual's participation in it would be appropriate because the individual meets the trial's protocol, or
- The individual provides medical and scientific information establishing that the individual's participation in the trial would be appropriate because he/she meets the trial's protocols

Qualifying Event

One of the following events that allows a qualified beneficiary to receive COBRA coverage:

- Termination of employment, other than for gross misconduct, or reduction of hours
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The employee becomes entitled to coverage under Medicare

Radiology Services

These include X-ray exams, radium, radon, cobalt therapy, ultrasound testing, radioisotopes, computerized axial tomography scans, magnetic resonance imaging scans and positron emission tomography scans.

Refractory Patient

An individual who does not achieve clinical disappearance of the disease after standard therapy.

Registered Provider

A participating or nonparticipating provider (or in-network or out-of-network PPO provider) that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

Relapse

When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient's condition.

Remitting Agent

Any individual or organization that has agreed, on behalf of the subscriber, to:

- Collect or deduct premiums from wages or other sums owed to the subscriber and
- Pay the subscriber's BCBSM bill

Rescission

The cancellation of coverage that dates back to the effective date of the member's contract and voids coverage during this time.

Research Management

Services, such as diagnostic tests, which are performed solely to support the sponsoring organization's research. They are not necessary for treating the patient's condition.

Residential Psychiatric Treatment Facility

A facility that provides residents with 24-hour mental health care and treatment, 7 days a week. The facility must participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

Residential Substance Abuse Treatment Program

A program that provides medical and other services specifically for substance abusers in a facility that operates 24 hours a day, seven days a week. Treatment in a residential program is sometimes called "intermediate care."

Respite Care

Relief to family members or other persons caring for terminally ill persons at home.

Reversible Treatment

Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- This treatment is **not** intended to cause permanent change to a person's bite or position of the jaws.
- This treatment is designed to manage the patient's symptoms. It can include, but is not limited to, the following services:
 - Arthrocentesis
 - Physical therapy (see Page 72 for physical therapy services)
 - Reversible appliance therapy (mandibular orthotic repositioning)

Rider

A document that changes a certificate by adding, limiting, deleting or clarifying benefits.

Section 7: Definitions

Right of Recovery

The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

Routine Patient Costs means all items and services related to an approved clinical trial if they are covered under this certificate (or any riders that amend it) for members who are not participants in an approved clinical trial. They do not include:

- The 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 patient, or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sanctioned Prescriber

Any provider who has been disciplined under Section 1128 and Section 1902(a)(39) of the Social Security Act; excluded or suspended from participation in Medicare or Medicaid; whose license to issue prescriptions has been revoked or suspended by any state licensing board; or whose prescribing habits have been determined by BCBSM to deviate significantly from established standards of medical necessity.

Screening Services

Procedures or tests ordered for a patient (or for almost all patients of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a physical are considered screening services.

Secondary Plan

The health care plan obligated to pay for services after the primary plan has paid for services.

Self-Dialysis Training

Teaching a member to conduct dialysis on himself or herself.

Semiprivate Room

A hospital room with two beds.

Service Area

The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.

NOTE

BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers' claims will not be subject to BlueCard rules.

Services

Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease, injury, condition or pregnancy.

Skilled Care

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
- Provided by a registered nurse or a licensed practical nurse supervised by a registered nurse or physician

Skilled Nursing Facility

A facility that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

Small Bowel Transplant

A procedure in which the patient's small intestine is removed and replaced with the small intestine of a cadaver.

Special Foods for Metabolic Disease

Special medical foods that are formulated for the dietary treatment of an inherited metabolic disease. The nutritional requirements of the patient are established by medical evaluation and the diet is administered under the supervision of a physician. These formulations are exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration.

Special infant formulas are liquid feedings used for the treatment of inherited metabolic diseases. These formulas can provide up to 85 percent of the protein, vitamin and mineral needs of an infant.

A low-protein modified food product is one specially formulated to provide less than one gram of protein per serving. It is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease, but does not include a food that is naturally low in protein.

Specialty Hospitals

Hospitals that treat specific diseases, such as mental illness.

ABG

Section 7: Definitions

Specialty Pharmaceuticals

Biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin. **Select specialty pharmaceuticals require preauthorization from BCBSM.**

Examples of specialty pharmaceuticals include, but are not limited to, the following:

- Drugs administered by infusion therapy providers
- Drugs administered in the office by health care practitioners
- Certain drugs to treat highly complex disorders, such as multiple sclerosis, lupus and immune deficiency
- Chemotherapy specialty pharmaceuticals dispensed at the pharmacy and self-administered, or administered by a health care practitioner at an approved facility or a physician's office



BCBSM will cover these drugs under the certificate that applies to the benefit. For example, drugs administered in the office by a health care practitioner are covered under the certificate that applies to your medical benefits.

Specialty Pharmacy

Companies that specialize in specialty pharmaceuticals and the associated clinical management support.

Speech and Language Pathology Services

Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

Spouse

An individual who is legally married to the subscriber and meets the group's eligibility requirements.

Stabilize

Stabilize, with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from a facility (or with respect to a woman who is having contractions, to deliver the child (including the placenta)).

Stem Cells

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

Subrogation

The assumption by BCBSM of your right, or the right of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

Subscriber

The person who signed and submitted the application for coverage.

Substance Abuse

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 abuse is alcohol or drug abuse or dependence as classified in the most current edition of the "International Classification of Diseases."

NOTE

Tobacco addictions are included in this definition.

Substance Abuse Treatment Program Services

Subacute services to restore a person's mental and physical well-being when the person is a substance abuser. Services must be provided and billed by an approved residential or outpatient substance abuse treatment program.

Syngeneic Transplant

A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient's identical twin to transplant into the patient.

Tandem Transplant

A procedure in which the patient is given chemotherapy followed by a blood stem cell (peripheral or umbilical cord blood) transplant or bone marrow transplant, and if the patient's cancer has not progressed, a second round of chemotherapy followed by a blood stem cell or bone marrow transplant. The second round of chemotherapy and transplant is usually performed within six months of the first transplant and if not, it must be approved by BCBSM. Tandem transplants are also referred to as dual transplants or sequential transplants. A tandem transplant is considered to be one transplant.

T-Cell Depleted Infusion

A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

Section 7: Definitions

Technical Surgical Assistance

Professional active assistance given to the operating physician during surgery by another physician not in charge of the case.

NOTE

Professional active assistance requires direct physical contact with the patient.

Terminally Ill

A state of illness causing a person's life expectancy to be 12 months or less according to a medically justified opinion.

Therapeutic Shoes

Therapeutic or diabetic shoes are prescribed by a physician or certified nurse practitioner and are either "off-the-shelf" or custom-molded shoes which assist in protecting the diabetic foot.

Total Body Irradiation

A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

Treatment Plan

A written plan that describes the goals, expected outcomes, type and limited duration of services to be provided to the member under the case management program. The treatment plan may include medically necessary services that BCBSM determines should be covered because of the member's condition as specified in the plan, even if those services are not covered under the patient's hospital and professional certificates. (Such services are referred to as non-contractual services.) All services described in the treatment plan must be ordered by the member's physician. Because plans that include non-contractual services are a binding contract between the member and BCBSM, they must be signed by the member (or representative) and the BCBSM case manager.

Treatment Plan for Autism Disorders

A written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist.

Measurable improvement in the member's condition must be expected from the recommended treatment plan. Once treatment begins, the plan will be subject to periodic assessment by a BCBSM nurse or case manager at three, six and/or nine months or at mutually agreed upon intervals.

There are two levels to the treatment plan:

- The approved autism evaluation center will recommend an initial high-level treatment plan.
- The board certified behavior analyst will develop a detailed treatment plan specific to applied behavior analysis treatment.

Section 7: Definitions

Urgent Care

Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm. Urgent care centers are not the same as emergency rooms or doctors' offices.

Valid Application

An application for Medicare benefits filed by a member with ESRD according to the rules established by Medicare.

Voluntary Sterilization

Sterilization that is not medically necessary according to generally accepted standards of medical practice and is performed strictly at the request of the patient.

Waiting Period

Defined by Medicare as the period of time (up to three months) before a member with ESRD, who has begun a regular course of dialysis, becomes entitled to Medicare. Entitlement begins on the first day of the fourth month of dialysis, provided the member files a valid application for Medicare.

Ward

A hospital room with three or more beds.

We, Us, Our

Used when referring to Blue Cross Blue Shield of Michigan.

Well-Baby Care

Services provided in a physician's office to monitor the health and growth of a healthy child.

Working Aged

Employed individuals age 65 or over, and individuals age 65 or over with employed spouses of any age, who have group health plan coverage by reason of their own or their spouse's current employment.

Working Disabled

Disabled individuals under age 65 who have successfully returned to work but continue to have a disabling impairment.

You and Your

Used when referring to any person covered under the subscriber's contract.

DB

Section 8: Other Information You Should Know About Your Coverage

Blue Cross Blue Shield of Michigan wants you to be satisfied with the services you receive as a member. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact Customer Service. The telephone number can be found on the back of your Blues ID and the top right hand corner of your Explanation of Benefit Payments statements.

Grievance Process

We have a formal grievance and appeals process if you are unable to resolve your concerns through Customer Service, or wish to contest an adverse benefit decision.

An adverse benefit determination is a denial, reduction, 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 a plan, and including, with respect to group health plans, 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.

If you choose to file a grievance or appeal:

- You will not incur additional charges for filing a grievance or appeal, and you may submit written materials or testimony to help us in our review at any step of the grievance or appeals process.
- You may authorize another person, including your physician, to act on your behalf at any stage in the standard internal grievance procedure. Your authorization needs to be in writing. Please call the customer service number on the back of your Blues ID and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.
- Although we have 35 days to give you our final determination, you have the right to allow us additional time if you wish.
- You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service free of charge.

The grievance and appeals process begins with an internal review by BCBSM. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.

Standard Internal Grievance Process

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

Section 8: Other Information You Should Know About Your Coverage

Grievance Process (continued)

Standard Internal Grievance Process (continued)

Mail your written grievance to:

Appeals Unit
Blue Cross Blue Shield of Michigan
P.O. Box 2459
Detroit, MI 48231-2459

Once we receive your grievance, we will contact you to conduct or schedule a conference. That will be your opportunity to provide us with any additional information or testimony you want us to consider in reviewing your claim. You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at our headquarters in Detroit, during regular business hours. Our written resolution will be our final determination regarding your grievance.

If you disagree with our final determination, or if we fail to provide it to you within 35 days of the date we received your original written grievance, you may request an external review from the Michigan Department of Insurance and Financial Services.

Standard External Review Process

Once you have exhausted our standard internal grievance process, you or your authorized representative may request an external review from the Director of Financial and Insurance Services.

The standard external review process is as follows:

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

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

2. If your request for external review concerns a medical issue and is otherwise found to be appropriate for external review, the Director will assign an independent review organization, consisting of independent clinical peer reviewers, to conduct the external review.
 - You will have an opportunity to provide additional information to the Director within seven days of submitting your request for an external review. We must provide documents and information considered in making our final determination to the independent review organization within seven business days after we receive notice of your request from the Director.
 - The assigned independent review organization will recommend within 14 days whether the Director should uphold or reverse our determination. The Director must decide within seven business days whether or not to accept the recommendation and will notify you. The Director's decision is the final administrative remedy under the Patient's Right to

**Section 8: Other Information You Should
Know About Your Coverage**

Independent Review Act of 2000.

172 COMMUNITY BLUE LG

Section 8: Other Information You Should Know About Your Coverage

Grievance Process (continued)

Standard External Grievance Process (continued)

If your request for external review is related to nonmedical issues and is otherwise found to be appropriate for external review, the Director's staff will conduct the external review.

The Director's staff will recommend whether the Director should uphold or reverse our determination. The Director will notify you of the decision, and the Director's decision is your final administrative remedy.

Expedited Internal Grievance

If a physician substantiates (either orally or in writing) that adhering to the timeframe for the standard internal grievance process would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance.

You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service, or if you believe we have failed to respond in a timely manner to a request for benefits or payment.

The procedure is as follows:

- You may submit your expedited internal grievance request by telephone to 313-225-6800. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone.
- We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Director of the Department of Insurance and Financial Services.

Expedited External Grievance

If you have filed a request for an expedited internal grievance, you may request an expedited external review from the Director of Insurance and Financial Services.

You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service.

The expedited external review process is as follows:

- Within 10 days of your receipt of our denial, termination or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Director by calling 1-877-999-6442 to request the forms required.

Section 8: Other Information You Should Know About Your Coverage

Grievance Process (continued)

Expedited External Grievance (continued)

- Mail your request, including the required forms that we will give you, to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Immediately after receiving your request, the Director will decide if it is appropriate for external review and assign an independent review organization to conduct the expedited external review. If the independent review organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Director should uphold or reverse our determination.

The Director must decide within 24 hours whether or not to accept the recommendation and will notify you. The Director's decision is the final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Pre-Service Appeals

For members who must get approval before obtaining certain health services.

If your health plan requires you to get approval before obtaining certain health services, and you disagree with our decision not to approve a service, you have the right to appeal it.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the customer service number on the back of your Blues ID card.

All appeals must be requested in writing. We must receive your written request within 180 days of the date you received notice that the service was not approved.

Requesting a Standard Review

You may make the request yourself, or your doctor or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the customer service number on the back of your Blues ID and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.

Your letter requesting a review must include the following information:

- Your contract and group numbers, found on your Blues ID card
- A daytime phone number for both you and your representative
- The patient's name if different from the member

Section 8: Other Information You Should Know About Your Coverage

- A statement explaining why you disagree with our decision and any additional supporting information

Pre-service Appeals (continued)

Requesting a Standard Review (continued)

Once we receive your appeal, we will provide you with our final decision within 30 days.

Requesting an Urgent Review

If your situation meets the definition of urgent under the law, your review will be conducted as soon as possible; generally within 72 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an urgent review. You may also request a simultaneous external review.

For more information on how to request an urgent review or simultaneous external review, call the customer service number listed on the back of your Blues ID card.

For more information

At your request and without charge, we will send you details from your health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

To request information about your plan or the medical guidelines used, or if you need help with the appeal process, call the customer service number on the back of your Blues ID card.

Other resources to help you

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). You can also contact the Department of Insurance and Financial Services for assistance.

Other Provisions of your Coverage

Genetic Testing

We will not:

- Adjust premiums for this coverage on genetic information related to you, your spouse or your dependents
- Request or require genetic testing of anyone covered under this certificate
- Collect genetic information from anyone covered under this certificate at any time for underwriting purposes

PNB

Section 9: How to Reach Us

This section lists phone numbers and addresses to help you get information quickly. You may call or visit our BCBSM Customer Service center.

To Call

Most of our BCBSM Customer Service lines are open for calls from 8:30 a.m. to noon and from 1 to 5 p.m., Monday through Friday. Please have your ID card with your group and contract numbers ready when you call.

Area code 248, 313, 586, 734, 810 or 947

Southeast Michigan toll-free1-877-790-2583

Area code 231, 269 or 616

West Michigan toll-free1-800-972-9797

Area code 517 or 989

Central Michigan toll-free1-800-258-8000

Area code 906

Upper Peninsula toll-free.....1-800-562-7884

For when you are out-of-state, call BlueCard1-800-810-2583

For when you are out of the country, call BlueCard Worldwide.....1-804-763-1177
(call collect)

To Visit

BCBSM Customer Service centers are located throughout Michigan. Check the following list or visit our website at bcbsm.com to find the center nearest you. The centers are open Monday through Friday, 9 a.m. to 5 p.m.

Detroit

600 E. Lafayette Blvd., Detroit 48226
Downtown, three blocks north of Jefferson at St. Antoine

Flint

4520 Linden Creek Parkway, Suite A, Flint 48507

Grand Rapids

86 Monroe Center N.W., Grand Rapids 49503

Holland

151 Central Ave., Holland, 49423



Section 9: How to Reach Us

To Visit (continued)

Lansing

232 S. Capitol Ave., Lansing 48933

Marquette

415 S. McClellan Ave., Marquette 49855

Up on the hill

Portage

8175 Creekside Dr., Suite 100, Portage 49024

Traverse City

City Centre Plaza

202 State St., Traverse City 49686

Utica

6100 Auburn Road, Utica 48317

Diagonally across from the AAA building

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Form No. 679E



**State approved 02/15
Effective 2015**

A handwritten signature in black ink, appearing to be "D. J. D.", is located at the bottom right of the page.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions and conditions of your certificates and related riders remain unchanged and in full force and effect, except as otherwise provided in Rider MOPD LG.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 645F



State Approved 10/13

CD6

Covered Drugs Obtained From a Nonparticipating or Out-of-Network Pharmacy

When a nonparticipating or out-of-network pharmacy fills a prescription for injectable insulin, state-controlled drugs or any federal legend drugs, you must pay the pharmacist the full cost of the drug and submit a claim form and proof of payment to us.

We will reimburse you 75 percent (100 percent for emergency pharmacy services) of the BCBSM approved amount for the drug, minus your copayment.

Copayment Requirements

Your copayment for each covered prescription is:

- **\$10** for all generic drugs
- **\$20** for preferred brand drugs
- **\$40** for nonpreferred brand drugs

Your copayment will not be more than BCBSM's approved amount for covered drugs.

NOTE: You are required to pay the preferred or nonpreferred copayment for a brand name drug, even if the prescription is marked "Dispense as Written" or "DAW" or the brand drug has no generic equivalent.

These copayment levels also apply to drugs obtained by mail if you have coverage under a BCBSM mail order drug program.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions and conditions of your certificate and related riders remain unchanged and in full force and effect, except as otherwise provided in Rider PD-TTC \$10/\$20/\$40 LG.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 619F



State Approved 10/13

000

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER MOPD LG MAIL-ORDER PRESCRIPTION DRUGS

AMENDS

**ALL BCBSM LG GROUP BENEFIT CERTIFICATES THAT PROVIDE
PRESCRIPTION DRUG PROGRAM COVERAGE
(excluding Medicare Supplemental Plan H – Farm Bureau Certificate)**

Rider MOPD LG amends the certificates named above to provide coverage for drugs obtained from participating in-network mail-order providers.

This rider is effective when you, your employer or remitting agent is notified.



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

626

“The Language of Healthcare” or the “Definitions” section of your certificate is amended to add the following definitions:

Approved Amount

The lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) for a covered drug or service. The drug cost, dispensing fee and incentive fee are set according to our contracts with pharmacies. The approved amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Copayments that may be required of you are subtracted from the approved amount before we make our payment.

Out-of-Network Mail-Order Provider

A provider who has not been selected to provide covered drugs through our PPO program. Out-of-network mail-order providers have not agreed to accept the approved amount as payment in full for covered drugs provided to members in our PPO mail-order program.

Nonparticipating Mail-Order Provider

A provider who does not have an agreement with BCBSM to provide covered drugs through the Mail-Order Prescription Drug Program. Nonparticipating mail-order providers have not agreed to accept the approved amount as payment in full for covered drugs provided to members in our PPO mail-order program.

In-Network Mail-Order Provider

A provider selected by BCBSM to provide covered drugs through our PPO program. In-network mail-order providers have agreed to accept the approved amount as payment in full for covered drugs provided to members.

Participating Mail-Order Provider

A provider who has an agreement with BCBSM to provide covered drugs through the Mail-Order Prescription Drug Program. Participating mail-order providers have agreed to accept the approved amount as payment in full for the covered drugs provided to members.

The “Prescription Drug Coverage” section or the “Prescription Drugs” subsection of your certificate is amended to add the following language:

Covered Drugs Obtained from Participating/In-Network Mail-Order Providers

When a participating/in-network mail-order provider fills a prescription for a covered drug, we will pay the approved amount minus your copayment for the drug. Payment will be made directly to the mail-order provider.

The “Prescription Drugs Not Covered” section or the “Prescription Drugs” subsection of your certificate is amended by adding the following:

-Prescription Drugs Not Covered

- Covered drugs obtained from nonparticipating/~~nonpanel~~ out-of-network mail-order providers, including Internet providers
- More than a 90-day supply of a covered drug
- More than a 30-day supply of a covered prescription drug that BCBSM defines as a “specialty pharmaceutical” whether or not the drug is obtained from a mail-order provider. We may make exceptions if a member requires more than a 30-day supply.

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER CB-OV \$20 LG
COMMUNITY BLUE OFFICE VISIT
COPAYMENT REQUIREMENT**

AMENDS

**COMMUNITY BLUESM GROUP BENEFITS CERTIFICATE LG
679E**

Rider CB-OV \$20 LG amends the certificate named above to increase the copayment requirement for office visits by an in-network provider.

This rider is effective when you, your employer or remitting agent is notified.



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

BJ

The "What You Must Pay" section of your certificate is amended to increase the copayment requirement for covered office visits provided by an in-network provider as follows:

Copayment Requirement

In-network Provider

- **\$20** for each office visit including:
 - urgent care visits
 - office consultations

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions and conditions of your certificate and related riders remain unchanged and in full force and effect, except as otherwise provided in Rider CB-OV \$20 LG.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 682E



Bureau Approved TBD

A handwritten signature in the bottom right corner of the page.

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER CB-MTC \$20 LG
COMMUNITY BLUE MANIPULATIVE THERAPY
COPAYMENT REQUIREMENT**

AMENDS

**COMMUNITY BLUESM GROUP BENEFITS CERTIFICATE LG
679E**

Rider CB-MTC \$20 LG amends the certificate named above to increase the copayment requirement for chiropractic spinal manipulation and osteopathic manipulative treatment by an in-network provider.

This rider is effective when you, your employer or remitting agent is notified.



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Handwritten signature

The "What You Must Pay" section of your certificate is amended to increase the copayment requirement for chiropractic spinal manipulation and osteopathic manipulative therapy by an in-network provider as follows:

Copayment Requirement

In-network Provider

- **\$20** for chiropractic spinal manipulation and osteopathic manipulative therapy performed during your office visit. Covered services are subject to any visit limits in your certificate or related riders.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions and conditions of your certificate and related riders remain unchanged and in full force and effect, except as otherwise provided in Rider CB-MTC \$20 LG.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 691E



Bureau Approved TBD

Q26

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER CB-OPM-IN \$6350 LG
COMMUNITY BLUE ANNUAL OUT-OF-POCKET
MAXIMUM FOR IN-NETWORK SERVICES**

AMENDS

**COMMUNITY BLUE GROUP BENEFITS CERTIFICATE LG
679E**

**PREFERRED RX PROGRAM CERTIFICATE LG
834E**

Rider CB-OPM-IN \$6350 LG amends the certificates named above to increase the annual out-of-pocket maximums for services by an in-network provider.

This rider is effective when you, your employer or remitting agent is notified.



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OR

The “What You Must Pay” section of your medical certificate is amended to increase the annual out-of-pocket maximum for services by an in-network provider as follows:

Annual Out-of-pocket Maximum

In-network Provider Services

- **\$6,350** for one member
- **\$12,700** for a family

Your annual out-of-pocket maximum for in-network services will continue to be administered as described in your certificate. Under no circumstances will this amount exceed the maximum amount set by the federal government.

If you have BCBSM prescription drug coverage, the “Prescription Drug Coverage” section of your drug certificate is amended as follows:

Your cost-sharing requirements under your BCBSM prescription drug certificate and related riders also contribute to the annual out-of-pocket maximums stated above.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions, and conditions of your certificate and related riders remain in full force and effect, except as otherwise provided in Rider CB-OPM-IN \$6350 LG.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**



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IMPORTANT

BCBSM ADMINISTRATIVE FORM

NOT FOR EXTERNAL PUBLICATION

ADMINISTRATIVE FORM A-XEA LG (Administrative Form Only)

AMENDS

**ALL BCBSM LG BENEFITS CERTIFICATES
(that provide hospital-medical-surgical benefits)**

Administrative Form A-XEA LG is for **internal purposes only**. This rider will be attached to the coverage of **large insured** group members previously enrolled in Rider XVA **or** Rider XVA LG.



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This administrative form is being used for rating purposes and will be attached to the coverage of **large insured** groups previously enrolled in Rider XVA (#4725) **or** Rider XVA LG (#831F).

GENERAL

All the terms, definitions, limitations, exclusions and conditions of the member's certificate and related riders are **not affected** by Administrative Form A-XEA LG.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 831F



Effective 03/14
Administrative form.
State approval not required.

606

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER CB-OPM-ON \$12,700 LG
COMMUNITY BLUE ANNUAL OUT-OF-POCKET
MAXIMUM FOR OUT-OF-NETWORK SERVICES**

AMENDS

**COMMUNITY BLUE GROUP BENEFITS CERTIFICATE LG
679E**

**PREFERRED RX PROGRAM CERTIFICATE LG
834E**

Rider CB-OPM-ON \$12,700 LG amends the certificates named above to increase the annual out-of-pocket maximums for services by an out-of-network provider.

This rider is effective when you, your employer or remitting agent is notified.



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The "What You Must Pay" section of your medical certificate is amended to increase the annual out-of-pocket maximum for services by an out-of-network provider as follows:

Annual Out-of-pocket Maximum

Out-of-network Provider Services

- **\$12,700** for one member
- **\$25,400** for a family

Your annual out-of-pocket maximum for out-of-network services will continue to be administered as described in your certificate.

If you have BCBSM prescription drug coverage, the "Prescription Drug Coverage" section of your drug certificate is amended as follows:

Your cost-sharing requirements under your BCBSM prescription drug certificate and related riders also contribute to the annual out-of-pocket maximums stated above.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions, and conditions of your certificate and related riders remain in full force and effect, except as otherwise provided in Rider CB-OPM-ON \$12,700 LG.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 833E



State Approved 09/13

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IMPORTANT

Keep This Rider With Your Certificate

Rider SD-LG SPONSORED DEPENDENT

AMENDS

**ALL BCBSM LG GROUP BENEFIT CERTIFICATES
(excluding Dental and Vision Certificates)**

Rider SD-LG amends the certificates named above to add coverage for sponsored dependents.

This rider is effective when you, your employer or remitting agent is notified.



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Your certificate is amended as follows:

SECTION 1: Eligibility

We pay for the services covered under your certificate when provided to your sponsored dependents who meet **all** of the following requirements:

- they are listed as sponsored dependents by you on your application form;
- they are related to you by blood, marriage or legal adoption;
- they are over 19 years of age;
- they live with you;
- they receive more than half of their support from you, and
- they are not eligible as a dependent under the provisions of your contract.

SECTION 2: What You Must Pay

You must pay BCBSM monthly, and in advance, the additional rate needed to provide coverage for your sponsored dependents under this rider.

NOTE: We will adjust the rate for this rider from time to time by giving you, your employer or your remitting agent a 30 day written notice.

SECTION 3: Limitations and Exclusions

If your group coverage ends and you transfer to an individual plan, your sponsored dependents may also apply for their own individual plan.

We will not pay for services provided to your sponsored dependents if your certificate excludes sponsored dependents from coverage.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions and conditions of your certificate and related riders remain unchanged and in full force and effect, except as otherwise provided in Rider SD-LG.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 835F



**Blue Cross
Blue Shield
of Michigan**

A corporate organization and a dependent member
of the Blue Cross and Blue Shield Association

Bureau Approved TBD

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IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER PD-TTC \$10/\$20/\$40 LG
Prescription Drug - Triple-Tier Copayment**

AMENDS

**PREFERRED RX PROGRAM CERTIFICATE LG
834E**

**TRADITIONAL RX PROGRAM CERTIFICATE LG
777E**

Rider PD-TTC \$10/\$20/\$40 LG amends the certificates named above to require copayments based on the type of drug you obtain.

This rider is effective when you, your employer or remitting agent is notified.



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OR

"The Language of Health Care" section of your certificate is amended by adding the following definitions:

Generic Drug

A prescription drug that contains the same active ingredients, is identical in strength and dosage form, and is administered in the same way as a brand name drug.

Maximum Allowable Cost (MAC)

The most BCBSM will pay for certain covered drugs.

Nonpreferred Brand Drug

A brand name drug that is **not** on BCBSM's preferred drug list.

Preferred Brand Drug

A brand name drug that is on BCBSM's preferred drug list.

The "Prescription Drug Coverage" section of your certificate is replaced with the following language:

We will pay for each covered drug and each refill of a covered drug as follows:

Covered Drugs Obtained from a Participating or In-Network Pharmacy

When a participating or in-network pharmacy fills a prescription for a covered drug, we will pay the approved amount for the drug minus your copayment.

For MAC Drugs

(The section **For MAC Drugs** applies to the Preferred Rx Program Certificate only.)

When an in-network pharmacy fills a prescription with a MAC drug, we will pay the maximum allowable cost of the drug minus your copayment.

However, if you request a brand name drug and the prescriber did not write "Dispense as Written" or "DAW" on the prescription, you must pay:

- the difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug **plus**
- your copayment for the brand name drug

If the prescriber wrote "Dispense as Written" or "DAW" on the prescription, we will pay our approved amount, minus your copayment, for the brand name drug.

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER RXP LG PRESCRIPTION DRUG PREAUTHORIZATION REQUIREMENT

AMENDS

**ALL BCBSM LG PRESCRIPTION DRUG GROUP BENEFIT CERTIFICATES
(excluding Affinity, MESSA and MICHild certificates)**

Rider RXP LG amends the certificates named above to require approval of select prescription drugs before prescriptions are filled, and to provide coverage for select over-the-counter drugs as a prerequisite to the preauthorization process for select prescription drugs identified by BCBSM.

This rider is effective when you, your employer or remitting agent is notified.



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Your certificate is amended as follows:

The “Prescription Drug Coverage” section of your certificate is amended to add the following language:

We will pay for each covered drug, each refill of a covered drug, and select over-the-counter (OTC) drugs prescribed by a physician, as follows:

Mandatory Preauthorization

Preauthorization of select prescription drugs must be obtained from BCBSM before we will consider them for payment. If preauthorization is not requested or approval is not obtained, we will deny payment and you will be responsible for 100 percent of the provider’s charge.

We will pay our approved amount for select prescription drugs obtained from a pharmacy or, if your certificate provides the benefit, through our mail order prescription drug program if both of the following are met:

- The prescribing physician requests preauthorization and demonstrates that the select prescription drug meets BCBSM’s preauthorization criteria.
- We approve the request.

NOTE: Any deductibles or copayments required under your certificate and riders will apply to select prescription and over-the-counter drugs.

The “Language of Health Care” section of your certificate is amended to add the following definitions:

Preauthorization

A process that requires a physician to obtain approval from BCBSM before prescribing select prescription drugs.

Select Prescription Drugs

Prescription drugs identified by BCBSM as requiring preauthorization. A description of the drugs and the criteria for approval are provided in a list that is updated periodically by BCBSM. Your physician or pharmacist can call us for this list. Select prescription drugs do not include antineoplastic drugs or drugs needed to treat an immediate life-threatening condition.

Select Over-the-Counter Drugs

Over-the-counter drugs identified by BCBSM as a prerequisite to the preauthorization process for select prescription drugs. A prescription for the select OTC drug is required from the prescribing physician.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions and conditions of your certificate and related riders remain in full force and effect, except as otherwise provided in Rider RXP LG.

BLUES CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer

Form No. 664F



State Approval 10/13

ADP

PREFERRED RX PROGRAM CERTIFICATE LG

De



Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits for

AA000752 / XR001047

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Annual Out-of-Pocket Maximum	\$6,600 Individual, \$13,200 Family	These values do not accumulate. Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
Preventive Services:		
Preventive Office Visit / Physical Exam	Covered	
Well Baby Office Visit	Covered	
Routine Hearing Exam	Covered	
Routine Eye Exam	Covered	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	\$20 Copay	
Specialty Physician Office Visit	\$20 Copay	
Gynecology Office Visit	\$20 Copay	
Audiology Office Visit	\$20 Copay	
Eye Exam Office Visit	\$20 Copay	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Office Visit and Related Services	Not Covered	
Emergency/Urgent Care:		
Emergency Room Services	\$50 Copay	Copay will be waived if admitted
Urgent Care Facility Services	\$20 Copay	
Emergency Ambulance Services	Covered	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	
Bariatric Surgery & Related Services	\$1,000 Copay	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	Covered	Covered under Preventive Services
Subsequent Prenatal Office Visits	Covered	Covered under Preventive Services
Postnatal Office Visits	\$20 Copay	
Labor, Delivery and Newborn Care	Covered	
Mental/Behavioral Health:		
Inpatient Services	Covered	
Outpatient Services	\$20 Copay	
Substance Use Disorder:		
Inpatient Services	Covered	
Outpatient Services	\$20 Copay	
Other Services:		
Home Health Care	Covered	Unlimited
Hospice Care	Covered	Up to 210 days per lifetime
Skilled Nursing Care	Covered	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment, Prosthetic & Orthotics	Covered	Coverage provided for approved equipment based on HAP's guidelines
Hearing Aid Hardware	Not Covered	
Vision Hardware	Covered	Coverage for one pair of eye glasses each year. Detailed information regarding coverage of lenses and Collections Frames can be found in your policy or plan documents
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 100%	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception
Voluntary Termination of Pregnancy	Not Covered	Women: Covered as Preventive Services
Infertility Services	Covered	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Covered	One attempt of artificial insemination per lifetime
Pharmacy:		
Generic / Preferred Brand / Non-Preferred Brand	\$10 / \$20 / \$40 Copay	Retail: 35 day supply for non-maintenance drugs at one Copay; 35 day supply or 100 doses, whichever is greater, for eligible maintenance drugs at 1 Copay Mail Order: 90 day supply of non-maintenance drugs at 3 Copays less \$5.00; 90 day supply of eligible maintenance drugs at 1 Copay

Rev 08/2012

Benefit Riders: 599,573,126,124,118,034,016,014,012,096,K60,MHE

- * Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.
- * Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.
- * In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.
- * Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage for: Individual+Family | **Plan Type:** HMO


This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hap.org or by calling 1-800-422-4641.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,600 person / \$13,200 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, Balance Billed Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Does this plan use a <u>network of providers</u> ?	Yes. See www.hap.org or call 1-800-422-4641 for a list of preferred providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org .

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-800-422-4641 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay per visit	Not Covered	-----None-----
	Specialist visit	\$10 copay per visit	Not Covered	-----None-----
	Other practitioner office visit	\$10 PCP Other Practitioner copay per visit/ \$10 Specialist Other Practitioner copay per visit	Not Covered	Chiropractic Care and Acupuncture Not Covered
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org .
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Some services require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org .	Generic Drugs	\$10 copay/prescription (retail)	Not Covered	Applies to all categories below. Retail: 35 day supply for non-maintenance drugs at 1 copay; 35 day supply or 100 doses, whichever is greater, for eligible maintenance drugs at 1 copay. Mail Order: 90 day supply for non-maintenance drugs at 3 copays less \$5.00; 90 day supply of eligible maintenance drugs at 1 copay
	Preferred brand drugs	\$20 copay/prescription (retail)	Not Covered	
	Non-preferred brand drugs	\$20 copay/prescription (retail)	Not Covered	
	Specialty drugs	\$20 copay/prescription (retail)	Not Covered	

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need immediate medical attention	Emergency room services	\$50 copay per visit	\$50 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency Transport Only
	Urgent care	\$10 copay per visit	\$10 copay per visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fee	No Charge	Not Covered	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder outpatient services	\$10 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
If you are pregnant	Prenatal and postnatal care	\$10 copay per visit	Not Covered	No Charge for Prenatal care
	Delivery and all inpatient services	No Charge	Not Covered	Some services require prior authorization.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-800-422-4641 to request a copy.

AA000724 XR001038

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	-----None-----
	Rehabilitation services	No Charge	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services- Up to 730 days, renewable after 60 days
	Durable medical equipment	No Charge	Not Covered	Coverage provided for approved equipment based on HAP's guidelines. Some services require prior authorization.
	Hospice service	No Charge	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Eye exam	\$10 copay per visit	Not Covered	No Charge for preventive eye exam
	Glasses	Covered	Not Covered	Coverage for one pair of eye glasses each year. Detailed information regarding coverage of lenses and Collection Frames can be found in your policy or plan documents.
	Dental check up	Not Covered	Not Covered	-----None-----

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-800-422-4641 to request a copy.

AA000724 XR001038