UAW Retirees of Daimler Trucks North America Welfare Benefit Trust

Summary Plan Description
For Plan Benefits in Effect as of January 1, 2017

Table of Contents

Introduction

The UAW Retirees of Daimler Trucks North America (DTNA) Welfare Benefit Trust (the Trust) provides health care benefits, including medical, prescription drug, hearing, vision and dental coverage for eligible participants (the Plan). This Summary Plan Description (SPD) describes the benefits of the UAW Retirees of Daimler Trucks North America Welfare Benefit Trust available as of January 1, 2017.

2017 Benefit Changes: *This booklet includes benefit changes effective as of January 1, 2017. Any benefit change effective January 1, 2017 is highlighted in italics and indicated as a "**2017 Benefit Change**" (as shown here).* ***You will receive notice of any future significant changes to the Plan and its benefits.***

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

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

The Plan also provides:

- Hearing care benefits through BCBSM;
- Vision benefits through BCBSM's Blue Vision VSP; and
- Dental benefits to participants who are younger than age 65 and their dependents, through Oregon Dental Services, an offering of Moda Health.

Important Information – Enrollment in Medicare: This Plan provides medical and prescription drug benefits for Medicare-eligible retirees, spouses, dependents and surviving spouses through a program that is coordinated with Medicare. Therefore, when you become Medicare-eligible as a retiree, spouse, dependent or surviving spouse, you must enroll in both Medicare Part A and Part B to have coverage under this Plan. If you are eligible for Medicare, be sure to enroll in Medicare Parts A and B or you will not be covered under this Plan.

When you become eligible for Medicare:

- **Sign up for Medicare Parts A and B**
- **Notify BeneSys**, the Trust Administrator, and send a copy of your Medicare enrollment verification to BeneSys as soon as it is received.
- **Do not sign up for an individual Medicare Part D prescription drug plan**. If you sign up for an individual Medicare Part D plan, you will not receive medical or prescription drug coverage from this plan.

In general terms, a court-approved settlement agreement (*Meyers v. Daimler Trucks North America or* "the Settlement") required DTNA to contribute to the UAW Retirees of DTNA Welfare Benefit Trust, a Voluntary Employee Beneficiary Association (VEBA), to fund continued retiree health benefits for certain retirees who satisfy the retirement eligibility requirements specified in this SPD. The VEBA is a trust fund independent from DTNA and the UAW. A VEBA Committee manages the assets of the VEBA and administers the VEBA's benefits. DTNA has no authority or financial obligation with respect to the VEBA other than to satisfy its funding obligation under the Settlement.

This Plan is intended for individuals who are eligible for retiree medical benefits from DTNA upon retirement under the terms of the Prior (for Class Members as defined in the Settlement) or New (for Covered Group Members) Daimler Trucks-UAW Plan. This Plan is not available to:

- UAW-represented employees of DTNA hired on or after April 10, 2010 at Cleveland, Gastonia and Mt. Holly locations;
- UAW-represented employees of DTNA hired on or after July 12, 2010 at the Memphis PDC location;
- UAW-represented employees of DTNA hired on or after August 9, 2010 at the Atlanta PDC location;
- UAW-represented employees of DTNA hired on or after October 10, 2010 at the High Point TBB location; or
- Any employees of Detroit Diesel Corporation.

Your Responsibility

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

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

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

- **Street Address:** 700 Tower Drive, Suite 300, Troy, Michigan 49098
- **Mailing Address:** P.O. Box 4447, Troy, Michigan 48099-4447
- **Website:** www.ourbenefitoffice.com/uawdaimlerretirees
- **Phone:** (248) 641-4918 or toll-free (844) 582-4443
- **Fax:** (248) 813-9898
- **Office Hours:** Monday through Friday, 7:30 a.m. to 4:30 p.m.

This SPD describes how the Plan works, what benefits it provides and how to obtain those benefits. This SPD is only a summary of your benefits; full details of the Plan are set forth in the certificates, policies and schedules of the insurance carriers and benefit providers, the policies of the Committee and other documents that govern the Plan. In case of conflict between this SPD and those documents, the certificates, policies and schedules of the insurance carriers and benefit providers, those documents and not this SPD will govern, unless this SPD specifically states to the contrary. The UAW Retirees of Daimler Trucks North America Welfare Benefit Trust and the Plan are governed by the Committee. The Committee is the legal Plan Administrator. No one has the authority to speak for the Committee in explaining the eligibility rules or benefits of the Plan, except the full Committee or the Plan Administrator to whom the Committee has given such authority. The Committee has the right to interpret the Plan, and to change or eliminate benefits or amend or terminate the Plan at any time. The Committee's interpretation of the Plan is final and binding on all persons dealing with the Trust or claiming a benefit under the Plan. If a decision of the Committee, or its delegate, is challenged in court, that decision will be upheld under current law unless it is determined by the court to have been arbitrary and capricious.

Contact Information

This section includes a convenient list of telephone numbers, websites and other resources for the various benefits described in this document.

Plan/Program	Administrator	Contact Information
Eligibility and Administration	BeneSys	(248) 641-4918 (844) 582-4443 (toll-free) Fax: (248) 813-9898 **Website:** www.ourbenefitoffice.com/uawdaimlerretirees **Street Address:** 700 Tower Drive, Suite 300 Troy, MI 48098 **Mailing Address:** P.O. Box 4447 Troy, Michigan 48099-4447
Medical Benefits: Pre-Medicare Eligible	Blue Cross Blue Shield of Michigan	(800) 810-2583 www.bcbsm.com
Medical Benefits: Medicare-Eligible	Blue Cross Blue Shield of Michigan Medicare Advantage	(866) 684-8216 www.bcbsm.com/medicare
Prescription Drug Benefits	Express Scripts	(844) 567-8525 www.express-scripts.com
Hearing and Vision Benefits	Blue Cross Blue Shield of Michigan	(800) 810-2583 www.bcbsm.com
Dental Benefits	Moda Health	(888) 217-2365 www.modahealth.com

Eligibility and Participation

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

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

Eligibility

Retiree Eligibility

You are eligible for coverage if you are:

- A UAW-Represented DTNA Employee who retired directly from employment with DTNA or any predecessors before May 17, 2014, with eligibility for Retiree Medical Benefits under the terms of the Daimler Trucks-UAW Plan in effect at that time (generally age 55 or older with 10 years of pension service); or
- A UAW-Represented DTNA Employee who retired or retires directly from employment with DTNA on or after May 17, 2014, with eligibility for Retiree Medical Benefits under the terms of the Daimler Trucks-UAW Plan in effect at that time (generally age 60 or older with 10 years of pension service).
  Note: *An eligible UAW-Represented DTNA Employee who retires with 10 years of pension service after reaching age 55 but before reaching age 60 will be eligible for coverage as of the date he or she reaches age 60.*

  Special Note: *An eligible UAW-Represented DTNA Employee who had met the requirements for eligibility to retire for benefits under the original DTNA plan as of May 17, 2014 (age 55, 10 years of service) can continue working and retire with eligibility for coverage even if the Employee has not reached age 60.*

A “UAW-Represented DTNA Employee” for purposes of eligibility for retiree coverage under this Plan is a UAW-represented employee retiring directly from the:

- Cleveland, Gastonia and Mt. Holly, NC locations who was hired before April 10, 2010;
- Memphis, TN location who was hired before July 12, 2010;
- Atlanta, GA location who was hired before August 9, 2010; and
- High Point, NC location who was hired before October 10, 2010.

An employee of Detroit Diesel Corporation is not a “UAW-Represented DTNA Employee.”

Retiree Dependent Eligibility

Eligible dependents of a Retiree include your:

- Legal spouse (same-sex or opposite-sex); and
- Dependent children (eligible for coverage until the end of the calendar year in which they reach age 26).

Eligible children of a Retiree include your:

- Biological children;
- Adopted children (a copy of the petition for adoption must be submitted);
- Dependent stepchildren;
- Children under legal guardianship; you must provide either a:
  - Sworn statement that includes the date of petition for legal guardianship and the date the child established residency; or
  - Statement from the court verifying legal guardianship has been granted;
- Children eligible because a court order makes you or your spouse responsible for the child's health care.

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

Disabled Dependents

Disabled dependents are eligible for coverage at any age if they are totally and permanently disabled by age 26 and you notify the Plan in writing of the condition no later than the end of the calendar year in which the child turns 26. The disability must be due to developmental disability or physical disability that prevents your dependent from being self-supporting. You must also report the child as a dependent on your most recent federal income tax return.

Disabled dependents must be unmarried and dependent on you for support and care to be covered. You may be required to provide verification of a dependent's total and permanent disability.

Adding New Dependents

If you are a retiree who is younger than age 65, you may add new dependents by notifying BeneSys of the new dependent within 30 days after the event (e.g., marriage, birth or adoption). If you do not add a new dependent within 30 days, you can add them later if you meet the requirements for delayed enrollment for that dependent. **If you are a retiree who is age 65 or older, you may not add new dependents.**

Surviving Spouses and Dependents of Deceased Retirees

You are eligible for Plan coverage if you are the surviving spouse or other eligible dependent of a UAW-Represented DTNA retiree who was covered under the Plan as of the retiree's date of death.

Surviving Spouses and Dependents of Deceased Active UAW-Represented Employees

You are eligible for Plan coverage if you are the surviving spouse or other eligible dependent of a UAW-Represented DTNA Employee who dies while employed by DTNA and before retirement and who was eligible to retire as of the date of his/her death if you qualified for coverage under the terms of the Daimler Trucks-UAW Plan in effect at the time of the UAW-Represented DTNA Employee's death. ***Note:*** *A surviving spouse or other dependent eligible for coverage under this provision can enroll for coverage after exhausting six months of DTNA-paid COBRA coverage.*

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

Initial Enrollment

It is important that you contact the Plan Administrator within 30 days after you first become eligible to enroll.

If you do not contact the Plan Administrator at the time you first become eligible to enroll, you may not be able to enroll in the Plan later, unless you meet one of the conditions for delayed enrollment described below.

Your enrollment in the Plan is based on meeting the Plan's eligibility requirements and on all required documentation being completed and received by the Trust Administrator. If you do not provide all required documentation, such as proof of dependent status, Medicare information, and Social Security Number, your and/or your dependent's coverage may be delayed.

As a retiree, you may choose coverage for yourself only or for yourself and your eligible spouse and dependent(s). As a surviving spouse, you may choose coverage for yourself only or for yourself and your eligible dependent children. Your Plan will apply to all dependents covered under your enrollment. Unless specifically provided otherwise in the Plan, such a dependent has no individual right of enrollment, right to select coverage, or right to continue coverages under the Plan. To the extent possible based on the Medicare status of you and your dependents, your plan election will apply to all dependents covered by the Plan.

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

Requesting an Application

When you apply for retirement you should contact the Trust Administrator to request a Plan application. Be sure to complete the application and return all required documentation requested to the Trust Administrator, which will formally begin your retiree health care enrollment process.

If you are an eligible surviving spouse you should contact the Trust Administrator within 30 days of the death of the eligible active employee or retired participant and request an application to ensure that your coverage will be transitioned without interruption.

Your application will request that you provide the names of the dependents you want to enroll in your retiree health care plan. The application will also request documentation to enroll dependents; such as a marriage certificate to enroll a spouse or birth certificates to enroll eligible dependent children. If there are adopted children, stepchildren or principally supported children who you wish to enroll, proper documentation must be provided for those dependents as well.

Once your initial application is returned:

- Your monthly self-payment if necessary will be calculated by the Trust Administrator.
- Once your retirement is effective and you are enrolled in the Plan, you will receive any necessary ID cards.
- You must authorize the Trust Administrator to deduct your monthly contribution payment from your pension check.
- If your pension benefit is not enough to cover the monthly Contribution, you will receive a contribution notice to send the required amount via personal check.

Delayed Enrollment at Initial Eligibility for Coverage

When you first become eligible for enrollment in the Plan, you may elect to delay your participation in the Plan, provided the Plan's requirements are met. As the retiree, you can delay enrollment for yourself and your spouse and other dependents or for your spouse and other dependents only. You may not delay enrollment for yourself and enroll your spouse and dependents immediately upon your initial eligibility.

If you want to delay your participation in the Plan past the time you initially become eligible to participate in the Plan:

- You must notify the Plan Administrator within 30 days after you are initially eligible for coverage; and
- You (or your spouse or dependent) must meet one of the two conditions (A or B) for delayed enrollment described below.

A: Delayed Enrollment with Continuous Qualified Coverage Under Another Plan

- **Delayed Enrollment:** If you decline enrollment at the time of initial eligibility to participate in the Plan, enrollment can be delayed until later if the eligible person has continuous "qualified coverage" under another plan during the period enrollment is delayed (and for up to 30 days after the qualified coverage ends). Your coverage will not become effective until the Plan Administrator has confirmed your eligibility for coverage under the Plan. If delayed enrollment is not completed within that period, enrollment will not be available and the person will not be able to enroll in the Plan until the next annual enrollment date (see B below).

- **Qualified Coverage:** Qualified coverage is medical coverage under one of the following types of plans: employer-sponsored group health plans, federal or state employee benefits, COBRA continuation coverage, HMOs or other state-licensed health insurance, Association Health Plans (AHPs), individual health plans, state high-risk pools, public health plans (such as a plan offered by a state or by a foreign country), the Indian Health Service, Veterans' benefits or other coverage for the uniformed services, Medicaid, and Medicare.

  Coverage under the following kinds of plans does not count as qualified coverage: accident-only, disability, liability, workers' compensation, automobile medical payment and credit-only plans (such as mortgage insurance).

You must enroll for coverage within 30 days after your qualified coverage ends and you must submit proof of continuous qualified coverage satisfactory to the Plan Administrator.

B: Delayed Enrollment at Next Annual Enrollment Date

- If you decline enrollment at the time of initial eligibility to participate in the Plan, and you do not enroll in the Plan at the time qualified coverage ends, you can delay enrollment until the Plan's annual enrollment date.

- **Annual Enrollment Date:** The annual enrollment date is January 1 of each year. The annual enrollment date is the date your delayed enrollment becomes effective and coverage begins under the Plan. **You must notify the Plan Administrator at least 30 days before the annual enrollment date on which you want your coverage to begin. If your request for delayed enrollment is not received by the Plan Administrator within the 30-day period, you will not be able to re-enroll in the Plan on the following January 1, and the next opportunity to begin delayed coverage will be on January 1 of the following year.** ***Note:*** *If you are covered by Medicare, CMS enrollment rules may affect when you can enroll on a delayed basis. Check with the Plan Administrator to find out if there are any CMS requirements or limitations that might affect your ability to delay enrollment.*

- **Example:** You first become eligible to enroll yourself and your spouse on May 1, 2017. You decide to delay your enrollment in the Plan and notify the Plan Administrator. On August 1, 2017, you decide to begin your coverage under the Plan. As long as you notify the Plan Administrator and provide all required information before December 1, 2017, your delayed coverage would go into effect on January 1, 2018. If you do not notify the Plan Administrator by December 1, you will not be able to enroll in the Plan until January 1, 2019, provided you give notice to the Plan Administrator by December 1, 2018.

Opting Out of Coverage

Once you are enrolled in the Plan, you can "opt out" at any time—that is, suspend your coverage under the Plan and re-enter the Plan later—provided requirements are met. There is no limit on the length of time or the number of times you can opt out, as long as the requirements are met.

You must notify the Plan Administrator, in writing, of your desire to opt out. The notice should be given at least 30 days before the first day of the month you want your coverage to end. You can opt out for yourself and your spouse and other dependents, or just for your spouse and other dependents. Your spouse and other dependents cannot continue coverage if you opt out.

If you opt out of Plan coverage, you can resume coverage under the Plan later only at one of the two dates (A or B) described below.

A: Re-Enrollment with Coverage Qualified Coverage Under Another Plan

- Once you opt out of Plan coverage (for yourself or for yourself and your spouse and other dependents), you can re-enter the Plan later if you (and/or your spouse and other dependents, if applicable) have had "qualified coverage" under another plan continuously during the period you were not covered by this Plan. The qualified coverage must be continuous during the entire time you opted out of this Plan. If you opt out and your qualified coverage ends, you will have up to 30 days after the date your qualified coverage is discontinued to re-enroll in this Plan. If your request for re-enrollment is not received by the Plan Administrator within the 30-day period, you will not be able to re-enroll in the Plan until the next annual enrollment date (see B below). To re-enter yourself or an eligible dependent in the Plan, you must provide the Plan Administrator with satisfactory proof of continuous qualified coverage for each person you want to re-enroll in the Plan.

- **Qualified Coverage:** Qualified coverage is medical coverage under one of the following types of plans: employer-sponsored group health plans, federal or state employee benefits, COBRA continuation coverage, HMOs or other state-licensed health insurance, Association Health Plans (AHPs), individual health plans, state high-risk pools, public health plans (such as a plan offered by a state or by a foreign country), the Indian Health Service, Veterans' benefits or other coverage for the uniformed services, Medicaid, and Medicare.

  Coverage under the following kinds of plans does not count as qualified coverage: accident-only, disability, liability, workers' compensation, automobile medical payment and credit-only plans (such as mortgage insurance).

B: Re-Enrollment at Next Annual Enrollment Date

- Once you opt out of Plan coverage (for yourself or for yourself and your spouse and other dependents), you (and/or your spouse and other dependents, if applicable) can re-enter the Plan later, effective on the Plan's next annual enrollment date, provided you give timely notice to the Plan.
- **Annual Enrollment Date:** The annual enrollment date is January 1 of each year. The annual enrollment date is the date your re-enrollment in the Plan becomes effective and coverage begins under the Plan. **You must notify the Plan Administrator at least 30 days before the annual enrollment date on which you want your coverage to resume. If your request for re-enrollment is not received by the Plan Administrator within the 30-day period, you will not be able to re-enroll in the Plan on the following January 1, and the next opportunity to resume coverage will be on January 1 of the following year.**

Note: *If you are covered by Medicare, CMS enrollment rules may affect when you can re-enroll. Check with the Plan Administrator to find out if there are any CMS requirements or limitations that might affect your ability to re-enroll after opting out of the Plan.*

Example: See the example above under "Delayed Enrollment" to understand how the annual enrollment date works.

Enrollment in Medicare

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

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

When Coverage Begins and Ends

If You Are a	Your Coverage Begins	Your Coverage Continues	Your Coverage Ends on the Earliest of:
Retiree	On your retirement date (if eligible), but no earlier than age 60 if you were not eligible to retire under the terms of the Prior Plan on May 17, 2014	As long as you continue to meet the eligibility requirements and make any required payments	▪ The date of your death ▪ When you do not make required payments ▪ The date the Plan is terminated
Spouse	▪ On the date your retiree spouse's coverage begins; or ▪ If the retiree is younger than age 65, on the first of the month following the date you marry and apply for coverage	As long as you and your retiree spouse continue to meet the eligibility requirements and make any required payments	▪ The date of your death ▪ The date of a final decree of divorce from your retiree spouse ▪ When your retiree spouse's coverage ends for not making required payments ▪ The last day of the month in which your retiree spouse dies (however, you may be eligible for coverage as a surviving spouse) ▪ The date the Plan is terminated

If You Are a	Your Coverage Begins	Your Coverage Continues	Your Coverage Ends on the Earliest of:
Dependent Child	▪ On the date retiree coverage begins; or ▪ On the date of birth*; or ▪ As of the date of final adoption or the date of a petition for adoption if the child resides with the retiree*; or ▪ As of the date of marriage between the dependent child's parent and an eligible retiree*; or ▪ As of the date legal guardianship is granted or before that if a petition is filed for legal guardianship and residency is established*	As long as the retiree and you continue to meet the eligibility requirements and the retiree makes any required payments	▪ The date of your death ▪ When you no longer meet the Plan's eligibility rules ▪ When the retiree or surviving spouse removes you from coverage ▪ When required payments are not made on your behalf ▪ The last day of the month in which the retiree dies, unless you qualify as a disabled dependent (if there is no surviving spouse; coverage may continue after a retiree's death if there is a surviving spouse who continues coverage) ▪ The last day of the month in which the surviving spouse dies, unless you qualify as a disabled dependent ▪ The date the Plan is terminated ▪ The end of the calendar year in which you reach age 26, unless you qualify as a disabled dependent

If You Are a	Your Coverage Begins	Your Coverage Continues	Your Coverage Ends on the Earliest of:
Surviving Spouse of a Retired Employee	On the first day of the month after the month in which the retiree dies, as long as you have been covered as a dependent spouse under the Plan	As long as you continue to meet the eligibility requirements and make any required payments	▪ The date of your death ▪ When you do not make any required payments ▪ The date the Plan is terminated
Surviving Spouse of an Active Employee	After exhausting six months of DTNA-paid COBRA coverage	As long as you continue to meet the eligibility requirements and make any required payments	▪ The date of your death ▪ When you do not make any required payments ▪ The date the Plan is terminated

* *You must enroll any new dependent within 30 days of the dependent becoming eligible to be covered as of the date of the event. If you do not notify the Trust Administrator within 30 days of a dependent becoming eligible, you will only be able to cover the new dependent if you meet the requirements for delayed enrollment as described in the "Delayed Enrollment at Initial Eligibility for Coverage" section on page 8 and the "Opting Out of Coverage" section on page 11. If you are a retiree age 65 or older, you are not eligible to enroll new dependents under any circumstances.*

When coverage ends, you may be eligible to continue coverage under COBRA (see the "COBRA Continuation Coverage" section, beginning on page 123.

Removing a Dependent from Coverage

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

Monthly Contributions

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

Monthly payment contributions are subject to change from time to time; you will be notified of the amount of any required monthly contributions.

Enrollment

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

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

Pre-Medicare Medical Benefits

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

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

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

If You Are Medicare-Eligible

If you are eligible for Medicare, but a covered dependent is not (or vice versa), you and your dependent(s) will have different medical coverage. Once you or an eligible dependent become Medicare-eligible, you or your eligible dependent is covered under the Plan's Medicare-Eligible medical coverage, as described in the "Medicare-Eligible Medical and Prescription Drug Benefits" section, beginning on page 63.

How the Plan Works for Pre-Medicare Participants

- **Contributions:** To be covered under the Plan, you must make any required contributions to the Trust.
- **Providers:** The Plan includes a PPO network, the Blue/Blue Preferred Network, administered by BCBSM. BCBSM's network contracts with physicians, hospitals and other medical facilities. Providers in the network, which can change at any time, have agreed to accept this Plan's terms. Every time you need care, you have the option of using a provider in the Plan's network (network provider) or one that does not participate in the network (out-of-network provider). What the Plan pays for most covered services depends on if you use a network or out-of-network provider. Generally, the Plan pays a higher percentage when you use network providers. See the "Preferred Provider Organization (PPO)" section (page 199) for more information.
- **Annual Deductible:** Each year, between January 1 and December 31, you are responsible for paying a certain amount of covered expenses before the Plan begins to pay most benefits.
  - The deductible applies separately to each person.
  - Once you or a family member meets your individual deductible, you or your family member are not required to meet any further deductibles for the remainder of the calendar year. Once your family members reach the family maximum, no further individual deductibles are required for the remainder of the calendar year.

- The annual deductibles for network and out-of-network care are separate and do not count toward each other.
- All covered expenses are subject to the deductible unless specifically noted otherwise, such as network preventive services, which are not subject to the deductible.

- **Copayment:** A copayment is a flat dollar amount that you pay for certain covered services, such as physician office visits and emergency room care. Covered services with copayments are not subject to the deductible. Copayments apply toward meeting your out-of-pocket maximum.
- **Coinsurance:** Once you meet your individual deductible (or family members meet the family deductible), you and the Plan share the cost of covered services.
  - The amount the Plan pays varies depending on the service and whether you use network or out-of-network providers.
  - The percent the Plan pays for network providers is generally higher than what is paid for out-of-network providers.
  - For out-of-network providers, the Plan pays a percent of the allowed amount. The allowed amount is the maximum amount the Plan will pay for a covered service, according to certain standards and considerations established and periodically revised by BCBSM. Network providers have agreed to accept the allowed amount as payment in full, even if their billed charge is more. You are responsible for any charges that exceed the allowed amount.
- **Annual Out-of-Pocket Maximum:** Once amounts you pay for covered expenses reach the out-of-pocket maximum, the Plan pays 100% of most covered expenses for the remainder of the calendar year.
  - The out-of-pocket maximum applies separately to each person.
  - Once you or a family member meets your individual maximum, the Plan begins paying 100% for you or your family member;
  - Once your family members reach the family maximum, the Plan begins paying 100% for all covered family members.
  - Amounts you pay toward meeting the annual deductible count toward meeting the annual out-of-pocket maximum.
  - Charges for non-covered services, amounts over the allowed amount and any pre-certification penalties do not count toward the out-of-pocket maximum.
  - The network and out-of-network maximums are separate and do not count toward each other.
  - Some expenses may not be paid at 100% even after you meet your out-of-pocket maximum.

- **Maximum Benefits:** Certain covered expenses may be limited to an annual or lifetime maximum, as described in the "Summary of Pre-Medicare Medical Benefits" section, beginning on page 23.
  - Lifetime maximums refer to the maximum the Plan will pay for a covered service for a covered person during his or her lifetime.
  - Plan payments for network and out-of-network expenses apply to any maximum.

Medical Necessity

A service that you receive from a medical provider must be medically necessary to be covered under the Plan. In some cases, you are required to pay for services even when they are medically necessary. These limited situations are:

- When you do not inform the hospital that you are a BCBSM member either at the time of admission or within 30 days after you are discharged; and
- When you do not provide the hospital with information that identifies your coverage.

Preferred Provider Organization (PPO)

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

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

Finding a Network Provider

To find a network provider, contact BCBSM by:

• Going online to www.bcbsm.com; or

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

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

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

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

BlueCard Program

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

Travel Outside of the United States

When you travel outside of the United States, you still have access to your benefits as long as services are provided by a licensed physician or an accredited hospital.

Most hospitals and doctors in foreign countries will ask you to pay the bill upfront. Try to get itemized receipts, preferably written in English.

When you submit your claim, please indicate if the charges are in U.S. or foreign currency. Be sure to also indicate whether payment should go to you or to the provider. BCBSM will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, less any cost sharing that applies.

Utilization Review

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

Utilization review includes:

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

Pre-Certification

Pre-certification is required before any non-emergency, non-maternity inpatient admission.

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

If your hospitalization or continued stay is not pre-certified and the stay is not determined to be medically necessary, no benefits will be paid.

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

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

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

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

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

Pre-certification is not required to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology in the BCBSM network.

Individual Case Management Program (ICMP)

Individual Case Management is a voluntary program through which care is provided outside a hospital setting. The program is designed to assist you if the cost of medical care is very high or when you would exhaust available benefits.

A case management analyst evaluates you for the ICMP when you have been referred by a hospital, physician or a family member. When you are accepted as a candidate for the ICMP, an analyst works with you, your family and physician to develop a personal treatment plan, called the alternative benefit plan. The plan is discussed with your family and your attending physician before the recommendations are finalized. The analyst explains all the benefits, resources, facilities and services that are part of the treatment plan. These can include services not normally included in your coverage. The analyst also identifies all payable services and payment arrangements related to the Plan.

Whenever possible, BCBSM will identify more than one provider for services recommended in the Plan. You and your family then have the option to select the provider.

After reviewing the alternative benefit plan documents, you and your family can decide whether or not to accept the plan. Participation is entirely voluntary. Once the plan is implemented, participation will be canceled in either of the following situations:

- Your condition no longer requires the extra benefits documented in the alternative benefit plan; or
- The total amount paid under the alternative benefit plan exceeds the amount that would be payable under your regular facility coverage.

If you have questions about individual case management, contact your BCBSM customer service representative.

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

Summary of Pre-Medicare Medical Benefits

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

	Network	Out-of-Network
Plan Feature		
Annual Deductible	$400 per person $800 per family	$800 per person $1,600 per family
Coinsurance (unless noted otherwise)	Plan pays 80%, you pay 20% after deductible	Plan pays 70%, you pay 30% after deductible ***Note:*** *Services without a network are covered at the network level.*
Annual Out-of-Pocket Maximum	$1,500 per person $3,000 per family ***Note:*** *Includes deductible, coinsurance and medical copayments (but not prescription drug copayments)*	$2,000 per person $4,000 per family ***Note:*** *Includes deductible and coinsurance*
Lifetime Maximum	None	
Preventive Services		
Well Child Care ***Limit:*** *Unlimited exams up to and including age 2*	Plan pays 100%	Not covered
Health Maintenance Exam ***Limit:*** *Beginning at age 3, 1 exam per calendar year*	Plan pays 100%	Not covered
Routine Physical Exam Related X-Rays, EKG and Lab Procedures (performed as part of health maintenance exam)	Plan pays 100%	Not covered

	Network	Out-of-Network
Gynecological Exam ***Limit:*** *2 per calendar year (in addition to health maintenance exam)*	Plan pays 100%	Plan pays 75% after deductible
Pap Smear Screening ***Limit:*** *1 per calendar year*	Plan pays 100%	Plan pays 75% after deductible
Mammography Screening ***Limit:*** *1 per calendar year*	Plan pays 100%	Plan pays 75% after deductible
Contraceptive Methods and Counseling	Plan pays 100%	Plan pays 75% after deductible
Prostate Specific Antigen (PSA) Screening ***Limit:*** *1 per calendar year*	Plan pays 100%	Plan pays 70% after deductible
Endoscopic Exams ***Limits:*** *1 per calendar year*	Plan pays 100%	Plan pays 75% after deductible
Immunizations (pediatric and adult) ***Limit:*** *According to the recommended schedule of the American Academy of Pediatrics and Advisory Committee on Immunizations*	Plan pays 100%	Plan pays 75% after deductible
Emergency Medical Care		
Hospital Emergency Room (qualified medical emergency)	Plan pays 100% after $100 copay/visit; copay waived if admitted	Plan pays 100% after $100 copay/visit; copay waived if admitted
Emergency Room (non-emergency use)	Plan pays 80%	Plan pays 70% after deductible
Urgent Care	Plan pays 100% after $50 copay/visit	Plan pays 100% after $50 copay/visit
Ambulance (medically necessary transport)	Plan pays 80%	Plan pays 80%

	Network	Out-of-Network
Physician Services		
Office Visit	Plan pays 100% after $30 copay/visit	Plan pays 70% after deductible
Office Consultation	Plan pays 100% after $30 copay/visit	Plan pays 70% after deductible
Pre-Surgical Consultation	Plan pays 100% after $30 copay/visit	Plan pays 70% after deductible
Diagnostic Services		
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Plan pays 100%	Plan pays 70% after deductible
Other Diagnostic Tests, X-Rays, Laboratory and Pathology	Plan pays 100%	Plan pays 70% after deductible
Radiation Therapy	Plan pays 100%	Plan pays 70% after deductible
Maternity Services Provided by a Physician		
Prenatal and Postnatal Care Visits	Plan pays 100%	Plan pays 70% after deductible
Delivery and Nursery Care	Plan pays 80% after deductible	Plan pays 70% after deductible
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care and Hospital Services and Supplies	Plan pays 80% after deductible	Plan pays 70% after deductible
Inpatient Medical Care	Plan pays 80% after deductible	Plan pays 70% after deductible

	Network	Out-of-Network
Alternatives to Hospital Care		
Hospice Care	Plan pays 80% after deductible	Plan pays 75% after deductible
Home Health Care	Plan pays 100%	Plan pays 70% after deductible
Skilled Nursing Facility ***Limit:*** *60 days per calendar year*	Plan pays 80% after deductible	Plan pays 70% after deductible
Surgical Services		
Surgery and Related Surgical Services	Plan pays 80% after deductible	Plan pays 70% after deductible
Bariatric Surgery	Plan pays 80% after deductible	Plan pays 70% after deductible
Sterilization—Males (excludes reversal sterilization)	Plan pays 80% after deductible	Plan pays 70% after deductible
Sterilization—Females (excludes reversal sterilization)	Plan pays 100%	Plan pays 70% after deductible
Human Organ Transplants		
Specified Organ Transplants—Designated Facilities Only (when coordinated through BCBSM Human Organ Transplant Program; (800) 242-3504)	Plan pays 100%	Not covered; only covered at designated facilities
Kidney, Cornea, Bone Marrow and Skin	Plan pays 100%	Plan pays 70% after deductible
Behavioral Health and Substance Abuse Treatment Services		
Inpatient	Plan pays 80% after deductible	Plan pays 70% after deductible
Outpatient	Plan pays 100% after $30 copay/visit	Plan pays 70% after deductible

	Network	Out-of-Network
Other Services		
Cardiac Rehabilitation ***Limit:*** *60 visits per calendar year, combined with chiropractic spinal manipulation, physical, occupational and speech therapy, pulmonary rehab and congestive therapy*	Plan pays 100% after $30 copay/visit	Plan pays 70% after deductible
Chiropractic Spinal Manipulation ***Limit:*** *60 visits per calendar year, combined with cardiac rehabilitation, physical, occupational and speech therapy, pulmonary rehab and congestive therapy*	Plan pays 100% after $30 copay/visit	Plan pays 70% after deductible
Durable Medical Equipment	Plan pays 100%	Plan pays 70% after deductible
Prosthetic and Orthotic Devices	Plan pays 100%	Plan pays 70% after deductible
Private Duty Nursing	Plan pays 80% after deductible	Plan pays 70% after deductible
Allergy Testing and Therapy	Plan pays 100% after $30 copay/visit	Plan pays 70% after deductible
Physical, Occupational and Speech Therapy ***Limit:*** *60 visits per calendar year, combined with cardiac rehabilitation, chiropractic spinal manipulation, pulmonary rehab and congestive therapy*	Plan pays 100% after $30 copay/visit	Plan pays 70% after deductible
Prescription Drugs	*See the "Pre-Medicare Prescription Drug Benefits" section, beginning on page 79*	
Hearing	*See the "Hearing Care Benefits" section, beginning on page 89.*	

	Network	Out-of-Network
Vision	*See the "Vision Benefits" section, beginning on page 92.*	
Dental	*See the "Dental Benefits" section, beginning on page 9891.*	

Pre-Medicare Medical Covered Expenses

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

See the "Summary of Pre-Medicare Medical Benefits" table, beginning on page 23, for details about any applicable deductibles, copayments, coinsurance, benefit maximums and limitations.

Hospital Inpatient Care

For an approved hospital admission, the Plan covers the inpatient hospital services listed in this section.

Pre-Certification of Hospital Admissions

Pre-certification is required for all inpatient hospital admissions. A pre-certification review determines if a hospital admission or service is appropriate. This process eliminates unnecessary inpatient hospital care and determines an appropriate length of stay for an admission. Approval of an admission does not guarantee payment.

- **Room and Board:** Benefits include the cost of a semi-private room, the use of special units such as intensive, burn or cardiac care, meals and special diets and general nursing care.
- **General Medical Care:** You have an unlimited number of inpatient days available for the diagnosis and treatment of general medical conditions. The following types of admissions are considered general medical care:
  - ***Maternity and Nursery Care:*** Coverage for obstetrical and maternity care includes delivery room costs and ordinary nursery care; benefits include termination of pregnancy regardless of medical necessity. Maternity services are covered for dependents.
  - ***Cosmetic Surgery:*** Medically necessary admissions for cosmetic and reconstructive surgery for the correction of birth defects, conditions resulting from accidental injuries or traumatic scars and the correction of deformities resulting from certain surgeries, such as breast reconstruction following a mastectomy.

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

Behavioral Health Care and Substance Abuse Treatment

Benefits include coverage for inpatient behavioral health care and inpatient substance abuse treatment in a BCBSM-approved facility. Benefits are also available when services are provided in BCBSM-approved day- or night-care centers.

Care provided during a behavioral health and substance abuse treatment admission can include individual and group therapy sessions and family counseling when provided through an approved facility.

Coverage is provided for the following inpatient services when provided by fully licensed psychologists with hospital privileges:

- Psychological testing;
- Individual psychotherapeutic treatment;
- Family counseling for members of a patient's family;
- Group psychotherapeutic treatment; and
- Inpatient consultations when your physician requires assistance of a consulting psychologist in diagnosing or treating your behavioral health condition.

Note: *Inpatient behavioral health care and substance abuse treatment admissions are covered only if they meet BCBSM severity of illness and intensity of service criteria. Your physician must call BCBSM Behavioral Health Pre-Certification Unit (Magellan Behavioral Health) to attain authorization for service(s) provided.*

Hospital Services and Supplies

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

- **Anesthesia:** Includes administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service;
- **Blood Services:** Blood derivatives, whole blood, blood plasma and supplies used for administering the services beginning with the first pint of blood;
- **Laboratory and Pathology Tests:** Laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service;
- **Drugs:** Medicines prescribed and given during a hospital admission;
- **Durable Medical Equipment:** Items such as oxygen tents, wheelchairs and other hospital equipment used during the hospital stay;

- **Medical and Surgical Supplies:** Gauze, cotton and solutions used during the hospital admission;
- **Prosthetic and Orthotic Appliances:** Items that are surgically implanted in the body, such as heart valves;
- **Special Care Units:** Operating, delivery and recovery rooms; and
- **Diagnostic and Radiology Services:**
  - ***CAT and MRI Scans:*** Scans of the head and body when required for eligible diagnoses and when performed in a facility approved by BCBSM;
  - ***Diagnostic Tests:*** EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury;
  - ***Therapeutic Radiology:*** Radiological treatment by X-ray, isotopes or cobalt for a malignancy; and
  - ***Diagnostic Radiology:*** Ultrasound and X-rays required for the diagnosis of an illness or injury.

Hospital Outpatient Care

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

- **Emergency Room Care:** Treatment of accidental injuries or conditions that BCBSM determines are medical emergencies. If you are not sure if your condition (such as high fever, sharp or unusual pain or minor injury) requires emergency care, but you think it needs prompt attention, it is best to call your doctor or your doctor's after hours phone number.
  - An accidental injury is physical damage caused by an action, object or substance from outside of the body. This includes strains, sprains, fractures, cuts and bruises, allergic reactions, frostbite, sunburn and sunstroke, swallowing poisons and medication overdosing and inhaling smoke, carbon monoxide or fumes.
  - A medical emergency is a condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury.

Emergency Services by Out-of-Network Providers

When an emergency situation occurs, you need to seek care from the nearest provider who may not always be a network provider. If you receive treatment from an out-of-network provider for a medical emergency or accidental injury, services are paid at the network benefit level. The treatment must be for a true emergency as determined by BCBSM.

- **Pre-admission Testing:** Pre-admission testing performed in the outpatient department of a hospital within seven days of a scheduled hospital admission or surgery. These tests must be valid at the time of admission and must not be duplicated during the hospital stay.
- **Physical, Occupational and Speech Therapy:** Physical, occupational and speech therapy services are payable when provided in the outpatient department of a participating hospital, a participating outpatient therapy facility or a physician's office. In addition, physical therapy services are payable in the offices of independent licensed therapists. Therapy must:
  - Be prescribed by the patient's attending physician;
  - Require the assistance and supervision of the appropriate licensed therapist;
  - Be designed to improve or restore the patient's functioning level after a loss in musculoskeletal functioning due to an illness or injury; and
  - Be given for a condition that is capable of significant improvement in a reasonable and generally predictable period.

  Coverage does not pay for:
  - Long-standing, chronic conditions, such as arthritis;
  - Health club membership or spa membership; or
  - Inpatient hospital admissions principally for speech or language therapy.
- **Cardiac Rehabilitation:** Cardiac rehabilitation services if provided:
  - In a hospital-based or freestanding (not owned or operated by a hospital) cardiac rehabilitation center;
  - By a licensed physician (M.D. or D.O.) or professionals working under the direct supervision of a licensed physician;
  - Within six months of a diagnosis of acute myocardial infarction, angina pectoris or a prior related professional cardiac service, including coronary artery bypass surgery, percutaneous transluminal coronary angioplasty, cardiac transplantation or heart valve surgery;
  - For physician prescribed exercises to cardiac patients during phase II of their cardiac rehabilitation treatment; and
  - Within the 12 week total time allowed for cardiac rehabilitation.

Phase II services include:

- Six-week program that follows inpatient admission or outpatient services for a heart condition;
- Complete medical history;
- Stress test with electrocardiogram monitoring;
- Lipid profile;
- ECG;
- Three exercise sessions per week; and
- Nutrition and risk factor recognition classes.

Note: *Patient education services and ECG testing are not covered as separately identifiable services when reported as part of cardiac rehabilitation.*

- **Outpatient Behavioral Health Care:** Psychological testing, individual and group therapy sessions and family counseling when provided through an approved facility, by a physician or by a fully licensed psychologist.
- **Outpatient Substance Abuse Treatment:** Outpatient substance abuse treatment provided at an approved substance abuse treatment facility.

Additional Hospital Services and Programs

- **Chemotherapy:** Chemotherapy treatment in a hospital, in the outpatient department of a hospital or in a physician's office. Benefits include the administration and cost of drugs when ordered by a physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration (FDA) for use in chemotherapy and provided as part of a chemotherapy program, if the treatment is not considered experimental or investigative. Coverage includes three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.
- **Hemodialysis:** Hemodialysis services to treat acute renal (kidney) failure and end stage renal disease. Treatment may take place in the outpatient department of a hospital, in a licensed facility or in the home. Home hemodialysis must be arranged by a physician and services must be billed by a participating hospital that has an approved hemodialysis program. Coverage includes the cost of the equipment, installation, training and necessary hemodialysis supplies.

  Note: *Dialysis services for the treatment of End Stage Renal Disease (ESRD) are coordinated with Medicare. It is important for individuals with ESRD to apply for Medicare coverage regardless of age. BCBSM is the primary payer for up to 30 months if the member is under 65 and is eligible for Medicare solely because of ESRD.*

- **Home Hemophilia Program:** Necessary medications and supplies used to treat hemophilia in a home setting. All medications and supplies needed for the patient to self-infuse at home, including syringes, needles and the antihemophilic factor, must be supplied by a participating hospital. Benefits may also include training to the patient or a family member on how to inject the antihemophilic factor, when the training is provided through a participating hospital.
- **Home Health Care:** Home health care visits when the patient is referred to and accepted by a participating home health care agency. The services must be prescribed by a physician who submits a detailed treatment plan to the home health care agency and certifies that home health care is medically necessary. Home health care benefits include nursing services, physical, occupational or speech therapy, social service and nutritional guidance, medication, supplies and lab work.
- **Skilled Nursing Care:** A convalescent care facility provides skilled, comprehensive inpatient care for either a short or extended period. Coverage includes skilled nursing care in an approved skilled nursing facility when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve. Physician benefits for medical care are limited to two visits per week. Convalescent care benefits cannot be used for custodial care or care for mental deficiency, mental retardation, senile deterioration or cases in which the prognosis is unfavorable.

Physician Benefits

The Plan covers the following physician services:

- **Office Visits:** Visits to a physician's office, outpatient clinic or outpatient department of a hospital for the examination, diagnosis and treatment of general medical conditions. Services include medical care, consultations, medication and injections.
- **Preventive Services:**
  - Routine health maintenance exams;
  - Routine gynecological exam;
  - Well child care, which includes visits to a physician to monitor the development of a child;
  - Laboratory and screening services, which include routine laboratory, diagnostic tests and X-rays related to a routine exam, including, but are not limited to:
    - Chemical profile;
    - Complete Blood Count (CBC);
    - Fecal occult blood screening;
    - Urinalysis;
    - Chest X-ray; and
    - EKG.

- **Endoscopic Procedures:** When performed as routine screening:
  - Colonoscopy;
  - Sigmoidoscopy;
  - Flexible sigmoidoscopy; and
  - Procto-sigmoidoscopy.
- **Routine Mammograms:** Routine mammogram (breast X-ray) for female members. More frequent mammograms are covered as diagnostic services if requested by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.
- **Pap Smear:** Laboratory services for routine pap smear for female members. More frequent pap smears are covered as diagnostic services for the following conditions:
  - Previous surgery for vaginal, cervical or uterine malignancy;
  - Presence of a suspected lesion in the vaginal, cervical or uterine areas; and
  - Post-surgery.
- **Prostate Specific Antigen Screening:** PSA screening laboratory test for male members.
- **Immunizations:**
  - Childhood and adult immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that comply with the Affordable Care Act; and
  - Human Papilloma Virus (HPV) vaccine for females and males age 9 to 26.
- **Allergy Services:** Allergy testing and therapy when performed by or under the supervision of a physician, including scratch and puncture testing, allergy survey, allergy serum and therapeutic injections.
- **Chiropractic Services:** Services include new patient office calls (one every 36 months), office visits, chiropractic traction, chiropractic manipulation, physical therapy, X-rays and spinal and extra-spinal manipulation, when services are received from a chiropractor or other qualified provider.
- **Physician Emergency Care:** Physician services for the initial examination and treatment of accidental injuries and conditions determined by BCBSM to be medical emergencies.
- **Inpatient Medical Care:** While you are an inpatient, you are covered for an unlimited number of medical visits by a physician for general medical conditions that are not related to surgery or maternity care.

- **Inpatient Consultations:** In complicated situations, the physician in charge of the case may consult another physician for assistance or advice about diagnosis or treatment. Necessary inpatient consultations are covered when they are requested by the attending physician.
- **Pre-surgical Consultations:** A pre-surgical consultation can help you get additional information about the benefits and risks of your proposed surgery and inform you of any alternative treatments that may be available.

Maternity Care

Maternity care includes:

- Obstetrical services, including delivery and pre-and postnatal care visits;
- Initial inpatient examination of the newborn when performed by a physician other than the delivering provider;
- Termination of pregnancy regardless of medical necessity;
- Maternity services for dependents; and
- Maternity care when provided by a certified nurse midwife.

Delivery must be in a hospital or BCBSM-approved birthing center.

Surgery

Surgical procedures needed for the diagnosis and treatment of diseases and injuries are covered. Surgical benefits include all related pre- and post-operative medical care by the attending surgeon.

- Multiple surgeries (two or more surgical procedures during one operative session) are subject to payment limitations:
  - When the surgeries are through different incisions, the Plan pays the approved amount for the primary surgery (the procedure with the higher benefit payment), plus half the approved amount for any additional procedures.
  - When the surgeries are through the same incision, the Plan pays the approved amount for the primary surgery only. Physician payment for additional surgeries through the same incision is included in the amount paid for the primary surgery.
- Laser surgery when the procedure is not considered experimental or investigative and payment is not more than that allowed for conventional surgical procedures.

- Breast reconstruction surgery for:
  - Reconstruction of the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
- Cosmetic or reconstructive surgery only for the correction of birth defects, for conditions resulting from accidental injuries or traumatic scars and for correction of deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.
- Dental surgery for the removal of impacted teeth or multiple extractions only when the patient must be hospitalized for the surgery because a concurrent medical condition exists. The inpatient admission for the dental surgery must be considered medically necessary to safeguard the life of the patient.
- Voluntary sterilization for both male and female patients, regardless of medical necessity. Reversal procedures are not covered.

Ambulatory Surgery Care

The Plan includes coverage for surgical services performed in an ambulatory surgery facility. This generally includes elective surgery that does not require the use of hospital facilities but cannot routinely be performed in an office setting.

Technical Surgical Assistance

Surgical assistance provided by another physician when requested by the operating surgeon is covered. However, it is payable only when an intern or hospital physician is not available for assistance. The surgery requiring assistance must be an approved major surgical procedure.

Anesthesia

Your benefits include the administration of drugs or gases when they are necessary for a covered service, and when they are given by a physician other than the operating surgeon or an assistant or by a certified registered nurse anesthetist. Anesthesia provided by a nurse anesthetist under the supervision of an anesthesiologist also is covered.

TMJ Surgery

Temporomandibular Joint Syndrome (TMJ) or jaw-joint disorder benefits for TMJ or jaw-joint disorder are limited to surgery directly to the jaw joint, X-rays (including MRIs) and arthrocentesis (injection procedures). However, some symptom-management services are covered, such as office visits, reversible appliance therapy, physical medicine (diathermy, hot and cold applications) and medications.

Irreversible treatment of the mouth, teeth or jaw is intended to bring about permanent change in the positioning of the jaw or a permanent alteration of the vertical dimension. Reversible treatment of the mouth and jaw is not intended to result in permanent alteration of the bite; it is directed at managing the patient's symptoms.

Other than the exceptions noted, benefits are not payable for reversible or irreversible medical or dental treatment of the mouth, teeth, jaw, jaw joint and skull and the muscles, nerves and tissue related to the jaw joint. These exclusions include, but are not limited to, crowns, inlays, caps, restorations, grinding, orthodontics, dentures, partial dentures or bridges.

Diagnostic and Radiation Services

- **Diagnostic Radiology:** Outpatient diagnostic radiology services required for the diagnosis of an illness or injury when performed and billed by a physician. Services may be performed in the physician's office or in the outpatient department of a hospital. Covered services include ultrasound and diagnostic X-rays, MRI and CAT scans of the head and body when performed for an eligible diagnosis in approved facilities. Select services may require pre-certification.
- **Laboratory and Pathology Services:** Laboratory and pathology services performed in the physician's office or in the outpatient department of a hospital and ordered and billed by a physician, including laboratory and pathology tests required in the diagnosis of an illness or injury.
- **Diagnostic Tests:** Diagnostic tests performed in a physician's office or outpatient department of a hospital when performed and billed by a physician. Covered tests include EKGs, EMGs, EEGs, thyroid function tests, select sleep studies and nerve conduction studies required in the diagnosis of an illness or injury. Select services may require pre-certification.
- **Radiation Therapy:** Radiation therapy performed in a physician's office or outpatient department of a hospital when performed and billed by a physician. Covered services include radiological treatment by X-ray, isotopes or cobalt for a malignancy.

Additional Benefits

- **Acupuncture:** The following acupuncture procedures when performed by a M.D. or D.O. for:
  - Chronic headaches;

- Post therapeutic neuralgia;
- Myofascial complaint;
- Rheumatoid arthritis;
- Neuritis;
- Sciatica; and
- Osteoarthritis.

- **Ambulance Services:** Ground and air ambulance services required because of an injury or hospital admission. Services must be medically necessary and prescribed by the attending physician. The patient may be transported to and from the hospital, between hospitals and between hospitals and approved medical facilities. Services must be provided by a licensed ambulance company. This benefit includes the equipment used, mileage and waiting time. Services provided by a fire department, rescue squad or other carrier whose fee is a voluntary donation are not covered.
- **Prescribed Contraceptive Devices:** Physician-prescribed contraceptive devices, such as diaphragms and IUD or contraceptive implants designed to prevent pregnancy.
- **Durable Medical Equipment:** Benefits are covered for rental or purchase (whichever is less expensive) and repair of durable medical equipment appropriate for home use and prescribed by a physician. Examples of durable medical equipment are canes, wheelchairs and walkers. The equipment must be medically necessary for the treatment of an illness or injury or used to improve the functioning of the patient's body. Equipment primarily for the comfort or convenience of the patient is not covered.
- **Prosthetic and Orthotic Appliances:** External appliances to replace a missing part of the body or to correct any defect of form or function of the body. Benefits include temporary appliances, delivery, services and fitting charges. Appliances must be prescribed by a physician and supplied by a fully accredited facility approved by the American Board of Certification in Orthotics and Prosthetics. Adjustment or replacement of eligible appliances is payable only when required because of normal wear or growth or a change in the patient's condition. Examples of these appliances are braces and artificial arms and legs.
- **Prosthetic Appliances Following Mastectomy:** External breast prosthesis following a mastectomy when prescribed by a physician. Benefits cover two post-surgical forms and four surgical bras every benefit period. Replacements are payable only when required because of a significant change in body weight or when necessary for hygienic reasons.
- **Oxygen and Other Therapeutic Gases:** Oxygen and equipment to administer the oxygen when medically necessary and prescribed by a physician.
- **Optical Services Following Cataract Surgery:** Examination and fitting of one pair of contact lenses or eyeglasses when prescribed by a physician following cataract surgery. Cataract sunglasses are not covered.

- **Dental Services:** Dental services and appliances required for the treatment of an accidental injury. The injury must have been caused by an external force. Injuries resulting from biting or chewing are not covered unless they are the direct result of an act of domestic violence or a mental health condition.
- **Medical Supplies and Dressings:** Medically necessary medical supplies and dressings that are used to treat a diagnosed condition.
- **Podiatrist Services:** Routine foot care services.
- **Private Duty Nursing:** Private duty nursing when the patient's condition requires 24-hour, continuous skilled care by a professional nurse on a one-to-one basis. Non-skilled care or care provided by a nurse who ordinarily resides in the patient's home or is a member of the immediate family is not covered. The services must be prescribed by a physician and provided by a registered nurse or licensed practical nurse. The attending physician must complete a certification statement each month the patient is under care.
- **Pain Management:** Comprehensive evaluation and treatment of diseases, including the management of symptoms such as intractable pain that may be associated with these diseases.

Hospice Care

A hospice is an agency or facility that is primarily involved in providing care to terminally ill individuals. A patient is considered terminally ill when the attending physician has certified in writing that life expectancy is six months or less.

Hospice benefits replace the benefits normally available under your medical coverage with benefits that are specific to the patient's needs. These may include alternative services to provide more appropriate care for the patient. However, services for medical conditions unrelated to the terminal illness are subject to the Plan's medical coverage guidelines.

You may apply for hospice benefits only after discussion with and referral by your attending physician. All hospice services must be arranged through an approved hospice provider.

The hospice program provides four levels of care:

- **Routine Home Care:** Services provided to patients who are living at home and are not receiving continuous home care. Benefits include counseling, home health care and physical therapy. Such care must not exceed eight hours per day.
- **Continuous Home Care:** Nursing care services provided to patients during crisis periods to enable them to stay in their homes. Such care must be provided for a minimum of eight continuous hours per day.

- **Inpatient Respite Care:** Short-term inpatient services to allow home care providers short periods of relief. Such care must be provided in an approved facility on a non-routine or occasional basis and in increments of five days or less in any 30-day period.
- **General Inpatient Care:** Services for pain control and acute and chronic symptom management that cannot be provided in other less intensive settings.

Organ Transplants

The following types of human organ transplants are covered when received at a participating hospital or, where noted, in a BCBSM-approved transplant facility:

- **Organ and Tissue Transplants:** Services and expenses for transplanting organs and tissues to an eligible recipient when performed in a participating facility. Coverage includes evaluation and surgical removal of the donated organ (including skin, cornea and kidney) from a living or non-living donor.
- **Bone Marrow Transplants:** When directly related to two tandem transplants, two single transplants or a single and a tandem transplant per member, per condition and when pre-approved by BCBSM, the following services are covered:
  - Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. Immunizations are covered as recommended by the Advisory Committee on Immunization Practices (ACIP).
  - Allogeneic Transplants:
    - Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their 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 pre-approved;
    - 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 or Beta Thalassemia.)

      Note: *Harvesting and storage are 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 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; and
- Hospitalization.

Allogeneic transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients);
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients);
- 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);
- 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;
- Mucolipidoses (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; and
- Plasmacytomas.

- 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; and
  - Hospitalization.

  Note: *A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma. The Plan pays for up to two tandem transplants or a single and a tandem transplant per patient for this condition.*

  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; and
- Mantle cell lymphoma.

Note: *In addition to the conditions listed above, the Plan pays 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 state law requires that these drugs, and the reasonable cost of their administration, be covered.*

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

- Services that are not medically necessary.
- Services provided in a facility that does not participate with BCBSM.
- Services provided by persons or entities that are not legally qualified or licensed to provide such services.
- Services provided to a transplant recipient who is not a BCBSM member.
- Services provided to a donor when the donor's health care coverage will pay for the services.
- Services provided to a donor when the transplant recipient is not a BCBSM member.
- Any services related to or for allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements.
- Expenses related to travel 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

Hospital care for specified human organ transplants performed during the transplant benefit period is covered in full when the transplant is pre-approved by BCBSM and received at a BCBSM designated transplant facility. Benefits apply only to transplants of the:

- Combined small intestine-liver;
- Heart;
- Heart-lung(s);

- Liver;
- Lobar lung;
- Lung(s);
- Pancreas;
- Partial liver;
- Kidney-liver;
- Simultaneous pancreas-kidney;
- Small intestine (small bowel); and/or
- 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, the Plan covers:

- Facility and professional services;
- Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed. Payment is based on BCBSM's approved amount;
- Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered (the Plan pays for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP)); and
- 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: *The Plan covers any service needed to treat a condition as a direct result of the organ transplant surgery if it is a benefit under this Plan.*

The Plan also provides:

- Up to $10,000 for eligible travel and lodging during the initial transplant surgery. This includes:
  - 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).

    Note: *In certain limited cases, the Plan 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).

- Coverage to acquire the organ (the organ recipient must be a BCBSM member), which includes, but is not limited to:
  - Surgery to obtain the organ;
  - Storage of the organ; and
  - 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.

Note: *The Plan pays the BCBSM approved amount for the cost of acquiring the organ.*

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

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

- Services that are not BCBSM benefits.
- Services provided to a recipient who is not a BCBSM member.
- Living donor transplants not listed in this Plan.
- Anti-rejection drugs that do not have FDA approval.
- Transplant surgery and related services performed in a non-designated facility. You must pay for the transplant surgery and related services you receive in a non-designated 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, 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, greetings 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 before your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under this Plan.
- Experimental transplant procedures.

Oncology Clinical Trials

Covers 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 provided following an approved phase II or III clinical trial. This does not limit or preclude coverage of antineoplastic drugs when state law requires that these drugs, and the reasonable cost of their administration, be covered.

Pre-approval is required. If pre-approval is not obtained before you receive services or are admitted to a hospital, **the services, admission and length of stay will not be covered.**

The designated cancer center must submit its written request for pre-approval to:

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program
Mail Code 504C
600 Lafayette East
Detroit, MI 48226
Fax: (866) 752-5769

For questions, call 1-800-242-3504

The services are covered when directly related to a transplant. The transplant must be performed at a designated cancer center or its affiliate to be a covered benefit.

Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. The Plan pays for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

The Plan pays for the following only after they have been pre-approved by BCBSM:

- 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; and
  - Hospitalization.
- Allogeneic Transplants:
  - Blood tests to evaluate donors (if not covered by the potential donor's insurance);

- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is pre-approved;
- 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 (the Plan covers 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; and
- Hospitalization.

The Plan pays up to a total of $5,000 for travel and lodging expenses directly related to pre-approved services provided during an approved clinical trial. The expenses must be incurred during the period that begins with the date of pre-approval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect.

The Plan pays the expenses of an adult patient and another person, or expenses of a patient under the age of 18 years and expenses for two additional people, up to a combined maximum per patient and persons eligible to accompany the patient of:

- $60 per day for travel; and
- $50 per day for lodging.

Note: *Daily allowances may be adjusted periodically.*

Coverage does not pay for:

- An admission to a designated center or a length of stay at a designated center that has not been pre-approved.
- Services that have not been pre-approved.
- Services that are not medically necessary.
- Services provided at a non-designated 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 provided to a donor when the donor's health care coverage will pay for the 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.
- 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, babysitter or day care services, services provided by family members, reimbursement of food stamps, mail or UPS services, internet connection and entertainment (such as cable television, books, magazines and movie rentals).
- Any other services, admissions or lengths of stay related to any of the above exclusions.

Experimental Bone Marrow Transplants

The Plan covers hematopoietic transplants and related services and FDA-approved antineoplastic drugs to treat the conditions listed in this section. This does not limit or preclude coverage of antineoplastic drugs when state law requires that these drugs, and the reasonable cost of their administration, be covered.

Pre-approval is required. If pre-approval is not obtained before you receive services or are admitted to a hospital, **the services, admission and length of stay will not be covered.**

Your provider must submit its must submit its written request for pre-approval to:

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program
Mail Code 504C
600 Lafayette East
Detroit, MI 48226
Fax: (866) 752-5769

For questions, call 1-800-242-3504

The services are covered when directly related to two tandem transplants, two single transplants or a single and a tandem transplant per member per condition as covered.

The Plan pays for the following services only after they have been pre-approved by BCBSM:

- Blood tests to evaluate donors (if not covered by the potential donor's insurance);
- Search of the National Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is pre-approved;
- Infusion of colony stimulating growth factors;
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cells and/or umbilical cord blood;

  Note: *The recipient of harvested material must be a BCBSM member.*
- Purging or positive stem cell selection of bone marrow or peripheral blood stem cells for autologous transplants;
- 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 for allogeneic transplantation;
- Hospitalization;
- Services you receive as a donor of bone marrow and/or peripheral blood stem cells (e.g., infusion of growth stimulating factors, hospitalization, blood tests and harvesting), unless recipient is not a BCBSM member; and
- Immunizations against certain common infectious diseases during the first 24 months post-transplant. The Plan pays for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

The above services are payable for autologous and allogeneic transplants if they treat certain solid tumors involving breast (stages I, II, III and IV), colon, lung, brain, skin, epithelium of the ovaries, prostate, stomach, kidney, uterus or cervix.

The above services are also payable for allogeneic transplants from non-identical HLA donors when they treat the following conditions:

- Aplastic anemia;
- Acute lymphocytic leukemia;
- Acute nonlymphocytic leukemia;
- Chronic myeloid leukemia;
- Severe combined immune deficiency disease;

- Wiskott-Aldrich syndrome;
- Osteopetrosis;
- Beta-thalassemia, major;
- Neuroblastoma (Stage III or IV);
- Non-Hodgkin's lymphoma (low, intermediate or high grade); and
- Multiple myeloma (this condition is also payable when the donor is HLA identical).

Note: *Allogeneic transplants are considered experimental when an unrelated donor has more than one HLA genetic marker mismatch, and related donors have more than two HLA genetic marker mismatches.*

The Plan does not cover:

- A hospital admission or length of stay at a hospital that has not been pre-approved.
- Services that have not been pre-approved.
- Services that are not medically necessary.
- Services provided in a facility that does not participate with BCBSM.
- A transplant intended to treat a condition not described in this Plan.
- Services provided by persons or entities that are not legally qualified or licensed to provide such services.
- Expenses related to travel or lodging for the donor or recipient.
- Donor services intended to treat a condition not described in this Plan.
- Services provided to a transplant recipient who is not a BCBSM member.
- Services provided to a donor when the donor's health care coverage will pay for the services.
- Donor services when the transplant recipient is not a BCBSM member.
- Items, such as investigational drugs, that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company).
- Non-health care services and/or research management (such as administrative costs).
- Search of an international donor registry.
- Services not included in this Plan.
- Treatment of a condition not covered in this Plan.
- Any other services, admissions or lengths of stay related to any of the above exclusions.

Pre-Medicare Medical Exclusions

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

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

- The following amounts or charges may not be used to meet your out-of-pocket maximum:
  - Charges that exceed the approved amount;
  - Charges for non-covered services; and
  - Deductible or coinsurance required under other BCBS coverage.
- Care and services available at no cost to you in a veteran's, marine or other federal hospital or any hospital maintained by any state or governmental agency.
- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location.
- Custodial care, rest therapy and care in nursing or rest home facilities.
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition, such as a heart condition, exists.
- Treatment of temporomandibular joint syndrome and related jaw-joint problems by any method other than as specified in this handbook.
- Any medical care, hospitalization or service provided before the effective date of coverage or after the coverage termination date.
- Routine hospital outpatient care requiring repeat visits for the treatment of chronic conditions such as diabetes.
- Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication), basal metabolism tests or electrocardiography.
- Items for the personal comfort or convenience of the patient.
- Psychiatric services after determination that the patient's condition will not respond to treatment.
- Psychological tests for vocational guidance or counseling.
- Routine premarital or pre-employment exams.

- Routine digital rectal exams.
- Prescription drugs (generally covered under the freestanding program).
- Services and supplies that are not medically necessary according to accepted standards of medical practice.
- Services provided through a medical clinic or similar facility provided or maintained by an employer.
- Treatment of occupational injury or disease that the employer is obligated to furnish or otherwise fund.
- Care and services received under another plan offered by BCBSM or another BCBS plan.
- Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which the member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal law requires Medicare to be secondary.
- Cosmetic surgery solely for improving appearance, except as specified in this handbook.
- Treatment of a condition caused by military action or war, declared or undeclared.
- Services, care, devices or supplies considered experimental or investigative.
- Services for which a charge is not customarily made; services for which the patient is not obligated to pay.
- Dialysis services after 30 months of end stage renal disease treatment.
- Services that are not included in your employer's coverage documents.
- Charges from a non-participating provider that are in excess of the BCBSM approved amount.
- Charges for hospital room accommodations over and above the hospital's regular charges covered by your medical benefits.
- Transportation and travel except as specified in this handbook.
- Hearing exam and preparation, fitting or procurement of hearing aids (may be covered under your hearing care coverage).
- Eyeglasses or contact lenses and vision examinations for prescribing or fitting them (except for aphakic patients) or for soft contact lenses or sclera shells intended for use in the treatment of diseases or injury or as specified following cataract surgery (may be covered under your vision care coverage).
- Professional fees for injections given by anyone other than a physician.
- Injections for cosmetic purposes.
- Charges for examinations required by school, camp, licensing or for any other regulatory purpose.

- Hospital admission for weight control.
- Testing more frequently than necessary.
- Dental care and dental appliances except those specified in your coverage.
- Reversal of sterilization procedures (for males and females).
- Artificial insemination, in-vitro fertilization or embryo transfer procedures.
- Radial keratotomy.
- Diabetic supplies, including test strips, lancets, needles and syringes.

Pre-Medicare Prescription Drug Benefits

As part of your medical coverage, you receive prescription drug coverage that helps you pay the cost of prescribed medications. The Plan includes both a retail pharmacy and home delivery component.

Pre-Medicare prescription drug benefits are provided through Express Scripts (the pharmacy benefit manager).

Summary of Prescription Drug Benefits—Pre-Medicare

2017 Benefit Change: *Copayments highlighted in italics in the following chart are new as of January 1, 2017.*

Benefit Feature	Participating Pharmacy	Non-Participating Pharmacy
Plan Feature		
Deductible	None	
Out-of-Pocket Maximum	None	
Maximum Supply		
Retail	31-day	
Home Delivery (Mail Order)	90-day	
Copayments		
Tier 1: Generic	You pay: ▪ **Retail:** *$15 copay*/up to 31-day supply ▪ **Home Delivery:** *$30 copay*/90-day supply	Plan reimburses 75% of approved amount

Benefit Feature	Participating Pharmacy	Non-Participating Pharmacy
Tier 2: Preferred Brand	You pay: ▪ **Retail:** *$35 copay*/up to 31-day supply ▪ **Home Delivery:** *$70 copay*/90-day supply	Plan reimburses 75% of approved amount
Tier 3: Non-Preferred Brand	You pay: ▪ **Retail:** *$90 copay*/up to 31-day supply ▪ **Home Delivery:** *$180 copay*/90-day supply	Plan reimburses 75% of approved amount

How Pre-Medicare Prescription Drug Benefits Work

When you use a participating retail pharmacy or the home delivery program, you pay a copayment, which is a flat dollar amount, for each prescription you have filled; there is no deductible to meet. The copayment amount you pay for your prescription depends on the type of medication (generic or brand name, for example), as described in the "Summary of Prescription Drug Benefits—Pre-Medicare" table on page 53.

Express Scripts has negotiated discounted prices for prescription drugs under the Plan when a prescription is filled at a participating retail pharmacy or through home delivery.

If you have your prescription filled at a non-participating pharmacy, you must pay for your prescription at the time you pick it up and then submit a claim for reimbursement; the Plan will reimburse 75% of the approved amount.

Types of Medication

Generic and Brand Name Medications

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

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

Preferred and Non-Preferred Medications

Express Scripts has a list of preferred medications (sometimes referred to as a formulary). This is a list of safe, effective and FDA-approved prescription drugs that may be listed under different brand names. Medications on the Plan's preferred list generally cost less than other similar medications that are not included on the list.

Preferred Drug List Exclusions

The most current listing of preferred medications is available from Express Scripts by calling (844) 567 8525 or visiting www.express-scripts.com. Medications on the list may change periodically; new medications added or removed. If a change affects your prescription, you will be notified.

In most cases, if you fill a prescription for an excluded drug, you will pay the full retail price. To avoid paying full price, you can ask your doctor to prescribe one of the preferred alternatives. Costs for covered alternatives may vary. Log on to www.express-scripts.com/covered to compare drug prices.

Where to Have Your Prescription Filled

Retail Pharmacy

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

Express Scripts has a national network of participating retail pharmacies. You can have your prescription filled at a retail pharmacy for up to a 31-day supply.

To fill a prescription at a participating retail pharmacy:

- Get a prescription from your physician for up to a 31-day supply;
- Bring your prescription to a participating pharmacy;
- Show your Express Scripts ID card to the pharmacist;
- Verify that the pharmacist has the correct information about you; and
- Pay your copayment.

Finding a Participating Retail Pharmacy

To find a participating retail pharmacy, contact Express Scripts by:

- Going online to www.express-scripts.com; or
- Calling (844) 567 8525

Non-Participating Retail Pharmacy

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

To file a prescription drug claim:

- Request an itemized receipt from the pharmacy that includes the:
  - Date the prescription was filled;
  - Name and address of the pharmacy;
  - NDC (National Drug Code) number;
  - Name of drug and strength;
  - Quantity;
  - Days' supply; and
  - Prescription number.
- Complete an Express Scripts Prescriptions Direct Reimbursement Claim form. Forms can be requested through customer service or when you register at www.express-scripts.com. ***Note:*** *Use a separate claim form for each pharmacy from which you purchase prescriptions.*
- Attach your itemized receipt(s) to your claim form.
- Review your claim form to be sure it is accurate and complete. Incomplete forms will cause your payment to be delayed. Be sure to sign each claim and keep a copy of your claims and receipts.
- Mail completed claim forms to the address shown on the claim form.

All claims must be submitted within one year of the date purchased to be eligible for reimbursement.

Home Delivery Pharmacy

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

Contact Express Scripts for specific information on how to use the home delivery program. Follow the instruction in the materials you receive.

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

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

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

2017 Benefit Change:
Mandatory Home Delivery Program: *Since both you and the Trust save money when maintenance medications - prescriptions that are expected to be taken over the long term (longer than two refills) - are filled through the home delivery program, the Plan includes a mandatory home delivery program. If you are taking a maintenance medication, you are required to receive your maintenance medication prescription through the home delivery program. When you have a prescription for a maintenance medication, you are allowed* ***three*** *31 day fills at a retail pharmacy. After that, to have your prescription covered, you must use the home delivery program. If you do not use the home delivery program on the fourth fill,* ***you will be responsible for the entire cost of the prescription drug****. Please contact Express Scripts for a home delivery form.*

Specialty Pharmacy

When you use a medication that is classified as a specialty drug, then you or your physician must order that drug from Express Scripts' Specialty Pharmacy. Specialty drugs require special handling, dose administration or monitoring and are used to treat complex or rare medical conditions. Specialty medications are injectable, infused, inhaled or oral high-cost biotech products with unique handling and/or dosing requirements. Express Scripts has established a list of specialty medications that is periodically revised. In most situations, the specialty pharmacy will ship your medication and any required supplies you need directly to your home.

For more information on how to get specialty medications, contact Express Scripts.

Safety and Care Management Programs

2017 Benefit Change: *These programs were expanded as of January 1, 2017.*

The Trust's prescription drug benefits include a number of safety and care management programs, as described below. These programs are designed to ensure the medications you are being prescribed are appropriate and cost effective. If you are impacted by one of these programs, you and your physician will be notified when you fill your prescription.

- ***Quantity Limits:*** *To prevent overutilization, as well as waste or abuse, the number of pills dispensed each month may be limited for certain medications.*
- ***Step Therapy:*** *Certain brand name medications and specialty drugs may not be covered under the Plan until other similar acting but less costly drugs are tried first. These programs should be discussed with your physician.*

Prior Authorizations: *Certain drugs may require prior authorization before the medication can be dispensed. The prior authorization process is designed to encourage safe, cost-effective use of prescription medications by confirming the medical necessity of a specific medication before it is approved for coverage. Prior authorization focuses on medications that may have risks, serious side effects, dangerous drug interactions or restrictions for use with a specific condition. If a prescribed medication requires prior authorization, your doctor will need to initiate a review with Express Scripts. Your pharmacy will let you know if a medication you are taking requires prior authorization. If you already know that a medication you have been prescribed requires prior authorization, you can ask your doctor to request a review before filling your prescription.*

To initiate prior authorization, ask your doctor to contact Express Scripts (your doctor may call 1-800-922-1557 to begin the process). The review process usually takes 3-5 days. Both you and your doctor are sent a letter notifying you of the approval or denial of coverage. If your medication is not approved for coverage under the program, you will be responsible for the full cost of the drug.

Compound Drug Management: *Ingredients have been put on an inclusion list or an exclusion list based on various criteria, such as commercial availability, clinical evidence and cost. If a compound medication includes an ingredient on the exclusion list, the compound medication is not covered.*

Pre-Medicare Prescription Drug Coverage Expenses

Prescription medications covered under this Plan include:

- Federal legend drugs;
- State restricted drugs;
- ACA vaccines.

Compound Drug Management Program: This program is designed to ensure that the medications you are prescribed are appropriate and cost effective. Ingredients have been put on an inclusion list or an exclusion list based on various criteria, such as commercial availability, clinical evidence and cost. If you are impacted by one of these programs, you and your physician will be notified when you fill your prescription.

2017 Benefit Change: *If a compound medication includes an ingredient on the exclusion list, the compound medication is not covered.*

Contact Express Scripts for more information on specific medications covered under the Plan.

Pre-Medicare Prescription Drug Exclusions

In addition to any exclusion listed in the "Pre-Medicare Medical Exclusions" section (beginning on page 51), benefits are not provided for:

- Non-federal legend drugs.
- Federal legend non-drugs.
- Non-federal legend non-drugs.
- Investigational drugs.
- ***2017 Benefit Change:*** *Compounded medications including one or more uncovered ingredient.*

2017 Benefit Change: Proton Pump Inhibitors Exclusion: *The Plan does not cover Proton Pump Inhibitors (PPIs), such as Nexium and Prilosec, which are available over the counter at most pharmacies.*

Contact Express Scripts for more information on specific medications that are not covered under the Plan.

Medicare-Eligible Medical Benefits

The Trust provides medical benefits for Medicare-eligible participants through Blue Cross Blue Shield of Michigan's (BCBSM) Medicare Plus Blue Group PPO, which is a Medicare Advantage Preferred Provider Organization (MAPPO) plan.

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

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

For more information about Medicare, you can:

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

If You Are Not Medicare-Eligible

If you are not eligible for Medicare, but a covered dependent is (or vice versa), you and your dependent(s) will have different medical coverage. Before you or an eligible dependent become Medicare-eligible, you or your eligible dependent is covered under the Plan's pre-Medicare eligible medical coverage, as described in the "Pre-Medicare Medical and Prescription Drug Benefits" section, beginning on page 177.

How the Plan Works for Medicare-Eligible Participants

- **Medicare Premiums and Contributions:** To be covered under the Plan, you must make your contributions to the Trust, which are then used to pay the premiums for this Plan.
- **Providers:** The Plan includes a PPO network administered by BCBSM. BCBSM's network contracts with physicians, hospitals and other medical facilities. Providers in the network, which can change at any time, have agreed to accept this Plan's terms. Every time you need care, you have the option of using a provider in the Plan's network (network provider) or one that does not participate in the network (out-of-network provider). The amount you pay will depend on whether you receive covered services from a network provider, an out-of-network provider who participates with Medicare, or an out-of-network provider who does not participate with Medicare.
- **Annual Deductible:** Each year, between January 1 and December 31, you are responsible for paying a certain amount of covered expenses before the Plan begins to pay most benefits.
  - The deductible applies separately to each person.
  - The annual deductible applies to network and out-of-network care combined.

- All covered expenses are subject to the deductible unless specifically noted otherwise, such as preventive services, which are not subject to the deductible.

- **Copayment:** A copayment is a flat dollar amount that you pay for certain covered services, such as physician office and emergency room visits. Covered services with copayments are not subject to the deductible. Copayments apply toward meeting your out-of-pocket maximum.
- **Coinsurance:** Once you meet your deductible, you and the Plan share the cost of covered services.
  - The amount the Plan pays varies depending on the service and whether you use network providers, out-of-network providers who participate with Medicare, or out-of-network providers who do not participate with Medicare.
  - The percent the Plan pays for network providers is generally higher than what is paid for out-of-network providers.
  - For network providers, the Plan pays a percent of the Plan's approved amount (as determined in the contract between the provider and BCBSM).
  - For out-of-network providers who participate with Medicare, the Plan pays a percent of the Medicare payment rate for participating providers.
  - For out-of-network providers who do not participate with Medicare, the Plan pays a percent of the Medicare payment rate for non-participating providers. You are responsible for any charges that exceed the Medicare payment rate for non-participating providers.
- **Annual Out-of-Pocket Maximum:** Once amounts you pay for covered expenses reach the out-of-pocket maximum, the Plan pays 100% of most covered expenses for the remainder of the calendar year.
  - The out-of-pocket maximum applies separately to each person.
  - Deductible, copayment and coinsurance amounts apply toward meeting your out-of-pocket maximum.
  - Copayments, charges for non-covered services and amounts over the allowed amount do not count toward the out-of-pocket maximum.
  - Network and out-of-network expenses both apply toward meeting the maximum.
  - Some expenses may not be paid at 100% even after you meet your out-of-pocket maximum.
- **Maximum Benefits:** Certain covered expenses may be limited to a specific maximum, as described in the "Summary of Medicare-Eligible Medical Benefits" table (beginning on page 61).

BlueCard Program

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

Finding a Network Health Care Provider

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

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

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

Travel Outside of the United States

The Plan includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories for up to six months.

Your cost share amount is the same as if services are rendered in the United States.

Summary of Medicare-Eligible Medical Benefits

The Plan bases payment on the Medicare-approved amount, based on Medicare guidelines. The following services and supplies are covered under this Plan.

Plan Feature	Network and Out-of-Network Providers
Annual Deductible *Combined in and out-of-network*	$400 per person
Coinsurance	Plan pays 80% of approved amount, unless noted otherwise
Out-of-Pocket Maximum *Includes deductible, copayments and coinsurance*	$1,500 per person
Inpatient Care	
Home Health Care	Plan pays 100% of the approved amount

Plan Feature	Network and Out-of-Network Providers
Hospice	Hospice care from a Medicare-certified hospice (when you enroll in a Medicare-certified hospice program, hospice services are paid by original Medicare, not this Plan).
Inpatient Hospital Care *May require prior authorization. The Plan covers 90 days for a benefit period. A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care.*	
▪ Facility Evaluation and Management Services	Plan pays 100% of approved amount
▪ Medicare-Approved Clinical Lab and Preventive Services	Plan pays 100% of approved amount
▪ All Other Services	Plan pays 80% of approved amount after your deductible
Skilled Nursing Facility *May require prior authorization.*	***Limit:*** *120 days per year*
▪ Facility Evaluation and Management Services	Plan pays 100% of approved amount
▪ All Other Services	Plan pays 80% of approved amount after your deductible
Outpatient Care	
Ambulance Services	Plan pays 80% of approved amount after your deductible
Cardiac and Pulmonary Rehabilitation Services	Plan pays 80% of approved amount after your deductible
Chiropractic Services	You pay $20 copay per visit
Diabetes Programs and Supplies	Plan pays 100% of approved amount You may pay a pharmacy coinsurance for medical supplies obtained from a pharmacy. **Diabetic Shoes:** Plan pays 100% of approved amount after your deductible

Plan Feature	Network and Out-of-Network Providers
Diagnostic Tests, X-Rays, Lab Services and Radiology Services *May require prior authorization.*	Plan pays 100% of approved amount
Doctor Office Visits	You pay a $30 copay per visit
Durable Medical Equipment	Plan pays 100% of approved amount
Emergency Care	You pay $65 copay per visit for Medicare-covered emergency room visits; copay is waived if admitted within 3 days
Hearing Services ▪ Diagnostic Hearing Office Visit ▪ Diagnostic Testing Services	 You pay $30 copay per visit Plan pays 100% of approved amounts
Kidney Disease and Conditions ▪ Dialysis Services ▪ Professional Charges ▪ Home Dialysis Equipment and Supplies ▪ Kidney Disease Education Services	 Plan pays 80% of approved amount after your deductible Plan pays 100% of approved amount Plan pays 100% of approved amount Plan pays 100% of approved amount
Outpatient Hospital Services	Plan pays 80% of approved amount after your deductible
Outpatient Mental Health Care *May require prior authorization.* ▪ Office Visits ▪ Mental Health Facility	 You pay $30 copay per visit Plan pays 80% of approved amount after your deductible
Outpatient Substance Abuse Care *May require prior authorization.* ▪ Office Visits ▪ Outpatient Facility	 You pay $30 copay per visit Plan pays 80% of approved amount after your deductible
Outpatient Rehabilitation Services *May require prior authorization.*	Plan pays 80% of approved amount after your deductible
Outpatient Surgery *May require prior authorization.*	Plan pays 80% of approved amount after your deductible

Plan Feature	Network and Out-of-Network Providers
Podiatry Services ▪ Office Visits ▪ Other Medically Necessary Services	 You pay $30 copay per visit Plan pays 100% of approved amount
Prosthetic and Orthotic Devices	Plan pays 100% of approved amount
Urgent Care (not emergency care)	You pay $30 copay per visit
Vision Services ▪ Office Visits ▪ Diagnosis and Treatment of Eye Diseases and Conditions ▪ Corrective Lenses Following Cataract Surgery	 You pay $30 copay per visit Plan pays 100% of approved amount Plan pays 100% of approved amount
Preventive Services and Wellness/Education Programs	Plan pays 100% of approved amount
Hearing Aids	Standard hearing aids are covered up to $2,500 every 36 months
Hearing Services–Routine Exam	You pay $30 copay per visit
Home Infusion Therapy	Plan pays 100% of approved amount
Private Duty Nursing	Plan pays 50% of approved amount, no deductible required; amounts do not apply toward your annual out-of-pocket maximum
SilverSneakers	Plan pays 100% of approved amount
Prescription Drugs	*See the "Medicare-Eligible Prescription Drug Benefits" section, beginning on page 81.*
Hearing	*See the "Hearing Care Benefits" section, beginning on page 8986.*

Medicare-Eligible Covered Medical Expenses

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

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

See the "Summary of Medicare-Eligible Medical Benefits" table, beginning on page 61, for details about any applicable deductibles, copayments, coinsurance, benefit maximums and limitations.

Inpatient Services

For an approved hospital admission, the Plan covers the inpatient hospital services listed in this section.

- **Home health agency care:** Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to:
  - Part-time or intermittent skilled nursing and home health aide services. To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.
  - Physical therapy, occupational therapy, and speech therapy.
  - Medical and social services.
  - Medical equipment and supplies.
- **Hospice care:** You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include:

- Drugs for symptom control and pain relief.
- Short-term respite care.
- Home care.

- **Inpatient hospital care:** Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient stay. Covered services include but are not limited to:
  - Semi-private room (or a private room if medically necessary).
  - Meals including special diets.
  - Regular nursing services.
  - Costs of special care units (such as intensive care or coronary care units).
  - Drugs and medications.
  - Lab tests.
  - X-rays and other radiology services.
  - Necessary surgical and medical supplies.
  - Use of appliances, such as wheelchairs.
  - Operating and recovery room costs.
  - Physical, occupational, and speech language therapy.
  - Inpatient substance abuse services.
  - Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant.
  - Transplant providers may be local or outside of the service area. If our in-network transplant services are at a distant location, you may choose to go locally or distant as long as the local transplant providers are willing to accept the Original Medicare rate. If Medicare Plus Blue PPO provides transplant services at a distant location (100 miles or more, one-way to the facility, from your home address), and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion up to $5,000; travel and lodging is covered for only one year after the initial transplant (includes up to five additional days prior to the initial transplant).

- Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.
- Physician services.

- **Inpatient services covered during a non-covered inpatient stay:** If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, the Plan will not cover your inpatient stay. However, in some cases, the Plan will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:
  - Physician services.
  - Diagnostic tests (like lab tests).
  - X-ray, radium, and isotope therapy including technician materials and services.
  - Surgical dressings.
  - Splints, casts and other devices used to reduce fractures and dislocations.
  - Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.
  - Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.
  - Physical therapy, speech therapy, and occupational therapy.
- **Skilled nursing facility (SNF) care:** No prior hospital stay is required. Covered services include, but are not limited to:
  - Semiprivate room (or a private room if medically necessary).
  - Meals, including special diets.
  - Skilled nursing services.
  - Physical therapy, occupational therapy, and speech therapy.
  - Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors).
  - Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.
  - Medical and surgical supplies ordinarily provided by SNFs.

- Laboratory tests ordinarily provided by SNFs.
- X-rays and other radiology services ordinarily provided by SNFs.
- Use of appliances such as wheelchairs ordinarily provided by SNFs.
- Physician/Practitioner Services.

Outpatient Services

- **Ambulance services**
  - Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.
  - Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.
- **Cardiac rehabilitation services:** Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.
- **Chiropractic services:** Covered services include manual manipulation of the spine to correct subluxation. See additional benefits for a description of additional chiropractic services.
- **Diabetes self-management training, diabetic services and supplies:** For all people who have diabetes (insulin and non-insulin users). Covered services include:
  - Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.
  - For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or 1 pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.
  - Diabetes self-management training is covered under certain conditions.

- **Durable medical equipment and related supplies**: Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. The Plan covers all medically necessary durable medical equipment covered by Original Medicare and obtained from a Medicare-certified DME provider. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.
- **Emergency care**: A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.
- **Hearing services**: Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist or other qualified provider. The Plan also includes both the routine hearing exam and hearing aid benefits. See additional benefits for a description.
- **Medicare Part B prescription drugs:** These drugs are covered under Part B of Original Medicare. Members of the Plan receive coverage for these drugs through the Plan. Covered drugs include:
  - Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services.
  - Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan.
  - Clotting factors you give yourself by injection if you have hemophilia.
  - Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant.
  - Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.
  - Antigens.
  - Certain oral anti-cancer drugs and anti-nausea drugs.
  - Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen, Procrit, Epoetin Alfa, Aranesp, or Darbepoetin Alfa).
  - Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.
- **Outpatient diagnostic tests and therapeutic services and supplies:** Covered services include, but are not limited to:
  - X-rays.

- Radiation (radium and isotope) therapy including technician materials and supplies.
- Surgical supplies, such as dressings.
- Splints, casts and other devices used to reduce fractures and dislocations.
- Laboratory tests.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.
- Other outpatient diagnostic tests.

- **Outpatient hospital services:** The Plan covers medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to:
  - Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery.
  - Laboratory and diagnostic tests billed by the hospital.
  - Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.
  - X-rays and other radiology services billed by the hospital.
  - Medical supplies such as splints and casts.
  - Certain screenings and preventive services.
  - Certain drugs and biologicals that you can't give yourself.
- **Outpatient mental health care**: Covered services include mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.
- **Outpatient rehabilitation services**: Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).
- **Outpatient substance abuse services**: Outpatient substance abuse services include counseling, medical testing and diagnostic evaluation. Coverage under Medicare Part B is available for treatment services provided in the outpatient department of a hospital. A coverage example is a patient who has been discharged from an inpatient stay for the treatment of drug substance abuse or who requires additional treatment but does not require services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.

- **Outpatient surgery**: Includes services provided at hospital outpatient facilities and ambulatory surgical centers.
- **Partial hospitalization services**: Partial hospitalization is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.
- **Physician/Practitioner services, including doctor's office visits:** Covered services include:
  - Medically-necessary medical care or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location.
  - Consultation, diagnosis, and treatment by a specialist.
  - Basic hearing and balance exams performed by your primary care provider or specialist, if your doctor orders it to see if you need medical treatment.
  - Certain telehealth services including consultation, diagnosis and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare.
  - Second opinion prior to surgery.
  - Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician).
  - One routine physical exam per year.
  - Total body skin examination performed by a trained health care professional, usually a dermatologist, to search for any unusual or suspicious lesions or conditions on the skin's surface, including hands and arms, legs and feet, torso, scalp, inside of the mouth and external genital area. Covered once in a lifetime.
- **Podiatry services:** Covered services include:
  - Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).
  - Routine foot care for members with certain medical conditions affecting the lower limbs.
- **Prosthetic devices and related supplies:** Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery. See "Vision Care" later in this section for more details.

- **Pulmonary rehabilitation services:** Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.
- **Services to treat kidney disease and conditions:** Covered services include:
  - Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, the Plan covers up to six sessions of kidney disease education services per lifetime.
  - Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area)
  - Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care).
  - Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments).
  - Home dialysis equipment and supplies.
  - Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply).
- **Urgently needed services:** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or out-of-network providers when network providers are temporarily unavailable or inaccessible.
- **Vision care:** Covered services include:
  - Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.
  - For people with diabetes, screening for diabetic retinopathy is covered once per year.
  - One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery).

Preventive

For all preventive services that are covered at no cost under Original Medicare, the Plan also covers the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a contractual cost share may apply for the care received.

- **Abdominal aortic aneurysm screening:** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.
- **Annual wellness visit:** If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.
- **Bone mass measurement:** For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered once every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.
- **Breast cancer screening (mammograms):** Covered services include:
  - One baseline mammogram between the ages of 35 and 39.
  - One screening mammogram every 12 months for women age 40 and older.
  - Clinical breast exams once every 24 months.
- **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease):** The Plan covers one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you are eating well.
- **Cardiovascular disease testing:** Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).
- **Cervical and vaginal cancer screening:** Covered services include:
  - For all women: Pap tests and pelvic exams are covered once every 24 months.
  - If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.
- **Colorectal cancer screening:**
  - For people 50 and older, the following are covered:
    - Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months.
  - One of the following every 12 months:

- Guaiac-based fecal occult blood test (Gfobt)
- Fecal immunochemical test (FIT)

- DNA based colorectal screening every 3 years.
- For people at high risk of colorectal cancer, the Plan covers:
  - Screening colonoscopy (or screening barium enema as an alternative) every 24 months.
- For people not at high risk of colorectal cancer, the Plan covers:
  - Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.

- **Depression screening:** The Plan covers one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.
- **Diabetes screening:** The Plan covers this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.
- **Glaucoma screening:** Glaucoma screening once per year for people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older, or are Hispanic American who are age 65 and older.
- **Health and Wellness education programs:** Supplemental programs designed to enrich the health and lifestyles of members. The Plan covers the following supplemental education and wellness programs:
  - Additional smoking and tobacco use cessation telephone-based support.
  - Telemonitoring Services.
  - SilverSneakers fitness program.
- **Hepatitis C screening:** For people who are at high risk for Hepatitis C infection, including persons with a current or past history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992, the Plan covers:
  - One screening exam.
  - Additional screenings every 12 months for persons who have continued illicit injection drug use since the prior negative screening test.

- **HIV screening:** For people who ask for an HIV screening test or who are at increased risk for HIV infection, the Plan covers one screening exam every 12 months. For women who are pregnant, the Plan covers up to three screening exams during a pregnancy.
- **Immunizations:** Covered Medicare Part B services include:
  - Pneumonia vaccine
    - An initial pneumococcal vaccine to Medicare beneficiaries who have never received the vaccine under Medicare Part B; and
    - A different, second pneumococcal vaccine 1 year after the first vaccine was administered
  - Flu shots, once a year in the fall or winter
  - Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
  - Other vaccines if you are at risk and they meet Medicare Part B coverage rules.
- **Medical nutrition therapy:** This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when ordered by your doctor. The Plan covers 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew the order yearly if your treatment is needed into the next calendar year.
- **Obesity screening and therapy to promote sustained weight loss:** If you have a body mass index of 30 or more, the Plan covers intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.
- **Prostate cancer screening exams:** For men age 50 and older, covered services include the following once every 12 months:
  - Digital rectal exam.
  - Prostate Specific Antigen (PSA) test.
- **Screening and counseling to reduce alcohol misuse:** The Plan covers one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.

- **Screening for lung cancer with low dose computed tomography (LDCT):** For qualified individuals, a LDCT is covered every 12 months. Eligible enrollees are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the enrollee must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.
- **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs:** The Plan covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. The Plan covers these tests once every 12 months or at certain times during pregnancy. The Plan also covers up to 2 individual 20 to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. The Plan will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.
- **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use):**
  - If you use tobacco, but do not have signs or symptoms of tobacco-related disease:
    - The Plan covers two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.
  - If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:
    - The Plan covers cessation counseling services. The Plan covers two counseling quit attempts within a 12-month period; however, you will pay the applicable inpatient or outpatient cost sharing. Each counseling attempt includes up to four face-to-face visits.
- **"Welcome to Medicare" preventive visit:** The Plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.

Additional Benefits

- **Chiropractic services:** Covered services include:

- Evaluation and management services.
- Spine X-rays and chiropractic radiology services.
- Chiropractic physical therapy visits.

- **Healthways SilverSneakers:** The SilverSneakers benefit doesn't include gym or health club memberships other than for those facilities that participate in the SilverSneakers fitness program. Benefits include:
  - Fitness program membership at any participating location across the country.
  - Customized SilverSneakers classes and seminars.
  - A trained Senior AdvisorSM at the fitness center to show you around and help get you started.
  - Conditioning classes, exercise equipment, pool, sauna and other available amenities.
  - SilverSneakers Steps in-home fitness program for members without convenient access to a SilverSneakers facility.
- **Hearing Aids:** A medical evaluation to find the cause of the hearing loss and determine if it can be improved with a hearing aid is covered as an office visit when furnished by a physician, audiologist, or other qualified provider. The following tests are covered under the hearing aids benefit:
  - A hearing aid evaluation test to determine what type of hearing aid should be prescribed.
  - A test to evaluate the performance of a hearing aid.
- **Hearing services – routine exam:** The following test is covered as an office visit under the hearing services benefit when furnished by a physician, audiologist or other qualified provider:
  - An annual routine exam to measure hearing ability.
- **Home infusion therapy:** Home infusion therapy is the continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy. Coverage for additional home infusion therapy service components are provided based on the member's condition. The additional Medicare Plus Blue home infusion therapy benefit provides coverage for the in-home administration of infusion therapy services when the Original Medicare coverage criteria are not met. Coverage is available when the infusion therapy is:
  - Prescribed by a physician to manage a chronic condition or to treat a condition that requires acute care if it can be managed safely at home.
  - Certified by the physician as medically necessary for the treatment of the condition.
  - Appropriate for use in the patient's home.
  - Medical IV therapy, injectable therapy or total parenteral nutrition therapy.

Components of care available regardless of whether the patient is confined to the home:

- Nursing visits.
- Durable medical equipment, medical supplies and solutions.
- Catheter care.
- Injectable therapy.
- Drugs.

- **Private duty nursing:** The Plan provides nursing to individuals who need skilled care and require individualized continuous 24-hour nursing care that's more intense than what is available under other benefits when ordered by a physician (M.D. or D.O.) who is involved with your ongoing care.
  - At least two trained caregivers (a family member, a friend, etc.) must be trained and competent to give care when the nurse is not in attendance.
  - The family or caregivers must provide at least 8 hours of skilled care/day.
  - Generally, more than 16 hours per day of Private Duty Nursing will not be approved.
  - However, up to 16 hours per day may be approved for up to 30 days while you are being transitioned from an inpatient setting to home.

  Private duty nursing does **not** cover services provided by, or within the scope of practice of, medical assistants, nurse's aides, home health aides, or other non-nurse level caregivers. This benefit is not intended to supplement the care-giving responsibility of the family, guardian or other responsible parties.

Medicare-Eligible Medical Exclusions

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

- Services considered not reasonable and necessary, according to the standards of Original Medicare.
- Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by the Plan and Original Medicare to not be generally accepted by the medical community. May be covered by Original Medicare under a Medicare-approved clinical research study.
- Private room in a hospital. Covered only when medically necessary.

- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.
- Basic household assistance, including light housekeeping or light meal preparation.
- Fees charged for care by your immediate relatives or members of your household.
- Cosmetic surgery or procedures. Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, fillings or dentures.
- Non-routine dental care. Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Routine foot care. Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
- Home-delivered meals.
- Orthopedic shoes. Covered if shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet. Orthopedic or therapeutic shoes for people with diabetic foot disease are covered.
- Reversal of sterilization procedures and or non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).

Medicare-Eligible Prescription Drug Benefits

As part of your medical coverage, you receive prescription drug coverage that helps you pay the cost of prescribed medications. The Plan includes both a retail pharmacy and home delivery component.

Medicare-eligible prescription drug benefits are provided through an Employer Group Waiver Plan (EGWP). An EGWP is a Medicare Part D Prescription Drug Plan (PDP). Medicare-eligible prescription drug coverage is provided through Express Scripts, the pharmacy benefit manager, who partners with the Centers for Medicaid and Medicare Services (CMS) to serve as a Medicare Part D plan sponsor and manage compliance with CMS regulations for PDP coverage for retirees.

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

Summary of Prescription Drug Benefits—Medicare-Eligible

2017 Benefit Change: *Copayments highlighted in italics in the following chart are new as of January 1, 2017.*

Benefit Feature	Participating Retail Pharmacy	Home Delivery
Plan Feature		
Deductible	None	None
Out-of-Pocket Maximum	None	None
Maximum Supply	31-day	90-day
Copayments	You pay:	You pay:
Tier 1: Generic	*$15 copay*/31-day supply	*$30 copay*/90-day supply
Tier 2: Preferred Brand	*$35 copay*/31-day supply	*$70 copay*/90-day supply
Tier 3: Non-Preferred Brand	*$90 copay*/31-day supply	*$180 copay*/90-day supply

How Medicare-Eligible Prescription Drug Benefits Work

When you use a participating retail pharmacy or the home delivery program, you pay a copayment, which is a flat dollar amount, for each prescription you have filled; there is no deductible to meet. The copayment amount you pay for your prescription depends on the type of medication (generic, preferred brand or non-preferred brand), as described in the “Summary of Prescription Drug Benefits—Medicare-Eligible” table on page 81.

Types of Medications

Both brand name and generic drugs are covered under the Plan. A generic drug is approved by the FDA as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

The amount you pay for a covered drug will depend on:

- **Your coverage stage.** The Plan has different stages of coverage. In each stage, the amount you pay for a drug may change. Please refer to your other plan documents for more information about your specific prescription drug benefit.
- **The drug tier for your drug.** Each covered drug is in one of three drug tiers. Each tier has a different copayment amount. The following "Drug Tiers" chart explains what types of drugs are included in each tier and how costs may change with each tier.

Drug Tiers

Tier	Includes	Helpful tips
Tier 1: Generic	Many commonly prescribed generic drugs and may include other low-cost drugs.	Use Tier 1 drugs for the lowest cost-sharing amount.
Tier 2: Preferred Brand	Mostly brand name drugs as well as some generic drugs.	Drugs in this tier will generally have lower cost-sharing amounts than non-preferred brand drugs.
Tier 3: Non-Preferred	Non-preferred brand name drugs as well as some non-preferred generic drugs.	Many non-preferred drugs have lower-cost alternatives in Tiers 1 and 2. Ask your doctor if switching to a lower-cost generic or preferred brand-name drug may be right for you.

Formulary

The list of drugs covered by the Plan is known as a "formulary." The formulary contains a list of highly utilized Medicare Part D drugs selected by Express Scripts Medicare in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary also includes information on requirements or limits for some covered drugs that are part of Express Scripts Medicare's standard formulary rules.

Express Scripts Medicare will generally cover a drug as long as the drug is medically necessary, the prescription is filled at an Express Scripts Medicare network pharmacy and other Plan rules are followed.

Formularies are subject to change. However, generally, Express Scripts Medicare will not discontinue or reduce coverage of a drug during a calendar year, except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes will not affect you if you are currently taking the drug.

If Express Scripts Medicare removes drugs from the Plan's coverage, adds prior authorization, quantity limits and/or step therapy restrictions on a drug or moves a drug to a higher cost-sharing tier and this change affects you, Express Scripts Medicare will notify you of the change at least 60 days before the change becomes effective. If the FDA determines that a drug the Plan covers is unsafe, or if the drug's manufacturer removes the drug from the market, Express Scripts Medicare will immediately stop covering the drug and provide notice to you if you are taking the drug.

If you have general questions about Medicare prescription drug coverage, call Medicare at (800) MEDICARE [(800) 633-4227], 24 hours a day, 7 days a week. TTY users should call (877) 486-2048. Or visit www.medicare.gov.

Preferred Drug List Exclusions

The most current listing of preferred medications is available from Express Scripts by calling (844) 567-8525 or visiting www.express-scripts.com. Medications on the list may change periodically; new medications may be added or removed. If a change affects your prescription, you will be notified.

In most cases, if you fill a prescription for an excluded drug, you will pay the full retail price. To avoid paying full price, you can ask your doctor to prescribe a preferred alternative. Log on to www.express-scripts.com/covered to compare drug prices.

Where to Have Your Prescription Filled

Network Pharmacy

Network pharmacies are those pharmacies that have made arrangements with Express Scripts Medicare to provide prescription drugs to plan members.

In most cases, your prescriptions are covered under Express Scripts Medicare only if they are filled at a network pharmacy or through the home delivery service. Once you go to one pharmacy, you are not required to continue going to the same pharmacy to fill your prescription, but can switch to any other network pharmacy.

Prescriptions are covered at out-of-network pharmacies only in emergency situations. If you have your prescription filled at a non-participating pharmacy, you must pay for your prescription when you pick it up and then submit a claim for reimbursement.

Pharmacies may be added or removed from the Express Script Medicare's list. For the most up to date list of network pharmacies:

- Go online to www.express-scripts.com; or
- Call (844) 567-8525

Home Delivery Pharmacy

You can get prescriptions shipped to your home through Express Scripts Medicare's network home delivery service, the Express Scripts Pharmacy[SM]. You may also have the choice to sign up for automated home delivery through the Worry Free Fills® program. Typically, you should expect to receive your prescription drugs within 10 days from the time that the home delivery pharmacy receives the order. If you do not receive your prescription drug(s) within this time frame, contact the Pharmacy.

Home Infusion Network Pharmacies

Home infusion network pharmacies specialize in the preparation of medications that are administered intravenously or by injection. The Plan covers your home infusion therapy if:

- Your prescription drug is on the Plan's formulary or you have a formulary exception;
- The Plan has approved your prescription drug for home infusion therapy; and
- Your prescription is written by an authorized prescriber.

Long-Term Care Network Pharmacies

Residents of a long-term care facility may access prescription drugs covered under the Plan through the facility's long-term care pharmacy or another network long-term care pharmacy. A long-term care pharmacy provides medications to residents of long-term care facilities, such as nursing homes and residential care facilities, mental health facilities, hospices and long-term care or skilled nursing care beds in hospitals.

Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) Network Pharmacies

Only Native Americans and Alaska natives have access to Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) Pharmacies through the Plan's pharmacy network. Those other than Native Americans and Alaska natives may be able to access these pharmacies under limited circumstances (e.g., emergencies).

Specialty Pharmacy

When you use a medication that is classified as a specialty drug, then you must order that drug from Express Scripts' specialty pharmacy, Accredo.

Accredo's specialty care services are dedicated to meeting the needs of people taking specialty medications. Accredo pharmacists and nurses of specialty care services are trained in specialty medications, their side effects and the conditions they treat. Many of these medications require injection or special handling. Specialty care services provide:

- Expedited shipping of specialty medications to the home or prescriber's office;

- Supplemental supplies, such as needles and syringes, which are needed to administer the medication, at no additional charge; and
- Scheduling of refills and coordination of services with home care providers, case managers and prescribers or other healthcare professionals.

For more information, contact Accredo at (866)892-9976. Representatives are available Monday through Friday, from 8:00 a.m. to 11:00 p.m., Eastern time and Saturdays, from 8:00 to 5:00 p.m., Eastern time.

Safety and Care Management Programs

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** You or your doctor is required to get prior authorization for certain drugs. This means that you will need to get approval from the Plan before you fill your prescriptions. If you do not get approval, the drugs may not be covered. These drugs are noted with "PA" next to them in the Plan's formulary.

  Some drugs may be covered under Part B or under Part D, depending on your medical condition. Your doctor will need to get a prior authorization for these drugs as well, so your pharmacy can process your prescription correctly.
- **Quantity Limits:** For certain drugs, the amount of the drug that will be covered by the Plan is limited. The Plan may limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, the Plan may limit coverage for your prescription to no more than one pill per day. These drugs are noted with "QL" next to them in the Plan's formulary.
- **Step Therapy:** In some cases, you are required to first try certain drugs to treat your medical condition before the Plan will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Plan will then cover Drug B. These drugs are noted with "ST" next to them in the Plan's formulary.

You may be able to find out if your drug has any additional requirements or limits by looking at the Plan's formulary, which was provided to you when you became covered under the Plan. The formulary is also available by visiting Express-Scripts at www.express-scripts.com or calling customer service at the number on the back of your ID card.

You can ask Express Scripts Medicare to make an exception to certain restrictions or limits; contact Express Scripts Medicare for more information on how to request an exception.

Medicare-Eligible Prescription Drug Coverage Expenses

Prescription medications covered under this Plan include:

- Federal legend drugs;
- State restricted drugs;
- ACA vaccines.

Compound Drug Management Program: This program is designed to ensure that the medications you are prescribed are appropriate and cost effective. Ingredients have been put on an inclusion list or an exclusion list based on various criteria, such as commercial availability, clinical evidence and cost. If you are impacted by one of these programs, you and your physician will be notified when you fill your prescription.

2017 Benefit Change: *If a compound medication includes an ingredient on the exclusion list, the compound medication is not covered.*

Contact Express Scripts for more information on specific medications covered under the Plan.

Medicare Part B Prescription Drugs

If you are eligible for Medicare, the Plan's Medicare-eligible prescription drug benefits cover Medicare Part B prescription drugs.

Medicare-Eligible Prescription Drug Exclusions

In addition to any exclusions listed in the "Medicare-Eligible Medical Exclusions" (beginning on page 80) section, benefits are not provided for:

- Non-federal legend drugs.
- Federal legend non-drugs.
- Non-federal legend non-drugs.
- Investigational drugs.
- ***2017 Benefit Change:*** *Compounded medications including one or more uncovered ingredient.*

Contact Express Scripts for more information on specific medications that are not covered under the Plan.

Requirements for Coverage

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

- Be specifically listed as covered by the Plan.
- Not be a Plan exclusion.
- Not exceed any Plan maximum or limitation.
- Be obtained according to Plan terms.
- Be provided while coverage is in effect.
- Be medically necessary (except for preventive care), which means it is provided by a physician or other health care provider exercising prudent clinical judgment to a patient to prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms.
- Be provided according to generally accepted standards of medical practice.
- Be clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease.
- Not primarily be for the convenience of the patient, physician or other health care provider.
- Not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

Hearing Care Benefits

Hearing care benefits are available to all eligible participants, regardless of whether you are Medicare-eligible or not.

In addition to your medical benefits, you also have coverage for hearing care. These benefits are designed to identify hearing problems and cover the appropriate corrective devices.

Hearing care benefits are provided through Blue Cross Blue Shield of Michigan (BCBSM). For more information, visit register or login in at www.bcbsm.com.

Summary of Hearing Benefits

The Plan provides the following hearing care benefits when received from a participating provider.

	Participating Provider
Frequency Limitation	Once every 36 months
Benefit Maximum	$1,000
Audiometric Exam	Plan pays 80%
Hearing Aid Evaluation	Plan pays 80%
Hearing Aid	Plan pays 80% You are responsible for the difference in cost between BCBSM's approved amount and the charge of the hearing aid
Hearing Aid Conformity Test	Plan pays 80%

Hearing Benefits Covered Expenses

Covered hearing care benefits include:

- **Audiometric exam**, which measures hearing ability, including tests for air and bone conduction, speech reception and speech discrimination;
- **Hearing aid evaluation**, which determines what type of hearing aid should be prescribed to compensate for loss of hearing;
- Hearing aid; and
- Hearing aid conformity text.

Note: *You must get a medical evaluation (sometimes called a medical clearance exam) of your ear by a physician-specialist before you receive a hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. This evaluation is not covered under the Plan's hearing care benefits, but may be covered under the Plan's medical benefits.*

A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified as an otolaryngologist. A physician-specialist determines if a patient has a hearing loss and if that loss can be offset by a hearing aid.

The Plan pays 80% of covered hearing care benefit expenses, up to $1,000 once every 36 months. You do not need to meet any deductible before benefits are paid.

Benefits are available from participating BCBSM providers only.

Keep in mind that the Plan pays benefits based on the approved amount. Generally, if you use a participating BCBSM provider, the provider's charge is the approved amount. However, when you do not use a participating BCBSM provider, the Plan only pays 80% ***of the approved amount***. If your provider charges more than approved amount, you are responsible for the additional amount.

Hearing Care Exclusions and Limitations

Hearing care benefits are not provided for:

- Any medical exam to determine possible hearing loss.
- Any exam by an audiologist that has not been ordered by a physician-specialist.
- A hearing aid ordered while you are covered by the Plan but delivered more than 60 days after coverage ends.
- Replacement of lost or broken hearing aids, unless this occurs after 36 months when benefits are renewed.
- Repair and/or replacement of parts.
- The difference in cost between an eyeglass-type hearing aid and a behind-the-ear hearing aid.
- Hearing aids that do not meet FDA and Federal Trade Commission requirements.

Vision Benefits

Vision benefits are available to all eligible participants, regardless of whether you are Medicare-eligible or not.

Vision benefits are designed to provide periodic eye examinations as well as corrective eyewear and other services to meet your visual needs.

Hearing care benefits are provided through Blue Cross Blue Shield of Michigan's (BCBSM) Blue Vision VSP program. To find a vision provider:

- Call (800) 877-7195; or
- Visit VSP's website at www.vsp.com

Summary of Vision Benefits

Note: *If you use an out-of-network provider, you are responsible for the difference between the approved amount and the provider's charge, less any applicable copayment.*

Covered Expense	VSP Provider	Out-of-Network Provider
Eye Exam ***Frequency:*** *once every 12 consecutive months*	Covered—$25 copay	Covered—No copay, reimbursed up to $46
Eyeglass Lenses ***Frequency:*** *1 every 12 consecutive months*	Covered—No copay, reimbursed up to a pre-determined amount based on lens type (exam copay applies to both lenses and frames)	Covered—No copay, reimbursed up to a predetermined amount based on lens type
Eyeglass Frames ***Frequency:*** *1 every 24 consecutive months*	Covered—No copay, reimbursed up to $75	Covered—No copay, reimbursed up to $75

Covered Expense	VSP Provider	Out-of-Network Provider
Medically Necessary Contact Lenses ***Frequency:*** *1 every 12 consecutive months*	Covered—No copay, reimbursed up to $250	Covered—No copay, reimbursed up to $250
Elective Contact Lenses (prescribed, but not medically necessary) ***Frequency:*** *1 every 12 consecutive months*	Covered—No copay, reimbursed up to $215 for contact lens exam (fitting and materials) and the contact lenses	Covered—No copay, reimbursed up to $215 for contact lens exam (fitting and materials) and the contact lenses

You may get either eyeglasses and frames or contact lenses, but not both.

Vision Benefit Features

Network Benefits

You receive network benefits when you use a VSP network provider, also called a VSP member doctor, which is an ophthalmologist or optometrist who participates in VSP's network.

Here is a look at how the Plan works when you use a **VSP network provider**:

- Locate a network provider by calling VSP at (800) 877-7195 or visiting www.vsp.com. There is no charge to receive provider lists or directories.
- Contact a network provider to schedule an appointment. When you make an appointment with the network provider, identify yourself as a Blue Vision VSP member so your provider knows to contact VSP for benefit authorization.
- If you are eligible for benefits, VSP will provide benefit authorization directly to your network provider.
- Your provider and VSP will handle the rest.

When you receive covered vision services from a VSP network provider, you receive the maximum level of coverage available under the Plan. Benefits are paid based on VSP's approved payment amount. Copayments are subtracted from the approved amount before the payment is made.

Out-of-Network Benefits

Out-of-network benefits apply when you receive services from a physician, optometrist or optician who is not part of VSP's network. Out-of-network providers have not agreed to accept the VSP approved amount as full payment for covered services.

If you go to an out-of-network provider (or a network provider without first receiving benefit authorization from VSP):

- You are responsible for payment in full to the provider at the time of service.
- You will need to file a claim with VSP for reimbursement.
- You may file the claim through www.vsp.com or mail in a claim form with a receipt.
- You will be reimbursed by VSP according to the out-of-network provider reimbursement schedule, as shown in the "Summary of Vision Benefits" table on page 9291.

Out-of-network reimbursement does not guarantee full payment.

Covered Vision Expenses

The Plan covers most routine eye care. Whether or not you use a network provider, here are some of the services and eyewear that are covered:

- **Eye Exam:** Complete eye exam by an ophthalmologist or optometrist. The exam includes history, visual acuity test, external examination of the eyes, binocular measure, ophthalmoscopic exam, tonometry (when indicated), medication for dilating pupils/desensitizing eyes for tonometry (if necessary) and summary of findings.
- **Lenses:** Standard eyeglass lenses when prescribed and dispensed by an ophthalmologist or optometrist.
  - Lenses may be molded or ground, glass or plastic.
  - Lenses must be equal in quality to the first-quality lens series made by American Optical, Bausch & Lomb or Tillyer and Univis.
  - The lens blank must meet Z80.1 or Z80.2 standards of the American National Standards Institute.
  - Lenses may be colorless or have rose tints #1 or #2, if therapeutically necessary (your provider may charge you for additional tinting other than for medically necessary rose tints #1 or #2).

- The lens blank of a standard lens must not exceed 60 millimeters in diameter (your provider may charge you for the difference in cost between standard and oversized lenses).
- VSP also covers special lenses, such as myodisc, lenticular myodisc, lenticular aspheric myodisc, aphakic (not covered for patients with aphakia), lenticular aphakic and lenticular aspheric aphakic.

- **Eyeglass Frames:** Standard eyeglass frames. A wide selection of frames is fully covered by VSP, up to the frame allowance. You should ask your doctor which frames are covered in full. You may select a more expensive frame and pay a cost controlled price difference.
- **Medically Necessary Contact Lenses:** Contact lenses are considered medically necessary if they are the only way to correct your vision to 20/70 in the better eye and they are the only effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature. Although a VSP network provider can prescribe medically necessary contact lenses, the provider must receive prior approval from VSP for the contacts to be covered as medically necessary. Coverage includes the fee for a contact suitability examination to determination to see if you can wear contact lenses.

You may get either eyeglasses and frames or contact lenses, but not both.

- **Elective Contact Lenses:** Elective contact lenses are prescribed but not medically necessary lenses, as described above. Plan reimbursement is towards contact lens exam (fitting and materials) and the contact lenses. You are responsible for the difference between the amount the Plan reimburses and the amount the provider charges.

Cosmetic Options

The Plan does not cover cosmetic options. However, as a Blue Vision VSP member, you may receive discounts when you purchase the following vision care products or services from a VSP network provider:

- Blended lenses;
- Oversize lenses (61 millimeters or greater);
- Progressive/multifocal lenses;
- Lenses tinted darker than rose tint #2, such as sunglasses;
- Photochromic lenses;
- Scratch coating/laminating of a lens(es);
- Cosmetic lenses/processes; and
- UV protected lenses.

Out-of-Network Provider Vision Claims

If you see an out-of-network provider, VSP will reimburse you up to the amount allowed under the Plan's out-of-network reimbursement rates. When you go to an out-of-network provider, you pay the entire bill when you receive services, and then submit a claim for reimbursement. You will need to include the following information when submitting a claim:

- An itemized receipt listing the services received;
- The name, address and phone number of the out-of-network provider;
- The covered member's identification number as it appears on the ID card;
- The covered member's name, phone number and address;
- The name of Plan;
- The patient's name, date of birth, phone number and address;
- The patient's relationship to the covered member (such as self, spouse, son, daughter, etc.)

Claims should be sent to:

Out-of-Network Claims
VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Claims must be submitted within 12 months from the date you received the vision services. Please keep a copy of the information for your records and send the originals to VSP.

Vision Benefit Exclusions and Limitations

Vision benefits are not provided for:

- Additional charges for:
  - Lenses tinted darker than rose tint #2 (such as sunglasses).
  - Oversize lenses (61 millimeters or greater).
  - Blended lenses.
  - Photochromic lenses.
  - Progressive/multifocal lenses.
  - Scratch coating/laminating of a lens or lenses.
  - Cosmetic lenses/processes.

- Two pair of glasses instead of bifocals.
- Anti-reflective lenses.

- Medical-surgical treatment.
- Medications administered during any service, except a vision examination.
- Services not prescribed by an ophthalmologist or optometrist.
- Special services, such as orthoptics, vision training, low (subnormal) vision aids, aniseikonic lenses or tonography.
- Replacement of broken or lost lenses or frames.
- Services received due to an eye disease, defect or injury resulting from an act of war, declared or undeclared.
- Services available at no cost to you or that no charge would be made in the absence of this coverage.
- Charges for lenses or frames ordered while you are eligible for benefits but delivered more than 60 days after coverage ends.
- Aphakic lenses when the patient lacks a natural lens.
- Charges for experimental or poor quality services.
- Services, eyeglasses or contact lenses that are not medically necessary (such as cosmetic or fashion glasses).
- A second vision exam by a physician or any eligible provider, regardless of the purpose.
- Insertion of new lenses into old or existing frames.
- Cosmetic contact lenses that do not improve vision.

Dental Benefits

Dental benefits are only available to you and your dependents if you are younger than age 65. Once you reach age 65, your and your dependent's dental benefits will end.

Dental Benefit Features

Providers

You may select any dentist to provide dental care. However, to help control costs, the Dental Plan gives you access to the MODA networks of dental providers. You may choose either a:

- Contracted dentist from the Preferred Provider Option (PPO) network; or
- Participating premier dentist from the Premier Dental (Premier) network.

When you use a PPO or Premier network dentist, there are no claim forms to file, the provider files claims for you.

There are differences in reimbursement for PPO network, Premier network and non-participating providers (providers that do not participate in one of the Plan's networks).

The amounts payable for services of a non-participating dentist are limited to the applicable percentages specified in the Plan for corresponding services in the non-participating dentist fee schedule. Non-participating dental providers are reimbursed at the lesser of the maximum plan allowance and the dental provider's actual billed fees.

Pre-determination

For expensive treatment plans, you may request a pre-determination of service. Your dentist may submit a pre-determination request to get an estimate of what the Plan would pay. The pre-determination will be processed according to the Plan's current benefits and returned to the dentist. You and your dentist should review the information before beginning treatment.

Optional Services

If a more expensive treatment than is functionally adequate is performed, the Plan will pay the applicable percentage of the maximum plan allowance for the least costly treatment. You are then responsible for the remainder of the dentist's fee.

Summary of Dental Benefits

The Plan bases payment on the maximum plan allowance, as follows.

Plan Feature	Coverage
Annual Deductible	$0
Annual Maximum Payment	$1,500
Class I: Diagnostic and Preventive	100%
Class II: Restorative, Oral Surgery, Endodontic and Periodontic	100%
Class III: Restorative, Prosthodontic, TMJ	100%
Orthodontia Lifetime Maximum	50% $1,500

Dental Covered Services

Generally dental services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical).

Class I Services

Diagnostic Services

Diagnostic services include:

- Periodic (routine) or comprehensive examinations or consultations, up to twice per calendar year;
- ***2017 Benefit Change:*** *Complete series X-rays or a panoramic film, up to once every five years as part of evidence-based dental practice;*
- ***2017 Benefit Change:*** *Supplementary bitewing X-rays, once every 12 months as part of evidence-based dental dentistry;*
- Complete series or panoramic, periapical, occlusal and bitewing X-rays; and
- ViziLite Plus TBlue, up to twice per calendar year.

Separate charges for review of a proposed treatment plan or for diagnostic aids, such as study models and certain lab tests, are not covered.

Preventive Services

- Prophylaxis (cleanings) or periodontal maintenance, up to twice per calendar year (additional cleaning benefit is available if you have diabetes or are in your third trimester of pregnancy provided you are enrolled in the Oral Health, Total Health program;
- Periodontal maintenance;
- Topical application of fluoride, up to twice per calendar year for participants age 18 and younger ***[2017 Benefit Change:*** *Covered twice per calendar year for members age 19 and older if there is a recent history of periodontal surgery or high risk of decay due to medical disease, chemotherapy or similar type of treatment not due to poor diet or oral hygiene];*
- Space maintainers *[**2017 Benefit Change:** Space maintainers for primary anterior teeth or missing permanent teeth are not covered]*; and
- ***2017 Benefit Change:*** *Sealants, limited to unrestored, occlusal surfaces of permanent molars.*

Class II

Restorative Services

Restorative services include amalgam fillings and composite fillings, inlays, gold fillings for the treatment of carious lesions (decay).

Crown buildups are included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.

A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

Oral Surgery

Oral surgery services include:

- Extractions, including surgical (a separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered);
- Other minor surgical procedures (surgery on larger lesions or malignant lesions is not considered minor surgery);
- Brush biopsy, limited to twice per calendar year (and limited to the sample collection and does not include coverage for pathology (lab) services); and
- General anesthesia or IV sedation (when administered by a dentist in conjunction with a covered surgical procedure performed in a dental office). General anesthesia and/or IV sedation is only a benefit when administered by a dentist in conjunction with covered surgery.

Endodontic

Endodontic services include procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

However:

- A separate charge for cultures is not covered;
- Pulp capping is covered only when there is exposure of the pulp; and
- The cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

Periodontic

Periodontic services included treatment of diseases of the gums and supporting structures of the teeth and/or implants. Services are limited as follows:

- Periodontal scaling and root planing is covered four times per calendar year;
- A separate charge for post-operative care done within three months after periodontal surgery is not covered; and

- ***2017 Benefit Change:*** *Full mouth debridement is limited to once in a two-year period and, if the member is older than age 18, only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.*

Miscellaneous Services

Miscellaneous services include:

- Occlusal adjustment; and
- Periodontic appliances and bite guards.

Class III

Restorative Services

Restorative services include cast restorations such as crowns, onlays or lab veneers, necessary to restore decayed or broken teeth to a state of functional acceptability. Restorative services are limited as follows:

- ***2017 Benefit Change:*** *Cast restorations and prosthodontics (e.g., bridges, dentures, partials, including alternate benefits) are covered once every seven years;*

- If a tooth can be restored by an amalgam or composite filling, but another type of restoration is selected, covered expense will be limited to a composite; and
- Crowns are only a benefit if the tooth cannot be restored by a routine filling.

Prosthodontic Services

Prosthodontic services include:

- A bridge or denture (full or partial denture), limited to once in a seven-year period and only if the tooth, tooth site or teeth involved have not received a cast restoration benefit in the last seven years;
- Bridges;
- Partial and complete dentures;
- Denture relines;
- Repair of an existing prosthetic device;
- Tissue conditioning; and
- Surgical placement and removal of implants are covered, including:

  - ***2017 Benefit Change:*** *Crown over an implant is covered once per lifetime of the implant;*

  - An alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device (frequency limitations for prosthetic devices apply to alternate benefits, once in any seven-year period);

  - ***2017 Benefit Change:*** *The final implant-supported bridge retainer and implant abutment or pontic, limited to once per tooth or tooth space over the lifetime of the implant;*

  - Implant-supported bridges are not covered if one or more of the retainers is supported by a natural tooth; and

  - These benefits or alternate benefits are not provided if the tooth, implant or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 60-months.

Prosthodontic services are limited as follows:

- **Full, Immediate and Overdentures:** If personalized or specialized techniques are used, the covered amount is limited to the cost for a standard full denture (temporary, interim or provisional), complete dentures are not covered;
- **Partial Dentures:** A temporary (interim) partial denture is only a benefit when placed within two months of the extraction of an anterior tooth or for missing anterior permanent teeth of members age 16 or younger. If a specialized or precision device is used, covered expense is limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to decayed or broken teeth.

Fixed bridges or removable cast partial dentures are not covered for participants younger than age 16.

TMJ Services

TMJ services include non-surgical services and appliances. Surgery is not covered for TMJ.

Orthodontia Services

Orthodontic services are procedures for correcting malocclusioned teeth. Services covered, up to the lifetime maximum, include:

- Habit breaking appliances;
- Minor tooth guidance appliances;
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment;
- Post treatment stabilization;
- Full-banding treatment; and
- Monthly, active treatment visits.

For non-participating providers, the Plan pays the lesser of 50% of the orthodontist's fees or the maximum plan allowance.

Oral Health, Total Health Program

Visiting a dentist on a regular basis and keeping the mouth healthy is critical to keeping the rest of the body healthy.

Studies have indicated a relationship between periodontal disease, bacteria in the mouth and various health problems. These problems can include pre-term, low birth weight babies and diabetes. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

To address these issues, you may enroll in the Oral Health, Total Health program.

Diabetes

If you have diabetes, elevated blood sugar levels can have a negative effect on your oral health. Diabetes increases the risk of cavities, gum disease, tooth loss, dry mouth and infection. Conversely, poor oral health can make diabetes more difficult to manage. Infections may cause blood sugar to rise and require more insulin to keep it under control.

If you are diabetic, and enroll in the program, you are eligible for a total of four prophylaxes (cleanings) or periodontal maintenance sessions per calendar year. However, this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is as listed in this section.

To enroll, complete and return the Oral Health, Total Health enrollment form along with proof of diabetes diagnosis. The enrollment form can be accessed by visiting myMODA or by calling MODA's Dental Customer Service Department.

Pregnancy

Keeping the mouth healthy during a pregnancy is important for you and your baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease are more likely to have a baby that is born too early and too small.

Research suggests that periodontal disease triggers increased levels of biological fluids that induce labor. Furthermore, data suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby.

You should talk to your dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. By enrolling in the Oral Health, Total Health program, you are eligible for a prophylaxis (cleaning) or periodontal maintenance in the third trimester of pregnancy regardless of normal plan frequency limits. However, this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is as listed in this section.

Dental Benefit Exclusions

Not every dental service or supply is covered by the Plan. The Plan covers only those services and supplies that are dentally necessary and specifically listed as covered. Charges made for the following are not covered, except as otherwise listed as covered by the Plan.

- The Plan's obligation to make payments for treatment ceases upon termination of treatment for any reason before completion.
- The Plan's obligation to make payments for treatment ceases on termination of eligibility.
- Repair or replacement of an appliance provided under the Plan is not covered.

- If treatment began before eligible under the Plan, the Plan bases its obligation on the balance of the dentist's normal payment pattern; the orthodontic maximum applies to this amount.
- **Anesthesia or Sedation:** The Plan does not cover general anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions.
- **Anesthetics, Analgesics, Hypnosis and Medications:** Hypnosis, premedications, analgesics (e.g. nitrous oxide), local anesthetics or any other prescribed drugs.
- **Benefits Not Stated:** Exclusions include all other services or supplies not specifically included in this SPD as covered dental services under the Plan.
- **Claims Not Submitted Timely:** Claims submitted more than one year after the date of service are not covered.
- **Congenital or Developmental Malformations:** Services or supplies caused by or provided to correct congenital or developmental malformations, including, but not limited to, cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia and fluorosis (discoloration of teeth).
- **Cosmetic:** Procedures, appliances, restorations or any services that are primarily for cosmetic purposes.
- **Experimental Procedures:** Experimental procedures or supplies.
- **Facility Fees:** Hospital or facility charges for services or supplies or additional fees charged by the dentist for hospital, extended care facility or home care treatment.
- **Gnathologic Recordings:** Gnathologic recordings or similar procedures.
- **Instructions or Training:** Plaque control and oral hygiene or dietary instruction.
- **Localized Delivery of Antimicrobial Agents:** Localized delivery of antimicrobial agents via a controlled release vehicle into diseased cervicular tissue.
- **Missed Appointments:** Charges for missed or broken appointments.
- **Periodontal Charting:** A separate charge for periodontal charting.
- **Precision Attachments (Rebuilding or Maintaining Chewing Surface, Stabilizing Teeth):** Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion or for stabilizing the teeth; including services only to prevent wear or protect worn or cracked teeth, such services include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting and night guards (occlusal guard).
- ***2017 Benefit Change: Service Related Condition:*** *Services covered by your military or veterans coverage.*
- **Services on Tongue, Lip or Cheek:** Services performed on the tongue, lip or cheeks.
- **Services Otherwise Available:** This exclusion includes:

- Services for injuries or conditions that are compensable under workers' compensation or employer's liability laws;
- Services that are provided by any city, county, state or federal law, except for Medicaid coverage;
- Services that are provided, without cost, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan; or
- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had you enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, including amendments.

- **Services Provided By a Relative:** The Plan will not reimburse services provided by participants or their relatives. Relatives include a spouse, domestic partner, child, sibling or parent of a participant or his or her spouse or domestic partner.
- **Taxes.**
- **Third Party Liability Claims:** Services and supplies for treatment of illness or injury for which a third party is or may be responsible to the extent of any recovery received from or on behalf of the third party; this includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage or similar contract or insurance when such contract or insurance is issued to, or makes benefits available to, a member, whether or not such benefits are requested.
- **TMJ:** Surgical treatment of any disturbance of the temporomandibular joint (TMJ).
- **Treatment After Coverage Ends:** The Plan does not cover services provided or supplies furnished after the date coverage ends, except for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after eligibility ends. This provision is not applicable if the Plan transfers its coverage to another carrier.
- **Treatment Before Coverage Begins:** Dental services started before you are eligible for such services under the Plan.
- **Treatment Not Dentally Necessary:**
  - Services that are not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan;
  - Services that are inappropriate with regard to standards of good dental practice; and
  - Services with poor prognosis.

Coordination of Benefits

Generally, information in this section relates to pre-Medicare eligible participants. See the “Coordination with Medicare” section on page 110 for information about what applies if you are Medicare-eligible.

Coordination of benefits (COB) is how health care plans coordinate benefits when you are covered by more than one health care or motor vehicle insurance plan. The Plan requires that your benefit payments be coordinated with benefit payments from another health care or motor vehicle insurance plan for services that may be paid under either plan, so that payment responsibilities will be fair. If you are covered by more than one health care or motor vehicle insurance plan, COB guidelines, explained in this section, determine which plan pays for covered services first. COB letters of inquiry, which request information about other plans, may be sent on an annual basis to keep records up to date.

The plan that pays first is the **primary** plan. The primary plan must provide you with the maximum benefits available to you under that plan. The plan that pays second is the **secondary** plan. The secondary plan provides payments toward the balance of the cost of covered services, up to the total allowed amount.

COB makes sure that the level of payment, when added to the benefits payable under another plan, will cover up to the total of the eligible expenses. COB also makes sure that the combined payments of all coverage will not exceed the actual cost approved for your care.

Guidelines to Determine Which Plan is Primary and Secondary

- If a plan does not have a COB provision, then that plan is primary.
- If a plan does have a COB provision, the plan that covers the patient as the employee (subscriber) is primary and pays before a plan that covers the patient as a dependent.
- If a dependent child is covered under either parents’ (or legal guardians’) plans, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.

- For children of divorced or separated parents, benefits are determined in the following order, unless a Qualified Medical Child Support Order or divorce decree places financial responsibility on one parent:
  - Plan of the custodial parent;
  - Plan of the custodial parent's new spouse (if remarried);
  - Plan of noncustodial parent; and
  - Plan of noncustodial parent's new spouse (if remarried);

  Note: *If custody is not known, then the birthday rule is used to determine the order of benefits for children of divorced, separated or never married parents.*

When an employee is the subscriber on multiple group health insurances policies:

- If both contracts are either "active employee" or are "retired employee," then the policy in effect the longest is the primary plan, and the other policy is the secondary plan. *(**Note:** Refers to coverage supplied by the employer group, not which health insurance carrier has supplied coverage longer.)*.
- If one policy is "active employee" and one is "retiree/laid-off COBRA," then the "active employee" policy is the primary plan and the "retiree/laid-off COBRA" employer policy is the secondary plan.
- If the primary plan cannot be determined by using the above guidelines, then the plan covering the dependent child the longest is primary.

Updating COB Information — Your Responsibility

It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, notify BCBSM immediately. To ensure BCBSM can serve you best, respond to requests for COB information quickly. BCBSM will request updated COB information yearly. If COB information, such as cancellation of other coverage, switching other coverage carriers or changes in custody or court ordered coverage for dependent children is not updated, claims could reject inappropriately or send incorrect messages to your health care providers.

If the information you provided on your latest COB letter of inquiry is more than one year old and a claim is submitted under your coverage for your spouse or dependent children, the claim will be temporarily held. BCBSM will send you a new letter of inquiry requesting information about other carriers. When you respond, BCBSM will update your record. Your claim will then be processed according to the appropriate COB rules.

Important: If you do not respond to BCBSM's letter of inquiry within 45 days of receipt, the claim will be denied due to lack of current COB information. In addition, all other claims for your spouse and other dependents will be denied until the COB letter of inquiry is returned.

Specific Information about Your COB

The Plan includes non-duplicative COB payment. This means:

- When this Plan is the secondary (or tertiary) payer, you remain responsible for all primary patient liability resulting from primary insurance sanctions, penalties or network restrictions, unless your primary insurer is an HMO.
- As secondary (or tertiary) payer, BCBSM will not apply contract network restrictions unless the primary insurer denied benefits for the service.
- As secondary (or tertiary) payer, BCBSM will cover the remaining non-sanctioned patient liability up to the amount BCBSM would have paid had this Plan been primary for BCBSM covered services only.

Filing COB Claims to your Secondary Carrier

Always have your health care provider submit claims to your primary carrier first. Then have your provider submit a claim for the secondary balance to BCBSM. If your provider will not submit a secondary claim to BCBSM, then you can submit the claims as follows:

- Obtain an explanation of benefits from the primary carrier.
- Ask your provider for an itemized receipt or detailed description of the services, including charges for each service.
- If you made any payments for the service, provide a copy of the receipt you received from the provider.
- Make sure the provider's name and complete address are on your receipts. Also include the provider's tax ID number.
- Send these items to the appropriate address as indicated on the claim.

Please make copies of all forms and receipts for your own files, because we cannot return the originals to you.

Auto Insurance Coverage

If you or your eligible dependents are involved in a motor vehicle accident, payment for medical services will be coordinated between BCBSM and your auto insurance carrier as follows:

- Whether your auto coverage is coordinated or uncoordinated, your auto insurance carrier is primary.
- BCBSM is secondary to your auto insurance. BCBSM will reject auto accident related claims received without proof of primary payment by the auto insurer.

It is important that you discuss this with your auto insurance company.

Coordination with Medicare

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

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

Coordination with Medicaid

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

When the Plan Needs Information for Coordination of Benefits

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

Facility of Payment

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

Claims and Appeals

As a Participant in the Plan, you have the right to appeal decisions to deny or limit Plan benefits. You may also file an appeal to address concerns regarding eligibility (your or a dependent's right to participate in the Plan), confidentiality or privacy. Appeals of denied claims should be filed as described in the procedures set forth below, which supersede any conflicting appeals procedures described in the benefit booklets issued by insurance carriers.

The type of claim determines the way you appeal or ask for review of a denied or partially denied claim under the Plan. If the claim concerns health care benefits, the claims procedures and appeal rights are explained in the section titled "Medical, Prescription Drug, Hearing, Vision and Dental Claims and Appeals."

Examples of appeals of health benefit decisions would be situations where the Plan denies your claim in whole or in part because the treatment is not medically necessary or is not a covered benefit or treatment under the Plan. Other examples might be a situation where the Plan denies part of a claim because the amount charged by the hospital or physician is greater than the amount the Plan has agreed to pay or a prescribed drug is not one that the Plan covers.

If your claim involves eligibility to participate in the Plan or the application of other Plan rules, these claims and appeals procedures are explained in the next section titled "Eligibility Claims and Appeals." You must submit these claims to the Plan's Trust Administrator. Final review of appeals from these claim denials is conducted by the Trust's Claims and Appeals Subcommittee.

Examples of claims and appeals that must be submitted to the Trust Administrator or the Trust's Claims and Appeals Subcommittee would be an eligibility issue that resulted in a denial of a claim – for example, because a member's relative no longer meets the definition of dependent under the Plan.

If you want to make a claim or appeal a claim denial and you have a question as to whether your claim involves health benefits or another type of claim, you may review the applicable benefit summary attached to this booklet or contact the Trust Administrator.

Eligibility Claims and Appeals

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

The notice will include:

- The specific reason or reasons for the denial;

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

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

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

Medical, Prescription Drug, Hearing, Vision and Dental Claims and Appeals

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

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

Filing a Claim

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

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

Time Limit for Filing a Claim

You or your provider must file your claim within six (6) months after the date of service or treatment or receipt of supplies. No claim is eligible for payment if it is filed more than 12 months from the date the claim was incurred. However, your claim will not be invalidated or reduced if it is not reasonably possible to provide written proof of the claim within this period.

Claim Determinations

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

- **Urgent Care Claims:**
  - An urgent care claim is any claim for care or treatment where using the regular time-frame for processing the claim either:
    - Could seriously jeopardize your life or health or ability to regain maximum function; or
    - Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
  - If your claim is an urgent care claim for which pre-certification is required, you will be notified as soon as possible, taking into account the medical situation. A determination will be sent to you no later than 72 hours after your claim is received.
  - If you or your provider does not provide sufficient information to allow a determination on your urgent care claim, you will be notified as soon as possible, but not later than 24 hours after the claim is received. You will have a reasonable period (not less than 48 hours) to respond. After the additional information is received, you will be notified as soon as possible as to whether the claim is granted or denied.
  - If you do not follow procedures for filing your urgent care claim, you will be notified as soon as possible, but no later than 24 hours after your claim is filed. You may be notified by telephone, unless you specifically request that it be in writing.

- **Concurrent Care Claims:**
  - A concurrent care claim is one that is reviewed and possibly changed after a specified period. Usually this occurs if you are receiving ongoing treatment or the treatment is provided over a number of sessions.
  - You will be given notice of any reduction or termination in your benefits sufficiently in advance to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.
  - If you request to extend the course of treatment beyond the period or number of treatments in your initial claim, your request will be decided as soon as possible taking into account the medical situation. You will receive notice of the determination within 24 hours after receipt of the request, as long as the request is received at least 24 hours before the end of the prescribed period or number of treatments.
- **Pre-Certification Claims:**
  - A pre-certification claim is where the Plan requires you to obtain approval before you receive medical care, treatment or supplies.
  - You will be notified of a decision within a reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt of the claim.
  - The 15-day period may be extended for an additional 15 days due to circumstances beyond the Plan's control. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which a decision is expected.
  - If you do not follow procedures for filing your pre-certification claim, you will be notified as soon as possible, but no later than five days. You may be notified by telephone, unless you specifically request that it be in writing.
- **Post-Service Claims:**
  - A post-service claim is any claim that is not one of the types of claims discussed above.
  - You will be notified of a decision within a reasonable period, but not later than 30 days after receipt of the claim.
  - The 30-day period may be extended for an additional 15 days due to circumstances beyond the Plan's control. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which a decision is expected.

Appeal Procedures

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

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

- **Urgent Care Claims:** You can appeal by telephone, using the customer service number listed on your ID card. All necessary information, including the benefit determination on review, will be transmitted to you by telephone, facsimile or by another similar method.
- **All Other Claims:** You can call the toll-free customer service number on your ID card for information on filing all other appeals.

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

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

Appeal Determinations

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

Final Committee Appeal–For Pre-Medicare Eligible Participants Only

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

UAW Retirees of Daimler Trucks North America Welfare Benefit Trust

c/o BeneSys, Inc. (Appeals)
P.O. Box 4447
Troy, Michigan 48099-4447

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

No action at law or equity may be brought to recover under the Plan until these appeal rights have been fully exercised at all levels and the benefits requested in such appeal have been denied in writing, in whole or in part by the Committee. You should seek legal advice with respect to this requirement.

Physical Examination

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

Plan’s Right to Recover Overpayments or Improper Payments

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

If you make a material misrepresentation or provide false information on any application, claim, or document associated with the Plan, the Plan has the right to deny all or part of your claim or rescind (retroactively terminate) coverage, and the Plan may charge you for any expenses to the Plan resulting from the misrepresentation or false information, which could include the benefits paid, and the Plan’s attorney fees, costs, and any other expenses the Plan incurs. A material misrepresentation might be an untrue statement that leads the Plan to cover the person or to cover a medical condition of the person when the Plan would not have done so if it had known the truth. For example, if it is determined that a retiree enrolls an individual as a dependent in the Plan, and the retiree has reason to know that the person enrolled is not eligible for coverage as a dependent, that may constitute a misrepresentation of a material fact and could result in a retroactive termination of that ineligible dependent’s coverage and your being charged for resulting Plan expenses. Rescinding coverage means the Plan can cancel coverage effective on the date coverage was granted in reliance on the material misrepresentation. The Plan will provide at least 30 days’ advance written notice to each participant who would be affected before coverage is rescinded.

2017 Benefit Change: *Effective January 1, 2017, this 30-day notice does not apply to dental coverage.*

A retroactive termination is not a rescission to the extent it is attributable to a failure to timely pay required premiums or contributions for the cost of coverage. The Plan will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Plan reserves the right to recover from the covered person or provider the amount paid on claims incurred during the period for which coverage is rescinded.

Claims Administrator and Committee Discretion

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

Notice of Plan's Privacy Practices

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

Occasionally, the Committee or a benefits provider may need additional information from you. When you enroll in the Plan, you must agree to furnish the Committee or a benefits provider with all information that may be reasonably required regarding any matters pertaining to the Plan. If you do not provide this information when requested, payment of your Plan benefits may be delayed or denied.

By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Committee and its designees with all information or copies of records relating to the services provided to you. This applies to all Participants and Dependents whether or not they have signed the Participant's enrollment form. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Plan protect the confidentiality of your private health information. The Trust maintains a Notice of Privacy Practices that provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, please contact the Trust Administrator. This summary does not replace the Trust's Notice of Privacy Practices, which has many details regarding your HIPAA privacy rights. In the event of any inconsistency between this summary and the Notice of Privacy Practices, the terms of the Notice of Privacy Practices shall control. In order to obtain a copy of the Notice of Privacy Practices, contact the Trust Administrator.

The Trust will not use or further disclose information that is protected by HIPAA (known as "protected health information" or "PHI") except as necessary for treatment, payment, healthcare operations or as permitted or required by law. The Trust's obligation to protect your health information includes your "genetic information" under the Genetic Information Nondiscrimination Act (GINA). The Trust will treat your genetic information as PHI and will not use your genetic information for underwriting purposes.

The Committee hires professionals and other companies to assist it in providing benefits under the Plan. These entities, called "Business Associates," are required to observe HIPAA's privacy rules. In some cases you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that organization.

Under federal law you have certain rights with respect to your protected health information including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you and to request confidential communications. You also have the right to file a complaint with the Trust Administrator or with the Secretary of the Department of Health and Human Services if you believe your rights have been

violated. Instructions for filing a complaint with the Secretary of the Department of Health and Human Services can be found online at: www.askebsa.dol.gov or by calling 1-866-444-3272.

Plan Privacy Officer

If you have questions about the privacy of your health information or if you wish to file a privacy violation complaint, please contact the Trust Administration Office at:

Plan Privacy Office
UAW Retirees of Daimler Trucks North America Welfare Benefit Trust
P.O. Box 4447
Troy, Michigan 48099-4447

Subrogation and Reimbursement

Any reference in this section to “you” also includes your covered dependent or you or your dependent’s assignee or representative.

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

By accepting benefits provided by this Plan, you (and your dependents, heirs or estate) agree to reimburse the Plan for any benefits you may receive from a third party due to a judgment, settlement or otherwise, regardless of any offset for expenses, including legal fees, that you may owe, and before you pay any other individual, organization or entity out of that full or partial recovery. In other words, this Plan has first priority with respect to its rights under this subrogation rule. Any money you recover will be considered to be held in a constructive trust for the benefit of the Plan, regardless of who actually holds the money. You may not take any action that would prejudice or impair the Plan’s rights, and you are required to take any action, provide any information and assistance and sign any papers required by the Plan for the Plan to be able to enforce its subrogation rights. The Plan (and/or any of the Plan’s designees) is not responsible for attorney’s fees or costs you may incur or pay unless the Plan agrees in writing to pay these fees or costs in full or in part. If for any reason any of the Plan’s subrogation rights are compromised or diminished in any way, the Plan may treat the benefit amounts you received as a debt you have to the Plan and the Plan may pursue recovery of that amount from you and/or reduce or eliminate any future benefits that may be payable on your behalf until this debt is paid. The Plan will have a first priority lien on any recovery from a third party. This lien is binding on any attorney, insurance company, or other party who agrees or is obligated to make payment to you or your Dependents as compensation for any damages. The lien exists at the time the Plan pays medical benefits. If you or your Dependent files a petition for bankruptcy, you or your Dependent agrees that the Plan’s lien existed in time prior to the creation of the bankruptcy estate. If you have hired an attorney, and you and your attorney agree to honor the Plan’s first priority lien during any court proceedings, negotiations, or similar procedures, the Plan will consider reducing the amount of its recovery to allow for your attorney’s fees or court costs. To take advantage of this, you must have an express written authorization from the Plan or its representative.

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

You are expected to assist or cooperate with the Plan, including, if requested, by bringing legal proceedings against any appropriate persons, firms corporations or other entities. The Plan may withhold future benefits, up to the amount due under this subrogation rule, if you do not assist or cooperate, or if you fail to repay the Plan, the Plan may offset future payments for medical services you receive by withholding payments until the entire amount due is reimbursed.

COBRA Continuation Coverage

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

Qualified Beneficiaries

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

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

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

Qualifying Events

COBRA continuation coverage may be purchased as follows:

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

Notify the Fund Administrator of Qualifying Events

A Qualified Beneficiary (see above) must notify BeneSys within 60 days of when a qualifying event occurs, including the death of a retired employee or surviving spouse, or divorce or legal separation. **If the Qualified Beneficiary does not notify the Trust Administrator within 60 days of the qualifying event, he or she will lose the right to elect COBRA continuation coverage.** Notification should be sent to:

BeneSys
P.O. Box 4447
Troy, Michigan 48099-4447

Electing COBRA Continuation Coverage

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

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

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

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

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

Coverage Under COBRA

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

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

How Long COBRA Continuation Coverage Lasts

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

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

COBRA Continuation Coverage Cost

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

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

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

Keep the Fund Administrator Informed

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

Questions About COBRA Continuation Coverage

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

BeneSys
P.O. Box 4447
Troy, Michigan 48099-4447
(248) 641-4918 or toll-free (844) 582-4443
Fax: (248) 813-9898

Plan Administrative Information

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

Trust Name

UAW Retirees of Daimler Trucks North America Welfare Benefit Trust.

Plan Name

UAW Retirees of Daimler Trucks North America Welfare Benefit Trust.

Plan Sponsor and Plan Administrator

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

Trust Administrator

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

BeneSys
P.O. Box 4447
Troy, Michigan 48099-4447
(248) 641-4918 or toll-free (844) 582-4443
Fax: (248) 813-9898

Plan Sponsor Employer Identification Number (EIN)

47-6377585.

Plan Number

501

Plan Year

The Plan Year is January 1 and ending December 31.

Plan Type

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

Plan Funding

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

Medicare-eligible medical benefits are provided through a fully insured Medicare Advantage plan, which means these benefits are paid directly from the insurance company.

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

Agents for Service of Legal Process

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

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

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

Legal Actions

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

Plan Documents

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

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

Plan Interpretation

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

Plan Changes

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

Plan Discontinuation or Termination

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

Your ERISA Rights

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

Receive Information about Plan and Benefits

You have the right to:

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

Continue Group Health Plan Coverage

You may also have the right to continue health care coverage for yourself, spouse or dependents (if eligible) if there is a loss of coverage due to a qualifying event. (See the section entitled "COBRA Continuation Coverage".) You or your dependents may have to pay for this coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called Plan fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including an employer, union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision (without charge) and to appeal any denial, all within certain time schedules. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claim and appeal procedures.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Questions

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

U.S Department of Labor
211 W. Fort St., Ste. 1310
Detroit, MI 48226
(313) 226-7450,

Or at:

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

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

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

OTHER LEGAL PROTECTIONS

- **Women's Health and Cancer Rights Act:** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedemas. These benefits are provided the same as other benefits under the Plan.

- **Newborns' and Mother's Health Protection Act:** Under federal law, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. The mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). You are not required to obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- **Children's Health Insurance Program (CHIP) (if available in your state).** If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying the health premiums.

Important Notice

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

Notice of Nondiscrimination

2017 Benefit Change: *This section is provided in compliance with Section 1557 of the Patient Protection and Affordable Care Act for benefits in effect on and after January 1, 2017.*

The UAW Retirees of Daimler Trucks North America Welfare Benefit Trust complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Free language services to people whose primary language is not English, such as, qualified interpreters and information written in other languages.

If you need these services, contact Heather C. Carman, Trust Administrator, c/o BeneSys. Inc., 700 Tower Dr., Ste. 300, Troy, MI 48098, phone: 248-813-9800 ext. 3383, email: heather.carman@benesys.com.

If you believe that the UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust
Attn: Andrew Nickelhoff, Fund Counsel
Sachs Waldman, P.C.
2211 E. Jefferson Avenue
Detroit, MI 48207
(313) 965-3464

You can file a grievance in person or by mail or fax. If you need help filing a grievance, Andrew Nickelhoff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- Electronically through the Office for Civil Rights, Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; or
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW, Room 509F
  HHH Building
  Washington, DC 20201; or
- By phone at (800) 868-1019 (TDD: (800) 537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (844) 582-4443.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電(844) 582-4443.

بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust يلتزم
.الأصل الوطني أو السن أو الإعاقة أو الجنس

(رقم هاتف 582-4443 (844)ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1
الصم والبكم: 1-

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (844) 582-4443번으로 전화해 주십시오.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (844) 582-4443.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (844) 582-4443.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (844) 582-4443.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust ua raws cov kev cailij choj yuam siv ntawm Tsom Fwv Nrub Nrab Teb Chaw hais txog pej xeem cov cai (Federal civil rights laws) thiab tsis ciav-cais leejtwg vim nws hom neeg, nqaij tawv, lub tebchaws tuaj, hnub nyoog, kev tsis taus, los yog poj niam txiv.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (844) 582-4443.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (844) 582-4443.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (844) 582-4443 पर कॉल करें।

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (844) 582-4443.

Sumusunod ang The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (844) 582-4443.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (844) 582-4443.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (844) 582-4443.

The UAW Retirees of the Daimler Trucks of North America Welfare Benefit Trust tele ilana ofin ijoba apapo lori eto ara ilu atipe won ko gbodo sojusaju lori oro eya awo, ilu-abinibi, ojo-ori, abarapa tabi okunrin ati obinrin.

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi (844) 582-4443.