

MICHIGAN LABORERS' HEALTH CARE FUND

SUMMARY PLAN DESCRIPTION

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Section 1. Eligibility and Guidelines

The Michigan Laborers' Health Care Fund provides benefits for you, your spouse and your eligible dependents.

This section describes eligibility for health care and prescription drug benefits, burial benefits and accidental death and dismemberment benefits.

Active Employees

Eligibility for active employees is determined based upon contributions made for work performed within a specific number of months.

Initial Eligibility Requirements

You will become initially eligible (i.e. eligible for the first time) on the first day of the second month following the month in which you are credited with at least 700 hours of contributions made on your behalf for work performed within a six (6) consecutive month period. You will remain eligible for one (1) month.

For example, if you were credited with at least 117 hours in each of the six (6) consecutive months of January through June, you would be eligible for the month of August.

You do not have to satisfy the initial eligibility requirements if you have been eligible via employer contributions with the Laborers' Metropolitan Detroit Health Care Fund within the latest 60-month period and this Fund is now your Home Fund.

Continuation and Reinstatement of Eligibility

Once you have satisfied the initial eligibility provisions, you will continue to be eligible for three (3) consecutive months beginning with the second month following three (3) consecutive months for which contributions were received on your behalf for at least 350 hours.

For example, if you have satisfied the initial eligibility provisions and have been credited with at least 350 hours of contributions for the months of April, May and June, you will continue to be eligible for the months of August, September and October.

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Once you satisfy the initial eligibility provisions, you could also continue to be eligible for the second month following the end of a 12 consecutive month period during which contributions made on your behalf total at least 1,200 hours for work actually performed.

If you lose your eligibility for a period of less than 60 consecutive months, due to insufficient contributions made on your behalf, you will again be eligible on the first day of the second month following a period of three (3) consecutive months for which contributions of at least 350 hours of work have been made by a contributing employer on your behalf.

For example, if you have not been eligible for a period of six (6) months and you return to work for a contributing employer and contributions are made on your behalf for work performed during the months of June, July and August that total at least 350 hours, you would again be eligible on October 1, and would remain eligible for the months of October, November and December.

You can earn a maximum of 6 months of credited eligibility through a combination of the quarterly and the annual eligibility provisions.

If you have not satisfied either of the reinstatement provisions described above and are not eligible by employer contributions or disability hours in what would have been the 60th consecutive month of ineligibility and you were not eligible under the Laborers' Metropolitan Detroit Health Care Fund within the latest 60 months, you must satisfy the initial eligibility provisions again unless you had at least 700 hours of contributions made on your behalf by a contributing employer for work performed in the 60 months immediately preceding the month you return to work and none of the 700 hours are used toward eligibility.

Employment Outside the Jurisdiction

Frequently, Laborers accept employment outside the jurisdiction of their local union when there is no work available locally. The Plan has entered into reciprocity agreements with many other Funds covering Laborers that provide for the transfer of contributions back to this Fund. In most instances you must authorize the transfer of contributions in writing, although transfers between the Laborers' Metropolitan Detroit Health Care Fund and this Fund are automatic in some circumstances. Contact the Fund Office for more information.

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Disability Hour Credit

If you are unable to work due to an injury or illness, you may be entitled to receive disability hour credit during the period of the time you are disabled. Disability hours will be credited toward eligibility at the rate of six (6) hours per workday, up to a maximum of 120 hours per month for up to 26 consecutive weeks. To apply for disability hours you must submit a *Loss of Time* form to the Fund Office, completed by both you and your physician, within one (1) year of the date the injury or illness begins.

Certification for the purposes of receiving Disability Hour Credit must be obtained from a physician who is either an MD or DO.

Eligibility During Periods of Unemployment

If you are an active employee and would otherwise lose your eligibility because you did not work enough hours, you may continue your eligibility through self-payments. When you become ineligible, the Fund Office will notify you of your self-payment rights. To qualify for self-payments, you must be ineligible because of a lack of available employment as a Laborer within the jurisdiction of the Fund or because, even though you are currently working as a Laborer for a contributing employer, you have not worked enough hours to remain eligible. (Work in the "jurisdiction of the Fund" means work under a collective bargaining agreement that requires Fund contribution to be made for you.) Your Local Union must verify your status each month. Employees who are temporarily disabled may also make self-payments to continue their coverage.

The amount of the self-payment is determined by the Board of Trustees and may be adjusted periodically. You should contact the Fund Office for current rates.

The maximum number of months of self-payments that can be remitted under the Plan is 24 months.

Continuing Health Care Coverage Through COBRA

Coverage for you and your dependents ends upon loss of eligibility with the Michigan Laborers' Health Care Fund. In most instances, coverage will terminate when you are not credited with sufficient contributions or you fail to make self-payments on a timely basis.

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This section summarizes the rights and obligations of you and your eligible dependents under the Continuation Coverage provisions of the Consolidated Omnibus Budget Reconciliation Act, or "COBRA." You, your spouse, and your dependents should take time to read this section carefully.

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

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

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

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

Employee Right to Elect Continuation Coverage

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

The Trustees, through the Fund Office, determine when a Qualifying Event occurs as a result of a reduction of employer contributions or a termination of employment based on information contained on submitted employer contribution forms. The Fund Office will determine when the COBRA Qualifying Event has occurred within 120 days following receipt of the employer contribution form. The Fund Office will mail the COBRA election notice within 60 days after it has determined that you or a qualified beneficiary has lost eligibility for coverage. You have 60 days from the date you receive the election notice to elect to

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receive Continuation Coverage. If you do not elect coverage within 60 days, you no longer have a right to receive Continuation Coverage.

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

Continuation Coverage and "Self-Payments"

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

Your Spouse's Right to Elect Continuation Coverage

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

- Termination of your employment (for reasons other than gross misconduct), or a reduction in the hours worked which results in your losing eligibility under the Fund;
- Your death or the death of a Retired Participant;
- Divorce or legal separation from you; or
- You become entitled to Medicare and are not eligible to continue coverage for your spouse under another portion of the Plan or choose not to continue such coverage.

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

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Your Dependent Children's Right to Elect Continuation Coverage

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

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

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

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

Continuation Coverage for Disabled Persons

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

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

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

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

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

Employee Obligations to Notify the Fund Office of a Qualifying Event

COBRA requires that you or a family member notify the Fund Office immediately about a divorce, legal separation, or a child losing dependent status under the Plan. If such an event is not reported to the Fund Office within 60 days after it occurs, Continuation Coverage will not be permitted.

If you die, your surviving spouse (or dependent child) should contact the Fund Office immediately after your death. This assures that Continuation Coverage is offered to your surviving spouse and children at the earliest possible date.

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

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

The Fund Office may require you to provide information about your coverage under another group health care plan. The Fund may seek reimbursement directly from you if medical expenses are paid by the Michigan Laborers' Health

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Care Fund through Blue Cross Blue Shield of Michigan because you or your dependents do not notify the Fund of other health care coverage.

Second Qualifying Events

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

- Death of the employee, if he or she is a covered employee under the Plan;
- Divorce or legal separation of the employee and his/her spouse;
- The employee, if a covered employee under the Plan, becomes enrolled in Medicare (Part A, Part B, or both); or
- For dependant children, the dependant child ceases to satisfy the Plan's definition of a "dependent child" (The rules for second qualifying events also apply to newborn or adopted children.)

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

Proof of Insurability is Not Needed to Elect Continuation Coverage

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

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Procedure for Obtaining Continuation Coverage

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

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

Termination of Continuation Coverage

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

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

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

A Word about Confidential Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides stringent requirements for the Fund, its Trustees and its service vendors concerning the use and disclosure of Participants' personally identifiable 'Protected Health Information' (PHI). Broadly speaking, PHI includes demographic information about you and/or your dependents, such as your name, address, telephone number and Social Security Number, in conjunction with information concerning you and/or your dependents, such as: (1) eligibility for Benefits, (2) medical treatment provided or (3) payment for such medical

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treatment. Specifically, the Plan will use and disclose PHI only for purposes related to health care treatment, payment for health care and health care operations.

The Plan's use and disclosures of PHI is explained in detail in the Privacy Notice previously mailed to you. If you would like another copy of this notice, please contact the Fund Office.

The Plan and the Trustees are committed to observing these privacy rules and ensuring the confidentiality of your PHI. Your cooperation and understanding in working with the Plan to achieve compliance with these federal requirements is appreciated.

Health Insurance Portability and Accountability

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a preexisting condition exclusion generally may not be imposed for more than 12 months (18 months for late enrollees). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan or other source, a certificate or proof of coverage may help you obtain coverage without a preexisting condition exclusion. If you have questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C., 20210.

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

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Military Service Continuation Coverage

You are entitled to continue your Fund health care coverage for up to 24 months if you stop working in covered employment to enter the "uniformed services." You are considered to be in the uniformed services when you are in the Armed Forces or in active duty for training, inactive duty for training, or full time duty in the National Guard, the Air National Guard, or the commissioned corps of the Public Health Service. You may be required to pay a monthly fee to continue coverage. To assure that this coverage is provided on a timely basis, please notify the Fund Office immediately upon entry into the uniformed services. You should contact the Fund Office for more details.

Blue Cross Blue Shield Group Conversion Coverage

Blue Cross Blue Shield of Michigan individual coverage, called Group Conversion, is available to you either:

As an alternative to COBRA when you first become eligible for COBRA **or**

At the end of your COBRA eligibility period **if** you made all required payments during that period.

Your benefits may change under Group Conversion coverage, and the coverage will be limited to your immediate family, but there will be no interruption of coverage provided you pay the initial and subsequent bills. You must be a Michigan resident for at least six months out of each year to be eligible for this type of coverage.

To ensure continuous coverage, you must submit a written request for Group Conversion coverage to BCBSM within 30 days from the date you are no longer eligible for coverage through the Fund **or** within six months before the COBRA coverage ends. For additional information on how to apply for this coverage, contact the Fund Office or call the BCBSM customer service number in Section 2.

Self-Employed Laborers

Self-employed Laborers who have signed an appropriate agreement may participate in the Plan, and maintain coverage, by making contributions. Contact the Fund Office for details.

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Total and Permanent Disability Self-Payment Program

If you become totally and permanently disabled before the age of 65 and you are no longer receiving disability hour credit, you may continue your eligibility by making self-payments. To be eligible to make self-payments, you must be receiving pension benefits from one of the following sources:

1. The State of Michigan Laborers' District Council Pension Fund; or
2. The Laborers' Pension Trust Fund - Detroit & Vicinity; or
3. The Social Security Administration; or
4. The Laborers' International Pension Fund.

If you are not receiving a monthly pension benefit from one of the above sources, you may be eligible to participate in this self-payment program if you have been eligible by employer contributions in at least five (5) of the ten (10) years immediately preceding the date your disability begins.

You must be eligible by either employer contributions, disability hours or self-payments on the date you apply for coverage to be eligible to participate in the Total and Permanent Disability Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the active program.

You may continue coverage under the Total and Permanent Disability Self-Payment Program until one of the following occurs:

1. You fail to make your self-payment on time or in the proper amount;
2. You fail to remain a member in good standing with the local union unless otherwise waived for a non-bargaining unit employee covered under a signatory employer's participation agreement;
3. You become eligible for Medicare;
4. Termination or modification of the Total and Permanent Disability Self-Payment Program;
5. Your dependents no longer meet the definition of eligible dependent under the Plan;
6. Death of the totally and permanently disabled participant.

Participants with at least 15 years in the Laborers' Pension Fund who for extraordinary reasons do not remit self-payments until they receive a Social Security Disability Award and/or Pension Benefits, may file an appeal for reinstatement in the Plan.

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Schedule of Benefits for Totally and Permanently Disabled Participants

The schedule of benefits for Totally and Permanently Disabled Participants and their dependents (who are not eligible for Medicare) is the same as the schedule of benefits in effect for the Active (Non-Retired) Participants except that Totally and Permanently Disabled Participants and their dependents are not eligible for Disability Hour Credit, and Accidental Death and Dismemberment Benefits and the Totally and Permanently Disabled Participant must remit an additional monthly self-payment to be eligible for dental benefits. Dental Benefit coverage must be elected at the time of the first self-payment as a Totally and Permanently Disabled Participant.

The schedule of benefits for dependents of Totally and Permanently Disabled Participants who are eligible for Medicare is described in Section 11.

Early Retiree Self-Payment Program

If you retire before age 65, you and your dependents will be covered under the Early Retiree Self-Payment Program until you become eligible for Medicare, if you are receiving monthly pension benefits from one of the following sources:

1. The Michigan Laborers' District Council Pension Fund; or
2. The Laborers' Pension Trust Fund - Detroit & Vicinity; or
3. The Social Security Administration; or
4. The Laborers' International Pension Fund.

You must be eligible by either employer contributions or active self-payments on the date of retirement to be eligible to participate in the Early Retiree Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the active program.

You may continue coverage under the Early Retiree Self-Payment Program until one of the following occurs:

1. You fail to make your self-payment on time or in the proper amount;
2. You fail to remain a member in good standing with the local union unless otherwise waived for a non-bargaining unit employee covered under a signatory employer's participation agreement;
3. You become eligible for Medicare;

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4. Termination or modification of the Early Retiree Self-Payment Program;
5. Your dependents no longer meet the definition of eligible dependent under the Plan;
6. Death of the early retiree.

Schedule of Benefits for Early Retiree Self-Payment Participants

The schedule of benefits for Early Retiree Participants and their dependents (who are not eligible for Medicare) is the same as the schedule of benefits in effect for the Active (Non-Retired) Participants except that Early Retiree Participants and their dependents are not eligible for Disability Hour Credit, Accidental Death and Dismemberment Benefits; and the Early Retiree must remit an additional monthly self-payment to be eligible for dental benefits. Dental Benefit coverage must be elected at the time of the first self-payment as an Early Retiree Participant.

The schedule of benefits for dependents of Early Retiree Participants who are eligible for Medicare is described in Section 7 through 13.

Supplement to Medicare Program

Eligibility Provisions

This coverage is available to those retired participants and/or spouses who are 65 and/or eligible for Medicare. Widows eligible for Medicare may also be eligible for this coverage. Coverage is provided through Self-Payments under the Supplement to Medicare Program. To participate in this Program, a Retired Participant must:

1. Be eligible by employer contributions or self-payments at the time of application for the Supplement to Medicare;
2. Have been eligible as an Active Participant in at least ten (10) of the fifteen (15) years immediately preceding the date of retirement with at least 480 hours remitted in each of the ten (10) years;
3. Have both Parts A (Hospital) and B (Medical) coverage under Medicare. (A copy of the Retiree and/or Spouse's Medicare Card must be submitted);
4. Be a member in good standing with his Local Union unless otherwise waived for a non-bargaining unit employee covered under a signatory employer's participation agreement;
5. Have lost their coverage based on employer contributions.

The Retiree and/or his spouse is eligible to be added on the first day of the

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month following the month he/she becomes eligible for both Parts A & B of Medicare.

A Spouse or widow is eligible to be added to this program only if the Retiree meets provision numbers (1), (2), (3), (4), and (5) as shown above. In addition, the Retired Participant must be maintaining coverage for himself under one of the Retired Participant Self-Payment Programs.

Self-Payment Provisions

Method of Payment for Coverage

The Retired Participant covered under the Supplement to Medicare Program must have self-payments deducted from his Michigan Laborers' Pension Fund monthly benefit check. The appropriate authorization form must be executed by the 15th day of the month preceding the month such deductions are to begin. Authorization forms are available from the Fund Office. Cancellation of the deductions must be made in writing at least 60 days prior to the effective date of cancellation.

The amount of the monthly payment is established by the Trustees and may be changed from time to time. Current payment rates can be obtained from the Fund Office.

Provisions for Continued Participation

The Retired Participant may continue his coverage under the Supplement to Medicare Program until one of the following occurs:

1. Failure to remain a member in good-standing with his Local Union.
2. Termination or modification of the Supplement to Medicare Program.
3. Death of the Retired Participant.
4. Retired Participant loses his Medicare coverage.

The Retired Participant may continue coverage for his spouse and/or eligible dependent children under this Program until one of the following events occurs:

1. Failure to remain a member in good-standing with his Local Union.
2. Dependent no longer qualifies for Medicare.
3. Children no longer meet the definition of Dependent Child.
4. The Spouse no longer meets the definition of Spouse.
5. Termination or modification of the Supplement to Medicare Program.
6. Death of the Retired Participant.

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The widow of a Retired Participant may continue coverage under this Program until one of the following events occurs:

1. Dependent no longer qualified for Medicare.
2. Termination or modification of the Supplement to Medicare Program.
3. Remarries

Special Provisions

If the Retired Participant is single and remitting self-payments, and then marries, he may begin to cover his new spouse effective with the date of marriage, provided that proof of his marriage is submitted to the Fund Office within 30 days from the date of such marriage along with the additional pension deduction amount, if any. The current rates can be obtained from the Fund Office.

Schedule of Benefits for Participants on the Supplement to Medicare

Supplement to Medicare coverage works with Medicare to extend your health care benefits and provides the same benefits as the active participants receive. Your group coverage, in combination with Medicare, provides the benefits described in Section 6 through 13 of this SPD. The 20% co-payment up to \$1,200 for services applies annually. (The co-payment maximum does not include the prescription drug co-payment.)

Listed below is a brief summary of your Supplement to Medicare coverage:

- The Medicare in-patient and out-patient deductibles are covered at 80%
- The Medicare co-payment is covered at 80%.
- Hearing Care Benefits as described in Section 10
- Vision Benefits as described in Section 9
- Participants covered under the Supplement to Medicare program also have an opportunity, at the time of retirement, to elect to purchase Dental Coverage as described in Section 13

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Retiree Self-Payment Program

This program provides coverage for the eligible dependents of retired participants who are eligible for Medicare and therefore are no longer covered under the Plan. Your dependents will be eligible for coverage under the Retiree Self-Payment Program if you are receiving monthly pension benefits from one of the following sources:

1. The State of Michigan Laborers' District Council Pension Fund; or
2. The Laborers' Pension Trust Fund - Detroit & Vicinity; or
3. The Social Security Administration.

You must be eligible by either employer contributions, disability hours, or active self-payments on the date of retirement to be eligible to participate in the Retiree Self-Payment Program. Coverage under this program must begin immediately upon termination of coverage under the active program.

You may continue coverage under the Retiree Self-Payment Program until one of the following occurs:

1. You fail to make your self-payment on time or in the proper amount;
2. You fail to remain a member in good standing with the local union;
3. You become eligible for Medicare;
4. Termination or modification of the Retiree Self-Payment Program;
5. Your dependents no longer meet the definition of eligible dependent under the Plan;
6. Your death.

Schedule of Benefits for Retiree Self-Payment Participants

The schedule of benefits for the dependents of Retired Participants (who are not eligible for Medicare) is the same as the schedule of benefits in effect for the Active (Non-Retired) Participants except that dependents of Retired Participants are not eligible for Disability Hour Credit, Death Benefits, Accidental Death and Dismemberment Benefits and the Retiree's dependents must remit an additional monthly self-payment to be eligible for dental benefits. Dental Benefit coverage must be elected at the time of the first self-payment as a dependent of a Retired Participant.

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Surviving Spouse Self-Payment Program

This program provides coverage for the eligible dependents of deceased Participants who are not eligible for Medicare. Your dependents will be eligible for coverage under the Surviving Spouse Self-Payment Program if you were entitled to receive monthly pension benefits from the State of Michigan Laborers' District Council Pension Fund.

You must be eligible by either employer contributions, disability hours or self-payments on the date of death in order for your dependents to be eligible to participate in the Surviving Spouse Self-Payment Program. Coverage under this program must begin immediately upon the death of the participant and/or after the Participant's eligibility via employer contributions has been exhausted.

Your dependents may continue coverage under the Surviving Spouse Self-Payment Program until one of the following occurs:

1. Your dependents fail to make their self-payment on time or in the proper amount;
2. Your dependents become eligible for Medicare;
3. Termination or modification of the Surviving Spouse Self-Payment Program;
4. Your dependents no longer meet the definition of eligible dependent under the Plan.

All self-payments are due in the Fund Office on the first day of the month for which payment is being made. Self-payments should be made by check or money order, made payable to "Michigan Laborers' Health Care Fund." Coverage through the Self-Payment Program must be continuous. Anyone eligible to participate in the Self-Payment Program but who fails to make a self-payment within the allotted time and in the proper amount for a month will not be reinstated at any time in the future.

Once the Surviving Spouse remarries, he/she is no longer eligible to participate in the Surviving Spouse Self-Payment Program.

Active Employees and Their Spouses Who Are Age 65 or Older

If you continue to work beyond the date you or your spouse reaches age 65, you have the option of making either the Fund or Medicare your primary payor of benefits. The Fund will automatically be the primary payor unless you elect to have Medicare become the primary payor. Such an election must be in writing and filed with the Fund Office. Contact the Fund Office for more information.

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Dependents

Eligible Dependents include your spouse and any unmarried children until the end of the calendar year *before* the calendar year in which they reach 19. These can include:

- Your children by birth, legal adoption, or legal guardianship while in your custody and dependent on you.

Note: An adopted child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.

- Children of your spouse while they are in the custody of and legally dependent on your spouse and reside as members of your household.
- Children who do not reside with you but are your legal responsibility for the provision of medical care (e.g., children of divorce parents).

Disabled Dependents

Disabled dependents may be covered if they are totally and permanently disabled prior to the end of the calendar year that ends before they reach age 19, and you notify the Fund Office of the condition in writing. The disability must be from a medically determined mental or physical condition that prevents them from being self-supporting. They must be unmarried and dependent on you for support and care. You will be required to show verification of a dependent's total and permanent disability. Disabled dependents may remain covered to any age.

Dependents Between Ages 18 and 25

Dependents who meet the requirements listed below may continue to be covered by the Fund as a continuation member. You must apply for this coverage by the end of the year in which they reach 18. The coverage continues to the end of the year in which they reach age 25, if they remain eligible. Coverage for these dependents will be exactly the same as yours.

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- **Dependents between ages 18 and 23**

To be eligible, dependents between ages 18 and 23 must meet all of the following requirements:

- They are full-time students for at least five months of the year.
- They are unmarried and are related to you by blood or legal adoption.
- They have not provided more than half of their support.
- They reside with you for at least one-half of the year.

Coverage under these rules ends at the end of the calendar year *before* the calendar year in which they reach 24.

- **Dependents between ages 23 and 25.**

To be eligible when coverage ends under the rules in the prior section, dependents between ages 23 and 25 must meet all of the following requirements:

- They are full-time students for at least five months of the year.
- They are unmarried and are related to you by blood or legal adoption.
- They receive over one-half of their support from you.
- They reside with you for at least one-half of the year.
- They are not eligible for health care coverage as "qualifying children" of another person.

Coverage under these rules ends when the child reaches 25.

Special Rules

- If you are divorced, your children will be your dependents if they reside with you and/or you former spouse for at least half of the year and you and/or your former spouse provide more than one-half of their support.
- Children who live away from home temporarily (for example, when attending college) still are considered to reside with you.

Annual Certification

Each year, you must certify to the Fund that all of the children who you claim as dependents meet these requirements.

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Section 2 - How to Reach BCBSM

Customer Service Information

If you need to call or write BCBSM about a claim or your coverage, it's important to give BCBSM the contract number that's printed on your BCBSM ID card. **You'll receive the quickest service possible if you contact your BCBSM dedicated Customer Service Center.**

Use the phone number that's printed on the back of your ID card, or refer to the number below. Blue Cross Blue Shield of Michigan's customer service hours are Monday through Friday from 8:30 a.m. to 5 p.m.

To Call BCBSM	To Write BCBSM
1-800-252-1900	Blue Cross Blue Shield of Michigan Major Accounts Service Center, Mail Code X420 600 E. Lafayette Blvd. Detroit, MI 48226

- BlueCard Program (participating providers) 1-800-810-BLUE (2583)
- Hearing and Speech Impaired Customers
 - Area codes 248, 313, 586, 734, 810 and 947(313) 225-6903
 - Area codes 231, 269 and 616.....(616) 285-2114

Special Servicing Numbers

- Anti-Fraud Hotline..... 1-800-482-3787
- BlueHealthConnection®..... 1-800-755-BLUE (2583)
 - Hearing-impaired customers 1-800-240-3050
- BlueSafeSM Hotline 1-877-BLUESAFE (258-3723)
- Human Organ Transplant Program 1-800-242-3504
- Individual Case Management Program..... 1-800-845-5982
- Senior Help Line 1-800-327-9148

Web site Addresses

- BCBSM Home Page www.bcbsm.com
- Anti-Fraudwww.bcbsm.com/antifraud/contact.shtml

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Section 3 - General Information

Your Identification Card

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



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

Line 1: **Contract Number** is your identification number.

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

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

Line 3: **Group Number** tells BCBSM you are a BCBSM group participant.

Your BCBSM ID card is issued once you enroll for coverage. It lets you obtain services covered under your health care plan. Only the participant's name appears on the ID cards. However, the cards are for use by all covered dependents on your contract.

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Here are some tips about your ID card:

Carry your card with you at all times to help avoid delays when you need medical attention.

If you, or anyone in your family, need a card, please call the Fund Office for assistance.

Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.

Call the Fund Office if your card is lost or stolen. You can still receive services by giving the provider your contract number to verify your coverage.

Customer Service

As a Blues member you are very important. You should call the customer service number in Section 2 anytime you have a question about your health care plan.

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

Have your contract number ready

If you are questioning a service, please provide:

Patient and provider's name

Date the patient was treated

Type of service, such as an office visit

Charge for each service

When corresponding with BCBSM, please make sure your contract number is on each page and you should keep a copy for your records.

When visiting a BCBSM Customer Service office, please bring a copy of any bills, forms or other materials related to your inquiry.

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Preventing Fraud

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

Providers may ask for identification other than the BCBSM ID card. Checking the identification of the cardholder is one way of preventing unauthorized use of your card.

If you suspect health care fraud, let BCBSM know.

If your health care coverage is through BCBSM, call the Anti-Fraud Hotline at **1-800-482-3787**. Your call is strictly confidential.

Write BCBSM at the following address:

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

Contact BCBSM online at www.bcbsm.com/antifraud/contact.shtml

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Section 4 – Dependent Eligibility

Important: If you have a dependent who is no longer eligible for health coverage on your contract, BCBSM has many benefit options available to continue his or her coverage. Please call the customer service number in Section 2 for more information.

To Add a Dependent to Your Contract

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

The chart below shows the coverage effective date.

Dependent	Effective Date
Spouse	Date of marriage. (must submit a copy of the marriage certificate)
Newborn	Date of birth. (must submit a copy of the birth certificate)
Adopted child	Date of placement. Placement occurs when the member becomes legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.
Principally supported child	Nine months from the date support began. You may request to add the child after providing six months of support.
Child under legal guardianship	Date legal guardianship is granted or when the date of petition for legal guardianship and residency is established.
Child between 18 and 25	Can be added, but there may be additional cost to you, if eligible. You must notify the Fund Office within 30 days of the end of the calendar year before the calendar year in which your child turns 18.

** If the Fund Office is notified more than 30 days after the date of the event, the change to your contract could be delayed.*

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To Remove a Dependent from Your Contract

When you (the member) need to remove a dependent from your contract, notify your Fund Office and fill out an **Enrollment/Change of Status** form.*

Be sure to include your group and contract numbers, the dependent's Social Security number, the date you would like the dependent removed, and the reason for removing the dependent.

See the chart below for information about removing dependents. **Remember, if a dependent child is no longer eligible, you must notify your Fund Office promptly.**

Dependent	Reason for Removal	Effective Date
Spouse	Divorce or legal separation (must send a copy of Divorce Decree)	Date of the divorce or legal separation
Child	Marriage	Date of marriage
	Reaches 18 or 25 and is no longer eligible for coverage	The end of the calendar year before the calendar year in which the child turns 18 or 25
Any dependent	Death	First day following the date of death

** If your Fund Office is notified more than 30 days after the date of the event, the change to your contract will be delayed which may cause errors when your claims are processed.*

Please remember to report any membership changes to your Fund Office promptly so these changes can be reflected on your records.

If you fail to give timely notice of a divorce, you may be liable for any payments made by BCBSM on behalf of your ex-spouse for medical services that have been provided subsequent to the date of your divorce.

To Change Your Address

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

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Section 5. Choosing a Provider

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

- Blues participating providers
- How to locate Blues participating providers
- Nonparticipating providers
- BlueCard program
- Care out of the country

Your health care plan provides you with the highest level of benefits and the lowest of out-of-pocket costs when you choose participating providers. You also have the freedom to receive care from a nonparticipating provider, but with higher out-of-pocket costs.

Active Members – PPO Network

Comprehensive Major Medical PPO (CMM-PPO) uses a network of physicians, hospitals and other health care specialists who have signed agreements with BCBSM to accept the BCBSM approved amount as payment in full for covered services. When you use PPO providers, your out-of-pocket costs for covered services are limited to the **copayments** listed in Section 6.

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

- Choose a PPO provider by either logging onto the BCBSM Web site at www.bcbsm.com
- Or Calling the Customer Service number in Section 2 for assistance.
- Make your appointment directly with that provider.

Note: When scheduling your appointment, it's a good idea to confirm that the provider is in the BCBSM PPO network.

Just remember to select your provider from the BCBSM PPO network and you will stay in-network.

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

- Services for which a PPO network has not yet been established
- Services covered by a separate prescription drug, dental, vision or hearing plan

Special note for parents of students: If you have dependents attending school in Michigan, but living away from home, you should help them choose a PPO physician near their school. You may access the BCBSM Web site at www.bcbsm.com for PPO providers.

How Your CMM-PPO Health Care Plan Works

Your CMM-PPO health care plan gives you the choice of receiving care from a PPO physician or outside the network from any physician. The choice is always yours.

- When a PPO physician provides or refers your hospital and/or medical services, it is called "in-network."
- When a PPO physician **does not** provide or refer your hospital and/or medical services, it is called "out-of-network."

The following information will help you understand how your health care plan works.

Emergency and Referral Services

In certain situations, when you receive services outside the BCBSM PPO network, the out-of-network copayment may be waived. These situations include:

- **Referrals** – Services performed by a non-network provider are covered at the in-network level if your PPO physician coordinates them.

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

If you are referred to a non-network nonparticipating provider, you may be balanced billed and you may have to file your own claims. Therefore, if you are referred to a non-network physician who also is nonparticipating with BCBSM, be sure to discuss the physician's policy regarding fees, as you may be responsible for paying any amount above the BCBSM approved amount.

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- **Emergency Care** – If emergency care is needed, go to the nearest medical facility. The initial exam to treat a life-threatening medical emergency or accidental injury is covered at the in-network level when the diagnosis meets medical emergency guidelines.

Note: Follow-up care is not considered emergency care.

- **PPO Network Exceptions** – When you receive the following types of covered services from a non-network provider you are **not** required to pay the out-of-network copayment:
 - BCBSM approved home health care agencies (not covered by nonparticipating providers)
 - BCBSM approved hospice care programs (not covered by nonparticipating providers)
 - Freestanding substance abuse treatment programs (not covered by nonparticipating providers)
 - Ambulance providers
 - Durable medical equipment suppliers
 - Prosthetic and orthotic suppliers
 - Freestanding physical therapy facilities (not covered by nonparticipating providers)

Note: If these services are received from **nonparticipating** providers you may incur additional out-of-pocket expenses.

PPO network provisions do **not** apply to prescription drugs, hearing, dental and vision services.

Change in Network Status

Your physician is your partner in managing your health care. However, physicians retire, move, or otherwise cease to be affiliated with our PPO network.

If you have difficulty choosing another physician, please contact the BCBSM customer service office for assistance. If you wish to continue care with your current physician, a BCBSM customer service representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

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Non-Network Providers

When you receive care from a provider who is **not** in the BCBSM PPO network, without a referral from a PPO provider, your care is considered out-of-network. **When you receive services from a non-network provider, you are required to pay an additional (TOTAL COPAYMENT 30%) 10 percent out-of-network copayment up to a maximum of an additional \$1,000 per family (TOTAL FAMILY MAXIMUM \$2,200).** As stated this out-of-network copayment **is in addition** to any applicable in-network percent copayment required by your CMM-PPO plan.

Blues Participating Providers

If you choose to receive services from a non-network provider, you can still limit your out-of-pocket costs if the provider **participates in the BCBSM Traditional plan.**

If you use a Blues Traditional participating provider who does not participate in the BCBSM PPO network, the participating provider will:

- Bill BCBSM directly, which means you are **not** required to complete paper work or save and submit receipts.
- Not balance-bill you, so you are **not** responsible for any difference between the BCBSM payment and the provider's charges.

Retirees - Traditional Network

Comprehensive Major Medical – Traditional (CMM – Traditional) participating providers include physicians and other licensed professional providers, and hospitals and other approved facilities that have signed agreements with BCBSM to accept the BCBSM approved amount for covered services as payment in full, and they will not balance-bill you. Participating providers usually display the BCBSM emblem in their offices. When you use a Blues participating provider they bill BCBSM directly. This means you are not required to complete paper work or save and submit receipts.

Finding a Blues Participating Provider

To locate a Blues participating provider in Michigan:

- Log onto the BCBSM Web site at **www.bcbsm.com**
- Or call the customer service number in Section 1 for assistance

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- Make your appointment directly with that provider

Note: It's a good idea to ask if the doctor participates with BCBSM at the time you schedule your appointment or visit.

You do not have to choose just one provider for your care and you do not have to notify BCBSM if you choose to change providers.

Nonparticipating Providers

Nonparticipating providers have **not** signed agreements with BCBSM. If you receive services from nonparticipating providers, you are usually required to pay providers directly and may be required to submit a claim to BCBSM for payment.

When you use a provider **who does not participate** with BCBSM you will:

Receive payment directly from BCBSM (This amount may be significantly less than the amount the provider charges you.)

Be responsible for paying the provider

Be responsible for any difference between the BCBSM payment and the provider's charges

Nonparticipating Hospitals, Facilities and Alternatives to Hospital Care Providers (Active and Retiree)

BCBSM coverage at nonparticipating **hospitals is limited to services needed to treat an accidental injury or medical emergency**. There is **no coverage** for non-emergency hospital services received at a nonparticipating hospital or for services received at nonparticipating outpatient physical therapy facilities, mental health or substance abuse treatment facilities, ambulatory surgery facilities, end stage renal dialysis facilities, home infusion therapy providers, skilled nursing facilities or home health care agencies.

In Michigan – Payment for **emergency services** received from a Michigan nonparticipating hospital is limited to:

\$70 per day for inpatient services in accredited general acute care facilities

\$15 per day in accredited specialty hospitals

\$25 per condition for outpatient emergency services

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Outside of Michigan – Blue Cross will pay the approved amount for emergency services provided by an accredited nonparticipating hospital outside of Michigan if the hospital participates with another Blue Cross Blue Shield Plan or is located in an area not served by another Blue Cross Blue Shield Plan.

BlueCard Program

When you need medical care **outside of Michigan**, just call the toll-free number below and you will be directed to the nearest Blues participating provider. BlueCard participating providers will bill their local Blue Plan for covered services you receive. You are responsible only for applicable copayments and for services not covered by your plan.

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

1. **Call 1-800-810-BLUE (2583)** for the names and addresses of doctors and hospitals in the area where you need care.

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

2. When you arrive at a doctor's office or hospital, show your BCBSM ID card. Remind the provider that you are covered under the BlueCard Program and to include the alpha prefix (three characters preceding the contract number on your BCBSM ID card) on all claims.
3. Pay applicable copayments required by your plan.

Important: If you receive services from a nonparticipating provider you may need to submit itemized receipts directly to BCBSM. Also **BlueCard does not include prescription drugs, dental, vision and hearing services.**

Care Out of the Country

Your coverage applies no matter where you are only if:

The hospital is accredited

The physician is licensed

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Most hospitals and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. When you submit your claim, tell BCBSM if the charges are in U.S. or foreign currency. Be sure to indicate whether payment should go to you or the provider. Blue Cross will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, minus applicable copayments that may apply.

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Section 6. How Your Comprehensive Major Medical (CMM) PPO or Traditional Plan Works

This section provides information to help you understand how your Comprehensive Major Medical (CMM) PPO or Traditional health care plan works.

Benefit Period

Payment of your CMM benefits, including copayments and annual dollar maximums, are based on a benefit period beginning January 1 and ending December 31. Your first benefit period may be shorter, depending on the date you become eligible for coverage.

Payment of Benefits

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

Dollar Maximums

Payment for covered services is limited to a **lifetime** dollar maximum of \$5 million per member. Within this maximum the following limitations apply:

A lifetime benefit maximum of \$3,000 per member for **outpatient** substance abuse treatment

\$700 per calendar year for spinal manipulation services

Your Out-of-Pocket Costs

For most covered services, you are required to pay a portion of the approved amount through copayments.

Your Deductible

You do not have a deductible.

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Your Copayment

For most covered services you are required to pay a percentage of the BCBSM approved amount, called your "**copayment.**" Your copayment is **20** percent of the BCBSM approved amount for covered services provided by Blues participating or nonparticipating providers.

Note: For PPO Out-of Network services, an additional 10% copayment will apply up to an additional \$1,000 family maximum. (See Section 5)

Your Copayment Maximum

After you have paid **\$1,200** per contract, per calendar year in copayments for in-network general services, you do not need to pay any further copayments for the rest of that year. However, you are still required to pay copayments for mental health care, substance abuse treatment and private duty nursing services.

The following **cannot** be used to meet your copayment maximum:

- Mental health care, substance abuse treatment, chiropractic care and private duty nursing copayments

- Charges for non-covered services

- Charges in excess of the BCBSM approved amount

- Deductibles or copayments required under other Blue Cross Blue Shield of Michigan coverage

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Section 7. Your Comprehensive Major Medical (CMM) Health Care Benefits (PPO and Traditional)

This section explains the medical benefits available to you under the Comprehensive Major Medical (CMM) health care plan. Please check each section of this booklet carefully for a complete explanation of your benefits.

Note: Unless otherwise indicated, all services described in this section are subject to the copayments listed in the previous section.

- **Medical Necessity**

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

The covered service is for the treatment, diagnosis, or symptoms of an injury, condition or disease.

The service, treatment or supply is **appropriate** for the symptoms and is consistent with the diagnosis.

Appropriate means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The services are not mainly for the convenience of the member or health care provider.

The treatment is not generally regarded as experimental or investigational by Blue Cross Blue Shield of Michigan.

The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment Programs.

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

When you don't inform the hospital that you are a Blue Cross Blue Shield member either at the time of admission or within 30 days after you have been discharged.

When you fail to provide the hospital with information that identifies your coverage.

- **Services Before Coverage Begins or After Coverage Ends**

Unless otherwise stated in this booklet, BCBSM will not pay for any services, treatment, care or supplies provided before your coverage under this certificate becomes effective or after your coverage ends.

If your coverage begins or ends while you are an inpatient at a facility, the BCBSM payment will be based on the facility's contract with BCBSM. The BCBSM payment may cover:

The services, treatment or supplies you receive during the entire admission **or**

The services, treatment or supplies you receive while your coverage is in effect.

In addition, if you have other coverage when you are admitted to or discharged from a facility, your other carrier may be responsible for paying for the care you receive before the effective date of your BCBSM coverage or after it ends.

- **Pain Management**

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

- **Inpatient Hospital Benefits**

Your coverage includes the following hospital services.

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- **Room and Board**

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

- **General Medical Care Days**

You have an unlimited number of inpatient days available for the diagnosis and treatment of general medical conditions.

The following types of admissions are also considered general medical care:

Maternity and nursery care – includes delivery room costs and routine nursery care for a newborn during an eligible mother's hospital stay. After the hospital stay, the newborn is covered as a dependent child. You must notify the Fund Office to add the child to your coverage within 30 days of birth. **Maternity benefits are limited to the participant or the participant's spouse.** Maternity benefits are **not** payable for dependent children.

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

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

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

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- **Mental Health Care and Substance Abuse Treatment**

Benefits are payable for up to **30** days per calendar year with a lifetime maximum of **90** days for inpatient mental health care and residential substance abuse. Benefits are payable when services are provided in BCBSM-approved hospitals and in approved day- and night-care centers.

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

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

Individual psychotherapeutic treatments

Family counseling for members of a patient's family

Group psychotherapeutic treatment

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

Important: Inpatient mental health care and substance abuse treatment admissions are covered only if they meet Severity of Illness and Intensity of Service criteria. Your physician must call the BCBSM Mental Health Precertification Unit at 1-800-762-2382 for guidance.

- **Inpatient Hospital Services and Supplies**

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

Anesthesia – administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service

Blood services – whole blood, blood derivatives, blood plasma and supplies used for administering the services

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

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Prosthetic and orthotic appliances – items that are surgically implanted in the body, such as heart valves

Special treatment rooms – operating, delivery and recovery rooms

Your coverage includes the following 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 Blue Cross

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

Diagnostic radiology – ultrasound and X-rays required for the diagnosis of an illness or injury

• **Outpatient Hospital Benefits**

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

• **Pre-Admission Testing**

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

• **Physical, Occupational and Speech Therapy**

Physical, occupational and speech therapy services (see *Glossary* for definitions) are payable when provided in:

The outpatient department of participating hospitals

Participating outpatient physical therapy facilities

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

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

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Your therapy **must**:

- Be prescribed by the patient's attending physician
- Require the assistance and supervision of the appropriate licensed therapist
- Be designed to improve or restore the patient's functioning level after a loss in musculoskeletal functioning due to an illness or injury
- Be given for a condition that is capable of significant improvement in a reasonable and generally predictable period of time

Examples of covered therapy are:

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

The Fund **does not** cover:

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

- **Emergency Medical Care**

Your coverage provides the following benefits:

Emergency Medical Care in the Emergency Room – Your benefits include the initial exam and treatment of accidental injuries or conditions determined by BCBSM to be medical emergencies (see *Glossary* for definitions).

Note: Routine care for minor medical problems such as headaches, colds, slight fever and back pain is not considered emergency care. Also, follow-up care is not considered emergency care.

Professional Ambulance Services – Ambulance services are covered to transport a patient up to 25 miles unless the destination is the nearest medical facility capable of treating the patient's condition. The service must be medically necessary, prescribed by a physician (when used for transferring a patient) and provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation.

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Air ambulance is covered when no other means of transport is available or the patient's condition requires air transport rather than ground ambulance. For air ambulance, the provider must be licensed as an air ambulance service and cannot be a commercial air carrier.

The Fund **does not** cover:

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

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

- **Outpatient Mental Health Care**

Your coverage includes psychological testing, individual and group therapy sessions, and family counseling. These services must be provided through an approved facility or by a physician or fully licensed psychologist.

Benefits are payable for up to **25** visits per member, per calendar year with a lifetime maximum of **70** visits. Benefits also include one outpatient psychological testing annually, with no copayment requirement.

- **Outpatient Substance Abuse Treatment**

Treatment is covered when provided in an approved outpatient substance abuse treatment facility. Benefits are payable up to the **\$3,000** lifetime benefit maximum.

- **Chemotherapy**

Treatment is payable in a hospital, in the outpatient department of a hospital, or in a physician's office. Your benefits include the administration and cost of drugs when ordered by a physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration for use in chemotherapy, and provided as part of a chemotherapy program. Your benefits also include three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.

- **Hemodialysis**

Hemodialysis services are covered to treat acute kidney failure and end stage renal disease (ESRD). You can receive treatment in the outpatient department of a hospital or in a licensed facility. You can also receive dialysis services in the

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home if the owner of the patient's home gives the hospital prior written permission to install the equipment.

Your physician must arrange for home hemodialysis and all services must be billed by a participating hospital that has an approved hemodialysis program. Benefits include cost of the equipment, installation, training and necessary hemodialysis supplies.

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

• **Alternatives to Hospital Care**

Your coverage provides the following benefits:

• **Home Hemophilia Program**

Your benefits include all medications and medical supplies needed for in-home treatment of hemophilia, including syringes, needles and the antihemophilic factor. You can receive treatment in the outpatient department of a hospital or a licensed facility. You can also receive dialysis services in the home, if the owner of the patient's home gives the hospital prior written permission to install the equipment. Your benefits also include training the patient or a family member on how to inject the antihemophilic factor, when the training is provided through an approved facility.

• **Home Health Care**

To receive benefits under the Home Health Care program, a physician who certifies that the patient is confined to the home due to illness, must prescribe and submit a detailed treatment plan to the home health care agency.

Once the agency accepts the patient into its program, the following services are covered when billed by the agency:

Part-time health aide services if the patient is receiving skilled nursing care or physical or speech therapy and the health care agency has identified a need for the patient to have these services

Social services and nutritional guidance when requested by the patient's physician

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Physical, speech and occupational therapy are payable when provided for rehabilitation

Nursing care when supervised by a registered nurse employed by the home health care agency

The Fund **does not** cover:

General housekeeping services

Transportation to or from a hospital or other facility

Elastic stockings, sheepskin or comfort items such as lotion, mouthwash, body powder, etc.

Physician services and custodial or non-skilled care

- **Skilled Nursing Care**

Care in an approved skilled nursing facility is covered when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve. In addition, BCBSM requires written confirmation of the need for skilled care from the patient's physician. Physician's benefits for medical care are limited to two visits per week. All services must be provided at a participating skilled nursing facility (see *Glossary*).

The Fund **does not** cover:

Custodial care

Care for senility or mental retardation

Care for substance abuse

Care for long-term mental illness

- **BlueHealthConnection® Program**

BlueHealthConnection is an integrated health care management program that provides you with the information, assistance and decision-making tools you need to take charge of your personal health care needs. Please call the number in Section 2 for more information.

BlueHealthConnection gives you access to:

Nurse health coaches 24 hours per day, seven days a week.

Guided self-management tools such as Web-based information, self-help handbooks and videos.

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Outreach programs by telephone or mail to assist you in understanding services available through BlueHealthConnection.

Integrated case and disease management for individuals with chronic illnesses such as diabetes, heart disease or acute illness.

Note: Integrated case and disease management (ICDM) is a voluntary program designed to help manage the health care of members with acute or chronic medical conditions, regardless of setting. The candidates for this program must meet the eligibility criteria listed below. BCBSM will pay for noncontractual services only when such services are specifically described in a signed treatment plan.

Eligibility for Integrated Case and Disease Management

BCBSM decides who is eligible for ICDM based on the following factors:

- Candidate's diagnosis
- Admission status
- Clinical status
- Scope of contractual benefits available to the candidate
- Availability of community services to the candidate and his or her family
- Personal and family support available to the candidate
- Substantial probability of lasting improvement in the candidate's clinical status within 12 months

Candidates for ICDM may be identified based on BCBSM claims data. In addition, BCBSM will consider referrals of candidates from such sources as:

- Attending physicians
- Hospitals
- Candidate or candidate's family
- Employer group

When the member is accepted as a candidate for ICDM, a personal **treatment plan** will be developed. The treatment plan describes the goals, expected outcomes, type and limited duration of services to be provided to the member under ICDM. It may include medically necessary services that BCBSM determines should be provided because of the member's condition as specified in the plan, even if those services are not covered under the member's hospital and professional certificates. (Such services are referred to as non-contractual services.)

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The member's physician must order all services described in the treatment plan. **BCBSM will pay only for the services, equipment and supplies specifically described in the signed treatment plan, which is a binding contract between the member and BCBSM.**

Termination of Integrated Case and Disease Management

BCBSM may terminate the treatment plan and the member's participation in ICDM if:

The member is no longer eligible to receive benefits under his or her BCBSM certificate.

The member voluntarily withdraws from the program.

The member meets the treatment plan goals. (Termination in these cases occurs when the case manager determines that the goals have been met. As a result, termination may occur well before any expiration period described in the treatment plan is reached.)

The member fails to meet the treatment plan goals within the time period specified in the treatment plan.

The time period described in the member's treatment plan expires.

The member (or his or her representative), treating physician or case manager determines that the member's participation in case management will no longer result in measurable improvement in the member's clinical status.

Limitations and Exclusions of the Integrated Case and Disease Management Program

Benefits provided under the ICDM program are applied to the lifetime maximum of your certificate, except where specifically waived by BCBSM.

Services described in the treatment plan will be provided only as long as the plan is in effect.

Coverage for non-contractual services under ICDM will only be provided for the specific conditions identified in the treatment plan. Treatment for other conditions remains subject to the terms of your underlying certificate(s).

BCBSM does not pay for any services provided by a relative of the patient.

- **Hospice Care**

A hospice is an agency that is primarily involved in providing care to terminally ill individuals and can be used as an alternative to hospitalization. A patient is considered terminally ill when the attending physician has certified in writing that life expectancy is six months or less.

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The patient, or representative of the patient, may apply for hospice care benefits after discussion with and referral by your attending physician. Your request must be in writing to the hospice agency **and all hospice services must be arranged through an approved hospice provider.**

Electing Hospice Benefits

Hospice benefits are divided into three election periods: two 90-day periods and one 30-day period. A patient must exhaust the two 90-day periods before electing the 30-day period. Election periods continue until the patient exhausts all three periods or cancels his or her hospice benefits.

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

Levels of Care

The hospice program provides four levels of care:

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

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

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

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

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Hospice Services

The following benefits are payable under the hospice program up to the dollar maximum amount that is reviewed and adjusted annually. Please call the customer service number in Section 2 for the current maximum amount.

Nursing care when provided by or under the supervision of a registered nurse

Medical social services by a qualified social worker, provided under the supervision of a physician

Counseling services for the patient and caregivers, when care is provided in the home and for family bereavement after the patient's death

Medical appliances and supplies to provide comfort to the patient and when approved by BCBSM

Durable medical equipment when furnished by the hospice program for the patient's home

Physical, speech and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional skills

Important: Hospice benefits are covered at 100 percent of the approved amount. There is a separate dollar maximum for services provided by a physician who is not part of the hospice team. Please call the customer service number in Section 2 for information about the current dollar maximum.

Human 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, and designated transplant facility.

Please call the customer service number in Section 2 for questions you have about cornea, kidney or skin transplants. Call the BCBSM Human Organ Transplant Program at 1-800-242-3504 for any questions you have about bone marrow or specified human organ transplant surgery.

Organ and Tissue Transplants

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

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Cornea

Kidney

Skin

Blue Cross Blue Shield of Michigan will pay for covered services for donors if the donor does not have transplant benefits under any health care plan.

Note: To determine donor benefits please call the customer service number in Section 2.

Hematopoietic Transplants

Your transplant benefits include transplants of the bone marrow, peripheral blood stem cells or umbilical cord blood. Benefits are payable for up to a maximum of two single transplants per member per condition. The lifetime dollar maximum and copayments in your health care plan apply to these transplant services.

Note: There is **no** travel benefit associated with this coverage.

Allogeneic (Allogenic) Transplants

Benefits for **allogeneic** transplants are payable only when the bone marrow, peripheral blood stem cells or umbilical cord blood of another person is transplanted into the patient. This includes syngeneic transplants, a procedure using the bone marrow, peripheral blood stem cells or umbilical cord blood from a patient's identical twin to transplant into the patient.

The Fund covers the following services:

Blood tests on immediate family members (mother, father, sister or brother) for evaluation as donors (if tests are not covered by the potential donor's health coverage)

Search of the National Bone Marrow Donor Program Registry for a donor (A search will begin only when the need for a donor is established.)

Infusion of colony stimulating growth factors

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 an immediate relative (mother, father, sister or brother) and has four of the six important HLA genetic markers as the patient.

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Donors outside of the immediate family must match five of the six important HLA genetic markers with the patient. This provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.

Note: Harvesting and storage will be covered if it is not covered by the donor's health coverage. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.

High dose chemotherapy and/or total body irradiation

Infusion of bone marrow, peripheral blood stem cells and/or umbilical cord blood

T-cell depleted infusion

Donor lymphocyte infusion

Hospitalization

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)

Aplastic anemia

Beta Thalassemia

Chronic lymphocytic leukemia

Chronic myeloid leukemia

Congenital leukocyte dysfunction syndromes

Congenital pure red cell aplasia

Glanzmann thrombasthenia

Hodgkin's disease (high risk, refractory or relapsed patients)

Kostmann's syndrome

Leukocyte adhesion deficiencies

Mantle cell lymphoma

Megakaryocytic thrombocytopenia

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Mucopolysaccharidoses (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

Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact

Multiple myeloma

Myelodysplastic syndromes

Myelofibrosis

Neuroblastoma (stage III or IV)

Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)

Osteopetrosis

Paroxysmal nocturnal hemoglobinuria

Primary amyloidosis (AL)

Severe combined immune deficiency disease

Sickle Cell Anemia (ss or sc)

Wiskott-Aldrich syndrome

X-linked lymphoproliferative syndrome

Autologous Transplants

Benefits also include transplants of the patient's own bone marrow (**autologous**) and/or transplanting the patient's own peripheral blood stem cells.

The Fund covers the following services:

Infusion of colony stimulating growth factors.

Harvesting (including peripheral blood stem cells pheresis) and storage of bone marrow and/or peripheral blood stem cells.

Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells.

High dose chemotherapy and/or total body irradiation

Infusion of bone marrow and/or peripheral blood stem cells

Hospitalization

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Note: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes. Benefits are payable for up to a maximum of two tandem transplants, or one single and one tandem transplant per patient.

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)
- Ewing's sarcoma
- Germ cell tumors of ovary, testis, mediastinum and retroperitoneum
- Hodgkin's disease (high risk, refractory or relapsed patients)
- Mantle cell lymphoma
- Medulloblastoma
- Multiple myeloma
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
- Primary amyloidosis
- Primitive neuroectodermal tumors
- Rhabdomyosarcoma
- Wilms' tumor

The Fund **does not** cover:

- Services **not** medically necessary
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Services rendered to a donor when the donor's health care coverage will pay for such services
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- An autologous tandem transplant for any condition other than germ cell tumors of the testes
- An allogeneic tandem transplant

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The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future

Services that are experimental and investigational

Any other services or admissions related to any of the above exclusions

- **Specified Oncology Clinical Trials**

Benefits are payable for bone marrow and peripheral blood stem cell transplants, their related services, and FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial. This benefit does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

In order for services to be payable as eligible benefits:

The inpatient admission to a hospital and the length of stay at the hospital **must** be medically necessary (in those cases requiring inpatient hospital treatment) and **preapproved**. A request for an admission and length of stay must be preapproved by BCBSM before the admission occurs.

Note: A preapproval is good only for one year after it is issued. However, preapproval services, admissions or lengths of stay will not be paid if you no longer have this coverage at the time services occur.

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

The proposed services **must** be medically necessary and rendered in a designated cancer center or in an affiliate of a designated center. The designated cancer center must submit its written request for preapproval to BCBSM Human Organ Transplant Program.

A designated cancer center is a site approved by the National Cancer Institute (NCI) as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request. An affiliate cancer center is a health care provider that has contracted with an NCI-approved cancer center to provide treatment.

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The patient **must** be an eligible BCBSM member with hospital/medical/surgical coverage.

Covered Services

Covered services are payable when directly related to a transplant covered under this benefit.

When **preapproved** by BCBSM, the following services are covered:

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 blood stem cells
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization

Allogeneic transplants

- Blood tests to evaluate donors (if not covered by the potential donor's insurance)
- Search of the National Bone Marrow Donor Program Registry for a donor (A search will begin only when the need for a donor is established.)
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell phereses) and storage of the donor's bone marrow, peripheral blood stem cells and/or umbilical cord blood (BCBSM will cover harvesting and storage even if the donor's insurance does not cover it.)
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells and/or umbilical cord blood
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Travel, Meals and Lodging

Blue Cross Blue Shield of Michigan will pay up to a total of \$5,000 for travel, meals and lodging expenses directly related to preapproved services rendered during an approved clinical trial. The expenses must be incurred during the

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

period that begins on the date of preapproval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect. Benefits are payable for the expenses of an adult patient and one companion (or two companions if the patient is under age 18).

Within the \$5,000, the following amounts apply to the **combined** expenses of the patient and eligible companion(s):

Up to \$60 per day for travel

Up to \$50 per day for lodging

Up to \$40 per day for meals

What's Not Covered

The Fund **does not** cover:

A hospital admission or a length of stay at a hospital that has not been **preapproved**

Services that have not been **preapproved**

Services that are not medically necessary

Services provided by persons or entities that are not legally qualified or licensed to provide such services

Services rendered to a donor when the donor's health care coverage will pay for such services

The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future

More than two single transplants per member for the same condition

Items, such as investigational drugs that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)

Nonhealth 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

Items not considered directly related to travel, meals and lodging expenses. They include, **but are not limited to**, dry cleaning, clothing, laundry services, kennel fees, entertainment (cable, movie rentals, televisions, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers, cards, stationery, stamps, household products,

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household utilities, including cell phone charges, maid, baby-sitter or day care services.

Experimental and investigational services not included in this benefit

Any other services, admissions or lengths of stay related to any of the above exclusions

• **Specified Human Organ Transplants**

Your benefits include coverage for specified human organ transplants performed during the transplant benefit period, as described below, when the transplant is preauthorized by BCBSM and received at a BCBSM-designated transplant facility. (A **designated facility** is one that BCBSM determines to be qualified to perform a specific organ transplant.) Please call the number in Section 2 for more information.

Benefits apply only to transplants of the:

Liver

Partial liver (a portion of the liver from a cadaver or living donor)

Heart

Lung(s)

Lobar lung (a portion of a lung from a cadaver or living donor to a recipient)

Heart-lung(s)

Pancreas

Simultaneous pancreas-kidney

Small intestine (small bowel, a procedure in which the patient's small intestine is removed and replaced with the small intestine of a cadaver)

Combined small intestine-liver

All covered 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 the transplant surgery and ends one year after the surgery.

Benefits are limited to a \$1 million lifetime maximum per member for each covered human organ transplant type.

Note: During the benefit period, copayments do not apply to the specified organ transplants and related procedures described in this section.

When directly related to the transplant, BCBSM will pay for the following medically necessary services:

Facility and professional services.

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Anti-rejection drugs and other transplant-related prescription drugs during and after the benefit period. Payment will be based on the BCBSM approved amount. The BCBSM payment for the drugs is limited only by the \$1 million lifetime maximum.

Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition occurs during the benefit period, and is a direct result of the organ transplant surgery. The Fund will cover any medically necessary service needed to treat a condition as a direct result of the organ transplant surgery, if it is a benefit under any of BCBSM's certificates.

Up to \$10,000 for travel, meals and lodging. This includes:

Cost of transportation to and from the designated transplant facility for the patient and one companion eligible to accompany the patient (or two companions if the patient is under age 18 or if the transplant involves a living related donor).

Reasonable and necessary costs of lodging for the companion(s) eligible to accompany the patient.

Reasonable and necessary costs of meals up to a combined maximum of \$40 per day for the patient and companion(s) eligible to accompany the patient.

The cost of acquiring the organ, which includes surgery to obtain the organ, storage of the organ and transportation of the organ. Also payment for covered services for a donor if the donor does not have coverage for transplant services under any health care plan. The total payment for all services combined for each organ transplant type will not be more than the \$1 million lifetime maximum.

The Fund **does not** cover:

Services that are not BCBSM benefits

Living donor transplants other than partial liver, lobar lung and kidney transplants that are part of a simultaneous pancreas-kidney transplant

Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin)

Anti-rejection drugs that do not have Food and Drug Administration marketing approval

Transplant surgery and related services that are not performed in a BCBSM designated transplant facility. You must pay for the transplant surgery and related services you receive in a nondesignated facility.

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Transportation, meals and lodging costs under circumstances other than those related to the initial transplant surgery and hospitalization

Items not considered directly related to travel, meals and lodging expenses. They include, **but are not limited to**, dry cleaning, clothing, laundry services, kennel fees, entertainment (cable, movie rentals, televisions, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers, cards, stationery, stamps, household products, household utilities, including cell phone charges, maid, baby-sitter or day care services.

Services prior to your organ transplant surgery, such as expenses for evaluation and testing, if not covered by your hospital/medical/surgical coverage

Experimental transplant procedures

Physician Benefits

Your coverage provides the following benefits for physician care.

Medical Necessity

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

The covered service is generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.

The covered service is essential or relevant to the evaluation or treatment of the disease, injury, condition or illness, and is not mainly for the convenience of the member or physician.

The covered service is reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

In the absence of established criteria, medical necessity will be determined by physician or professional review according to generally accepted standards and practices.

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The Blue Cross Blue Shield of Michigan determination of medical necessity for **payment** purposes is based on standards of practice established by physicians.

Preventive Care Services

The Fund covers the following preventive services:

Routine physical/gynecological exam – covers one physical exam **and** one gynecological exam provided in your physician's office and the following screening procedures, payable once per member, per calendar year:

- Chemical profile
- Complete blood count
- Fecal occult blood screening
- Urinalysis
- Endoscopy
- Sigmoidoscopy
- Chest X-ray
- EKG
- Colonoscopy
- Thyroid blood test
- CA-125 test

Pap smear – covers laboratory and pathology services for one routine Pap smear per member, per calendar year. The Pap smear must be prescribed and taken by a physician.

More frequent Pap smears are payable only when specifically prescribed for one of the following conditions:

- Previous surgery for vaginal, cervical or uterine malignancy
- Presence of a suspected lesion in the vaginal, cervical or uterine areas, as determined through clinical exam
- Post-surgery

Mammography screening – covers one mammogram (breast X-ray) for a woman from the age of 35 to 40. At 40 and older, one mammogram per calendar year is covered. More frequent mammograms are covered if requested by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.

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Prostate specific antigen (PSA) screening – covers one PSA screening laboratory test per member, per calendar year. An independent (non-hospital) laboratory must bill laboratory services.

Well-baby and child care visits – covers visits for children up to an including age six.

Immunizations – covers immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics.

- **Prescribed Contraceptive Devices**

Your benefits include coverage for physician-prescribed contraceptive devices, such as diaphragms, intrauterine devices, Norplants or contraceptive implants designed to prevent pregnancy.

- **Contraceptive Injections**

Administration of injectable contraceptive medications, as well as the cost of the medication, is payable under your medical-surgical coverage when provided by your physician. Contraceptive medication you obtain from a pharmacy is not covered under your medical-surgical coverage. When your physician injects contraceptive medication you purchased from a pharmacy, only the administration is payable under your medical-surgical coverage.

- **Office Visits**

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

- **Allergy Services**

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

- **Chiropractic Services**

Your benefits include the following chiropractic services.

New patient office visits – covers one every 36 months. A new patient is one who has not been seen by the same provider in 36 months.

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Office visits – covers one every calendar year for established patients.

Chiropractic traction – number of payable visits is determined by your physical therapy benefit.

Chiropractic manipulation – spinal manipulation services only are covered at 100 percent of the BCBSM approved amount (no copayment), up to a benefit maximum of **\$700** per member, per calendar year.

- **Maternity Care**

You have coverage for obstetrical services including delivery and pre- and post-natal care visits. The initial inpatient exam of the newborn is a benefit when performed by a physician other than the anesthesiologist or the delivering provider.

Note: Maternity care benefits also are payable when provided by a certified nurse midwife. Delivery must be in a hospital or BCBSM-approved birthing center.

- **Surgery**

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

Multiple surgeries (two or more surgical procedures performed by the same physician during one operative session) are subject to the following payment limitations:

When surgeries are through **different** incisions, BCBSM will pay the approved amount for the more costly procedure and one half of the approved amount for the less costly procedure.

When surgeries are through the **same** incision they are considered related and BCBSM will pay the approved amount only for the more difficult procedure.

Note: Blues participating providers accept BCBSM approved amounts as payment in full, less your copayment. However, nonparticipating providers may bill you for the difference.

Cosmetic or reconstructive surgery is covered only for the correction of birth defects, for conditions resulting from accidental injuries or traumatic scars and for correction of deformities resulting from certain surgeries, such as breast reconstruction following a mastectomy.

Breast reconstruction surgery is covered for:

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Reconstruction of the breast on which the mastectomy was performed.

Surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Dental surgery is covered for the removal of impacted teeth or multiple extractions (e.g. if the patient must be hospitalized for the surgery because a concurrent medical condition exists, such as a heart condition). 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 is covered regardless of medical necessity.

Technical Surgical Assistance

Technical surgical assistance (TSA) is a covered benefit for certain major surgeries that require surgical assistance by another physician. TSA is covered inpatient and outpatient, and in an approved ambulatory surgery facility.

Anesthesia

Services for giving anesthesia are payable to a physician other than the operating or assisting physician, and to certified registered nurse anesthetists. The Fund does not cover local anesthetics.

Temporomandibular Joint Syndrome (TMJ) or Jaw-Joint Disorder

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

If you are not sure that your prescribed treatment will be covered, ask your physician to contact BCBSM for approval before treatment begins.

Note: Irreversible treatment of the mouth, teeth, or jaw is intended to bring about permanent change to a person's bite or position of the jaws.

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It includes but is not limited to dentures, bridges, crowns, caps, inlays, restorations, grinding and orthodontics.

Reversible treatment of the mouth and jaw is not intended to result in permanent alteration of the bite or position of the jaws; it is directed at managing the patient's symptoms.

- **Emergency Care**

Your coverage provides payment of the BCBSM approved amount for the initial exam and treatment of accidental injuries or conditions determined by BCBSM to be medical emergencies (see *Glossary* for definition).

Note: Routine care for minor medical problems such as headaches, colds, slight fever or back pain is not considered emergency care.

- **Inpatient Medical Care**

Medical supervision by the attending physician is payable while you are in the hospital or in a skilled nursing facility for general medical conditions that are not related to surgery or maternity care. Inpatient medical care in a skilled nursing facility is limited to two visits per week.

- **Inpatient and Outpatient Consultations**

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

- **Diagnostic and Radiation Services**

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

Diagnostic radiology – covers X-rays, ultrasound, radioactive isotopes and Magnetic Resonance Imaging (MRI) and CAT scans of the head and body.

Laboratory and pathology tests

Diagnostic tests – covers EKGs, EMGs, EEGs, thyroid function tests, nerve conduction and pulmonary function studies.

Radiation therapy – covers radiological treatment by X-ray, isotopes or cobalt for a malignancy.

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- **Other Covered Services**

Your coverage includes the following services:

- **Blood Services**

Whole blood for transfusions is covered.

- **Oxygen and Other Therapeutic Gases**

Oxygen and equipment to administer the oxygen are covered when prescribed by a physician and medically necessary.

- **Optical Services Following Cataract Surgery**

Your benefits include the exam 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 are covered. An external force must have caused the injury. Injuries resulting from biting or chewing **are not** covered.

- **Durable Medical Equipment (DME)**

Benefits include rental or purchase (whichever is less expensive) and repair of durable medical equipment appropriate for home use and prescribed by a physician. The prescription must include a description of the equipment and a diagnosis. For rental equipment, a new prescription must be written when the current prescription expires.

The Fund **does not** cover:

Exercise and hygienic equipment

Comfort and convenience items

Self-help devices, such as elevators

Deluxe equipment, such as motorized wheelchairs unless medically necessary and required so the patient can operate the equipment themselves

Experimental or investigational equipment

- **Medical Supplies**

Your benefits include medical supplies and dressings for use in the home when prescribed by a physician for the treatment of a specific medical condition.

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- **Prosthetic and Orthotic Appliances**

Benefits are payable for prosthetic and orthotic appliances prescribed by a MD, DO, chiropractor, orthopedist, prosthetic or DME provider. Benefits cover temporary appliances, delivery, services and fitting charges. Adjustment or replacement of eligible appliances is payable only when required because of wear, growth or change in the patient's condition.

Your benefits also include one pair of shoe inserts (custom orthotic) per member, per calendar year. Corrective shoes are payable **only** when required to correct a physical defect and are attached to a leg brace.

The Fund **does not** cover:

Non-rigid devices and supplies such as elastic stockings, garter belts, arch supports, corsets

Supportive appliances for the feet other than stated above

Hearing aids (see Section 10) and hair prosthesis such as wigs or hair implants

- **Private Duty Nursing Services**

Private duty nursing is covered 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.

Services must be prescribed by a physician and provided by a registered or licensed practical nurse. The attending physician must complete a Certification Statement each month the patient is required to have private duty nursing care.

- **What's Not Covered**

Your CMM Plan **does not** cover:

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 exists

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Summary Plan Description

Treatment of temporomandibular joint syndrome (TMJ) and related jaw-joint problems by any method other than as specified in this booklet

Medical services or supplies provided or furnished while coverage is not in effect (that is, **before** the effective date of coverage or after the coverage termination date)

Health care services provided by persons who are not legally qualified or licensed to provide such services

Routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions

Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication), 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

Premarital or pre-employment exams

Services and supplies that are not medically necessary according to accepted standards of medical practice

Services provided through a medical clinic or similar facility provided or maintained by an employer

Treatment of occupational injury or disease that the employer is obligated to furnish or otherwise fund

Care and services received under another certificate offered by Blue Cross Blue Shield of Michigan or another Blue Cross Blue Shield plan

Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which a member is eligible (these services are not payable even if you have not signed up to receive the benefits provided by such programs.)

Cosmetic surgery and related services solely for improving appearance, except as specified in this booklet

Treatment of a condition caused by military action or war, declared or undeclared

Services, care, devices or supplies considered experimental or investigational

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Services for which a charge is not customarily made; services for which the patient is not obligated to pay or services without cost

Hearing exams and preparation, fitting or procurement of hearing aids (see Section 10)

Vision exams and eyeglasses or other corrective vision appliances except as specified in your coverage (see Section 9)

Dental services and appliances except those specified in your coverage

Dialysis services after 33 months of ESRD treatment

Services that are not included in your plan coverage documents

Transportation and travel except as specified in this booklet

Screening services, unless otherwise stated, excluding mammograms

Deductibles or copayments paid by the member under any other certificate

Physical therapy services performed by a chiropractor

Services, care, supplies, or devices not prescribed by a physician

Services provided during non-emergency medical transport

- **No-Fault Auto Insurance and BCBSM Coverage**

If you or an eligible dependent are involved in a motor vehicle accident, BCBSM will not pay for services related to an injury which is a direct or indirect result of an automobile accident. This applies whether or not you have no-fault automobile insurance. It is important that you discuss this with your auto insurance company.

Section 8. Prescription Drug Coverage

Your health plan includes coverage for the following prescription drug services.

What's Covered

You have coverage for:

- Federal legend and state-controlled drugs

- Compound medications containing at least one federal legend drug ingredient

- Oral, injectable (e.g., Depo Provera) or self-administered "Rx only" contraceptive medications when prescribed by a physician

Covered drugs may be dispensed in quantities of up to a 34-day supply for select maintenance drugs approved by BCBSM, a quantity of 100-units or a 34-day supply, whichever is greater, may be dispensed.

Generic Equivalent Drugs

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

Brand Name Drugs

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

- If your doctor prescribes a brand name medication to be "dispensed as written" when a generic alternative is available, the doctor must write "Dispense as Written" or "DAW" on the prescription order. **Even in this case, you will be required to pay the difference between the maximum allowable cost of the generic drug and the BCBSM approved amount for the brand name drug.**

- Also, if you request the brand name drug, you must pay the difference between the BCBSM approved amount for the brand name drug and the maximum allowable cost for the generic equivalent, in addition to your copayment.**

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Co-Branded Drugs

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

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

Your Copayment

Your copayment is:

\$20 for each generic drug

\$40 for each brand name drug even if the prescription indicates "DAW" or if there is no generic equivalent drug available

50 percent for drugs approved for elective drugs

Note: Elective drugs are lifestyle drugs such as those that treat sexual impotency or infertility, help in weight loss or help to stop smoking. They are not designed to treat acute or chronic illnesses or prescribed for medical conditions that have no demonstrable physical harm if not treated.

Choosing a Pharmacy

You can have your prescriptions filled at a network or non-network pharmacy. The choice is always yours. Remember that when your prescriptions are filled through a non-network pharmacy, you have higher out-of-pocket costs.

Network Pharmacy

A Michigan network pharmacy is one that is in the BCBSM Preferred RxSM network. Outside of Michigan, a network pharmacy is one that is in the MedImpact national network. Network pharmacies file claims for you and receive payment directly from BCBSM.

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When your prescriptions are filled through a network pharmacy, benefits will be payable at 100 percent of the approved amount less your copayment.

Important: Pharmacies outside Michigan must use the MedImpact BIN and PC number below to verify your eligibility, not the five-digit group number on your ID card.

MedImpact Rx BIN 0035855/Rx PCN 23615

If the pharmacist needs assistance, he or she may call the MedImpact Provider Help Desk at **1-800-239-1023**.

Non-Network Pharmacy

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

What's Not Covered

Your prescription drug coverage **does not** cover:

Drugs that cost less than your copayment

Administration of covered drugs or any covered drug entirely consumed at the time and place of the prescription

Refills not authorized by a physician

Any medication that does not require a prescription, except insulin

Therapeutic devices or appliances, even if prescribed by a physician (e.g., support garments regardless of their intended use)

More than a 34-day supply of a covered drug, except for specified maintenance drugs that are covered for 100-unit doses or 200-unit doses (retail pharmacy)

Refills dispensed after one year from the date of the original order

Prescription drugs that are used primarily for improving appearance rather than for treating a disease

Diagnostic agents

Any vaccine given solely to resist infectious diseases

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Any drug BCBSM determines to be experimental or investigational

Drugs or services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which you are eligible

Drugs or services obtained before the effective date or after the contract ends

More than 12 doses of an impotence drug such as Viagra in a 34-day period (BCBSM will pay up to 12 doses in a 34-day period if your physician receives prior approval from BCBSM.)

Nonpreferred co-branded drugs, unless they are preauthorized

Mail order drugs

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Summary Plan Description

Section 9. Blue Vision Coverage

The BCBSM Blue Vision plan promotes eye health wellness through a comprehensive eye care program. The program is designed to provide an eye exam as well as prescription eyewear and other services in order to meet your visual needs.

Blue Vision is a Preferred Provider Organization (PPO) program that uses the Vision Service Plan (VSP) provider network. VSP is the nation's largest provider of eye care wellness benefits.

- **Blue Vision Features**

Blue Vision provides these features:

Access to an extensive network of VSP providers in all 50 states. There are more than 1,100 provider locations in Michigan and 24,000 locations nationwide.

A wide selection of eyeglass frames available at each VSP provider location.

A 20 percent discount on a second pair of prescription glasses.

Discounts on non-covered lens options, such as blended lenses and scratch resistant coatings.

- **Questions**

When you have questions about your Blue Vision coverage, contact VSP, not Blue Cross Blue Shield of Michigan. To verify plan information, benefit eligibility and provider participation in the VSP network, you can visit the VSP Web site at **www.vsp.com** or call VSP's Member Services Support Line at **1-800-877-7195**. For hearing impaired with TYY equipment, please call 1-800-428-4833.

Written inquiries should be mailed to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

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- **Choosing a Vision Provider**

When you need eye care services, it's important that you know the difference between VSP providers and out-of-network providers.

- **VSP Providers**

A VSP provider is an ophthalmologist or optometrist who participates in VSP's network.

When covered eye care services are obtained from a VSP provider, you'll receive the maximum level of coverage available under your vision plan. The VSP provider accepts direct payment from VSP and accepts that payment plus applicable copayments as payment in full for covered services.

Using your VSP benefit is simple when you visit a VSP provider. You have no cards, no claim forms and no hassle. To use your benefits, simply:

- Make an appointment with a VSP provider

- Tell the provider you are a VSP member when making the appointment

- Provide the provider with the covered member's ID number

Your VSP provider and VSP will handle the rest by verifying your benefits and eligibility for services.

Note: Benefits are paid at the approved amount. Copayments are subtracted from the approved amount before the payment is made.

- **Finding a VSP Provider**

To locate a VSP provider near your home or work:

1. Log onto the VSP Web site at www.vsp.com
2. Call VSP's Member Services at **1-800-877-7195**

- **Out-of-Network Providers**

An out-of-network provider is an ophthalmologist or optometrist who has **not** agreed to accept the approved amount as full payment for covered services.

You have the option of seeing an out-of-network provider. Services obtained through an out-of-network provider are subject to the same time frames and copayments as services obtained through VSP providers.

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Benefits are payable up to the amount allowed under your vision plan, less your copayments, for eye exams, eyeglass lenses and frames, and contact lenses obtained from out-of-network providers. You are responsible for any difference between the allowance and the provider's charge.

For out-of-network reimbursement, you are required to pay the entire bill when you receive services. Log onto VSP's Web site and access the claim form to ensure a timely reimbursement. Simply:

Sign onto **www.vsp.com**

Select "Detailed Coverage" (or "More About My Benefits")

Click "Find out the Facts" for Out-of-Network Coverage at the bottom of the page

Click the link for "How to Request Reimbursement"

Follow the instructions

If you **do not have Internet access**, send the following information to VSP:

An itemized receipt listing the services received

The name, address and phone number of the out-of-network provider

The covered member's Social Security number or member identification number

The covered member's name, phone number and address

The name of the group

The patient's name, relationship to the Fund member (such as self, spouse, son, daughter, etc.), date of birth, phone number and address

Claims must be submitted to VSP within six months from your date of service. Please keep a copy of the information for your records and send the originals to the following address:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Note: VSP's out-of-network reimbursement schedule **does not** guarantee full payment, and VSP cannot guarantee patient satisfaction when services are received from an out-of-network provider.

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• **Your Copayment**

You are responsible for the following copayments:

\$**10** copayment for an eye exam

A combined \$**12.50** copayment for frames and lenses, **or** medically necessary contacts

Note: There is no copayment for prescribed contact lenses that are **not** medically necessary, but you are responsible for any charges that exceed the VSP payment.

• **Frequency Limitations**

Benefits provide:

One eye exam in any period of 24 consecutive months.

Note: The Fund will cover only one eye exam within a 24-month period, even if an optometrist recommends that the patient obtain an examination by a physician.

One pair of eyeglass lenses, with or without frames, **or** one pair of prescribed contact lenses (medically necessary and non-medically necessary) in any period of 24 consecutive months.

You may choose between glasses or contacts, but not both. If you choose contacts, you will not be eligible to receive glasses (lenses and frame) during the same service period.

• **Lens Options**

Lens options can enhance the appearance, durability and function of your glasses. Although your vision plan does not cover lens options, you will receive VSP's member preferred pricing when you purchase any of the following eyewear from a VSP provider:

Blended lenses

Oversize lenses

Lenses tinted darker than Rose tint #2 (such as sunglasses)

Photochromic lenses

Two pair of glasses instead of bifocals

Coating/laminating of a lens or lenses

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

Frames that exceed the plan allowance

Cosmetic lenses/processes

UV protected lenses

- **What's Covered**

Your eyecare benefits include:

- **Eye Exams**

The Fund will cover an eye exam by an ophthalmologist or optometrist. The exam must include the following:

History

Testing of visual acuity

External exam of the eye

Binocular measure

Ophthalmoscopic exams

Tonometry (test for glaucoma) when indicated

Medication for dilating the pupils and desensitizing the eyes for tonometry, if necessary

Summary of finding

- **Eyeglass Frames**

The Fund will cover standard eyeglass frames. Frames are provided based on a wholesale allowance of **\$40**, less your copayment.

If you select frames valued at more than the wholesale allowance, you will save 20 percent on your out-of-pocket costs.

Note: All VSP provider locations are required to stock at least 100 different frames within the frame allowance.

- **Eyeglass Lenses**

The Fund will cover 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

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

The lens blank must meet Z80.1 or Z80.2 standards of the American National Standards Institute

The lenses may be colorless or have Rose tints #1 or #2 if therapeutically necessary

Note: The provider may charge you for additional tinting other than for necessary Rose tints #1 or #2.

The lens blank of a standard lens must not exceed 65 millimeters in diameter

Note: The provider may charge you for the difference in cost between standard and oversize lenses.

The Fund will also cover the following special lenses:

Myodisc

Lenticular myodisc

Lenticular aspheric myodisc

Aphakic

Note: The Fund **does not** cover aphakic lenses for aphakia (lack of natural lens).

Lenticular aphakic

Lenticular aspheric aphakic

- **Other Vision Care Services**

The Fund will cover:

Prism when medically necessary

Slab-off prism when medically necessary

Special base curve lenses when medically necessary

Scratch guard coating on eyeglass lenses to provide protection against surface scratches

- **Contact Suitability Exam**

A contact suitability exam determines whether you can wear contact lenses. The fee for the exam is included in the BCBSM payment for the contact lenses.

- **Medically Necessary Contact Lenses**

The Fund will cover medically necessary contact lenses in full, less your copayment, when received from a VSP provider.

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

When medically necessary contacts are received from an out-of-network provider, benefits are covered up to a maximum of **\$210**, less your copayment. You are responsible for any difference between the approved amount and the provider's charge.

Contact lenses are considered medically necessary if:

They are the only way to correct vision to 20/70 in the better eye **or**

They are the only effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature

- **Elective Contact Lenses**

The Fund will cover elective contact lenses (contacts that are **not** medically necessary for the reasons listed under "Medically Necessary Contact Lenses"). When you choose contact lenses, you'll receive a **\$105** allowance that is applied toward the contact lens exam (fitting and evaluation) and the contact lenses. You are responsible for any cost exceeding the allowance.

Note: There is **no** copayment for contact lenses that are **not** medically necessary.

- **Safety Eyewear**

Union members can elect either safety glasses or regular glasses, but not both in a benefit period. The Fund will cover prescription safety lenses and frames, once every 24 months. Safety glasses will be reimbursed at the same approved amount for regular eyeglasses. The **\$12.50** copayment for eyeglasses will apply.

- **What's Not Covered**

Your vision care coverage **does not** cover:

Additional charges for:

Lenses tinted darker than Rose tint #2 (such as sunglasses)

Oversize lenses

Blended lenses

Anti-reflective lenses

Photochromic lenses

Laminating of a lens or lenses

Cosmetic lenses/processes

Two pair of glasses instead of bifocals

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

Medical or surgical treatment of the eyes

Services received as a result of an eye disease, defect or injury due to an act of war, declared or undeclared

Medications administered during any service except an eye exam

Services not prescribed by an ophthalmologist or optometrist

Special services such as orthoptics, vision training, low (subnormal) vision aids, aniseikonic lenses and tonography

Replacement of broken or lost lenses or frames

Services available at no cost to you for which no charge would be made in the absence of VSP coverage

Services not covered by your vision care coverage

Services or materials ordered or provided before the effective date of your coverage; lenses or frames ordered while you were eligible for benefits but delivered more than 60 days after your coverage ends

Care, services, supplies or devices that are personal or convenience items

Vision care services provided by persons who are not legally qualified or licensed to provide such services

Charges for completing insurance forms

Aphakic lenses when the patient lacks a natural lens

Charges for experimental or poor quality services

Services, eyeglasses or contact lenses that do not improve vision

A second eye exam by a physician or any eligible provider, regardless of the purpose

Charges for insertion of new lenses into "old" or existing frames

Care and services payable by government sponsored health care programs such as Medicare or TRICARE for which a member is eligible

Treatment of work-related injuries covered by workers' compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by an employer

Charges for tints that are not medically necessary

24 month limit

MICHIGAN LABORERS' HEALTH CARE FUND
Summary Plan Description

Section 10. Hearing Care Coverage

Your hearing care coverage is designed to identify hearing problems and provide benefits for corrective hearing devices.

Choosing a Hearing Provider

When you need hearing care, it is important to find out whether or not your provider participates with BCBSM.

Participating Providers

In Michigan and outside of Michigan where Blue Cross and Blue Shield plans contract with providers for hearing care services, BCBSM will pay the approved amount for hearing aids and related covered services only when obtained from participating providers.

You can locate a participating hearing provider in Michigan by:

Logging onto the BCBSM Web site at www.bcbsm.com

Calling the customer service number in Section 2

Nonparticipating Providers

Hearing care services are **not** covered when performed by nonparticipating providers unless **both** the following occur:

The services are performed outside of Michigan **and**

The local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services

In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed the BCBSM approved amount.

If your provider is outside of Michigan and does **not** have a contract with the Blues plan in that area, he or she may participate on a "per-claim" basis.

If the provider will not submit a claim for your covered services, you may submit an **itemized** payment receipt to BCBSM. BCBSM will pay you the approved amount.

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

Frequency Limitations

Hearing care benefits are payable **once every 36 months**. Blue Cross Blue Shield of Michigan will consider providing additional hearing care benefits if a physician-specialist sends BCBSM documentation of severe hearing loss that has occurred within 36 months. An example of severe hearing loss would be when a person wearing the hearing aid cannot distinguish normal speech 25 percent of the time.

Medical Evaluation

You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**

A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

What's Covered

You **must** receive the following services from **a participating hearing care provider**.

Blue Cross Blue Shield of Michigan will pay the approved amount for:

1. **Audiometric Exam** – evaluates the patient's hearing and measures hearing ability, including tests for air and bone conduction, speech reception and speech discrimination
2. **Hearing Aid Evaluation** – determines what type of hearing aid should be prescribed to compensate for loss of hearing
3. **Ordering and Fitting the Monaural Hearing Aid** – includes in-the-ear, behind-the-ear and basic hearing aids worn on the body, with ear molds if necessary

Note: Binaural hearing aids are covered if you have a hearing loss in both ears and the binaural aids are used to compensate for the loss of hearing. Two hearing aids ordered on different dates are not considered binaural hearing aids.

MICHIGAN LABORERS' HEALTH CARE FUND
Summary Plan Description

4. **Hearing Aid Conformity Test** – evaluates the performance of a hearing aid and its conformity to the original prescription after it has been fitted

What's Not Covered

Your hearing care coverage **does not** cover:

A medical evaluation by a physician-specialist to determine possible hearing loss

Medical or surgical treatment

Drugs or other medications

The trial and testing of different makes and models of hearing aids when the tests are not supported by the results of the most recent audiometric exam

Hearing aids ordered while you are a BCBSM member, but delivered more than 60 days after your coverage ends

Charges for audiometric exams, hearing aid evaluation tests, conformity tests and hearing aids not necessary, according to professionally accepted standards of practice, or which are not prescribed by the physician-specialist

Charges for spare hearing aids; replacement parts for and repairs of hearing aids

Replacements of lost or broken hearing aids, unless you have not used this benefit for at least 36 months

Any charges that **exceed** the BCBSM approved amount for a covered hearing aid if you obtain digitally-controlled programmable hearing devices or binaural hearing aids

Exams related to medical-surgical procedures such as tonsillectomies or myringotomies

All hearing care services and supplies provided by a **nonparticipating provider** in Michigan and outside of Michigan where the Blues plan contracts with providers for hearing care services

Hearing aids that do not meet Food and Drug Administration (FDA) and Federal Trade Commission (FTC) requirements

MICHIGAN LABORERS' HEALTH CARE FUND
Summary Plan Description

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MICHIGAN LABORERS' HEALTH CARE FUND
Summary Plan Description

Section 11. Medicare Coverage for Eligible Members

Medicare is a federal health care program designed to provide health care benefits to persons who are 65 or older, to persons who have End Stage Renal Disease (ESRD) and to certain disabled persons. The Social Security Administration is the sole authority for determining your Medicare eligibility. If you are enrolled in this coverage, you are called a "beneficiary."

You become eligible for Medicare when you are 65 (or earlier if you are disabled or have ESRD). If you are eligible by reason of age, you may enroll at any time during a seven-month period. This period begins three months before the month in which you reach 65, and includes the actual month of your birthday and the three months following your birthday month. During this period, you must apply for Medicare through your local Social Security Administration office.

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

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

Employed Persons Age 65 or Older

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

1. Continue your regular current coverage as your primary health care plan **(Option 1)** or
2. Select Medicare as your primary health care plan **(Option 2)**

The following explains these options:

Option 1 – You may continue your regular current coverage as your primary health care plan. This is automatic unless you indicate in writing that you do not want to continue this coverage.

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

Important: If you continue to be covered through your Fund for your primary health care benefits, you should still apply for Medicare benefits, especially Part A. Remember:

Part A of Medicare, the hospital insurance, is offered at no cost to you. It may provide **additional** benefits to your group coverage.

Part B of Medicare, the medical insurance, is available for a monthly premium. However, you can delay enrollment in Part B without penalty.

If you delay enrolling for Medicare Part B coverage when you reach 65, you may enroll during the special enrollment period that begins on the first day of the first month in which you are no longer covered by your group plan and ends two months later.

Option 2 – You may select Medicare as your primary health care plan. However, if you select this option, federal regulations prohibit your Fund from providing you with Supplemental coverage. You must file a written notice with your Fund Office, with Medicare and with BCBSM if you choose this option.

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

How Your BCBSM Supplemental Coverage Works

Your BCBSM Supplemental coverage is designed to ensure you receive the same level of health care coverage as those members with Traditional coverage. However, because you also have Medicare coverage, your Supplemental coverage is coordinated as follows:

If Medicare covers a service, then Medicare is considered the primary carrier and pays the claim first. Then, as your secondary carrier, BCBSM covers any Medicare Part A or B deductibles and coinsurance amounts **if the service is a benefit under your BCBSM Supplemental plan**, subject to BCBSM copayments.

Note: If Medicare covers the service in full, then your Supplemental coverage **has no responsibility** for the claim except if Medicare denies the claim.

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

If the service **is not covered by Medicare**, but covered under your Supplemental plan, then BCBSM is considered the primary carrier and pays the claim.

Always give your Medicare and BCBSM ID cards to your health care provider. This insures that both Medicare and BCBSM review your claims for payment.

All benefits covered and paid by BCBSM, either as the primary or secondary carrier, **are subject to applicable copayments and any benefit limitations and dollar maximums outlined in this booklet.**

Selecting a Health Care Provider

You may use providers who participate in the BCBSM Traditional Plan (called Blues participating providers) or nonparticipating providers for your health care needs. However, it is important to remember that when you use nonparticipating providers:

- BCBSM sends you the payment and you are responsible for paying the provider

- The BCBSM payment may be significantly less than the provider's charge

- You are responsible for any difference between the BCBSM payment and the provider's charges

BCBSM Supplemental Benefits

Your BCBSM Supplemental coverage ensures you receive the same level of health care coverage as those members with CMM coverage. Provided you are eligible for Medicare Parts A & B, the BCBSM Supplemental payment will be determined as follows:

Medical Coverage

Your Supplemental coverage, in combination with Medicare, provides the same benefits that are described in this booklet for those members with Traditional coverage. All benefits will be coordinated as described under "How Your BCBSM Supplemental Coverage Works."

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

Other Coverage

If your health care plan also includes prescription drugs, dental, vision and/or hearing benefits for those members with CMM coverage, then your BCBSM Supplemental coverage, in combination with Medicare, provides the same benefits described in this booklet. Applicable copayments, dollar maximums and benefit limits apply.

Medicare Part D – Prescription Drug Benefits

Because the Fund provides prescription drug coverage that is equivalent or better than the coverage offered through the Medicare Part D program, you should not enroll in the Medicare Part D program. Please contact the Fund Office for further information.

IF YOU ENROLL IN THE MEDICARE PART D COVERAGE, YOU WILL LOSE ELIGIBILITY TO PARTICIPATE IN THE MICHIGAN LABORERS' HEALTH CARE FUND.

MICHIGAN LABORERS' HEALTH CARE FUND
Summary Plan Description

Section 12. To File a Claim

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

To file your own claim, follow these steps:

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

Patient's name

Participant's name and contract number (from your ID card)

Provider's name, address, phone number, and federal tax ID number

Date and description of services

Diagnosis (nature of illness or injury)

Admission and discharge dates for hospitalization

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

The example below shows the information BCBSM requires in order to review your claim:

PHYSICIAN RECEIPT																			
1. NAME AND ADDRESS OF PROVIDER*	1 George S. Smith, M.D. 100 Market Street Hometown, State																		
2. FULL NAME OF PATIENT	2 For professional services to: John Doe																		
3. DATE OF SERVICE	3 DATE OF SERVICE																		
4. CHARGE	4 CHARGE																		
5. DIAGNOSIS AND TYPE OF SERVICE	5 DIAGNOSIS/SERVICE																		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">DATE OF SERVICE</th> <th style="width: 25%;">CHARGE</th> <th style="width: 50%;">DIAGNOSIS/SERVICE</th> </tr> </thead> <tbody> <tr> <td>5-31-90</td> <td style="text-align: right;">\$25.00</td> <td>Anemia/Office visit</td> </tr> <tr> <td>6-11-90</td> <td style="text-align: right;">\$15.00</td> <td>Sprained Ankle/ X-Ray, Ankle</td> </tr> <tr> <td>5-22-90</td> <td style="text-align: right;">\$ 8.00</td> <td>Anemia/Complete Blood Count</td> </tr> <tr> <td>6-5-90</td> <td style="text-align: right;">\$15.00</td> <td>Sprained Ankle/ X-Ray, Ankle</td> </tr> <tr> <td>6-3-90</td> <td style="text-align: right;">\$ 8.00</td> <td>Anemia/Complete Blood Count</td> </tr> </tbody> </table>	DATE OF SERVICE	CHARGE	DIAGNOSIS/SERVICE	5-31-90	\$25.00	Anemia/Office visit	6-11-90	\$15.00	Sprained Ankle/ X-Ray, Ankle	5-22-90	\$ 8.00	Anemia/Complete Blood Count	6-5-90	\$15.00	Sprained Ankle/ X-Ray, Ankle	6-3-90	\$ 8.00	Anemia/Complete Blood Count
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MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

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

2. Make a copy of all items for your files and send the original to BCBSM. It is important that you file claims promptly because most services have a two-year filing limitation.

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

3. If the patient does **not** have Medicare coverage, send all claim information to:

Blue Cross Blue Shield of Michigan
Major Accounts Service Center, Mail Code **X420**
600 E. Lafayette Blvd.
Detroit, MI 48226

• **Explanation of Benefit Payments (EOBP)**

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

The family members who received services.

The date services were provided ("claims processed from...to...").

"Summary of Balances" includes the provider(s) of the services, detail about charges and payments, including the amount saved by using BCBSM participating providers.

"Summary of Deductibles and Copayments" provides your deductible and copayment requirements as well as deductibles and copayments paid to date.

"Helpful Information" includes messages and reminders.

"Detail on Services" summarizes the BCBSM payment and shows your balance.

If you see an error, contact your provider first. If they cannot correct the error, call the customer service number on your EOBP.

MICHIGAN LABORERS' HEALTH CARE FUND

EXPLANATION OF BENEFIT PAYMENTS



THIS IS NOT A BILL

Statement Date: 06/13/98

Your Customer Service Phone Number Is:
NATIONWIDE TOLL-FREE 1-800-843-4876

81828-001
SMITH, JOHN
123 ELM LANE
FOREST PK OH 45240

Send Written Inquiries to this Address:
BLUE CROSS AND BLUE SHIELD OF MICHIGAN
STATE OF MICHIGAN
P.O. BOX 80380
LANSING MI 48908-0380

Group Name:
Group Number: 81828-001
Subscriber Name: SMITH, JOHN
Contract Number: 123456789
Coverage: HOSPITAL/PHYSICIAN

See your Health Care Benefits Certificate or
Benefits Guide for details on contract coverage.

Patient Name: SUSAN
Patient Birth Month/Year: 10/30

Summary of Balances (See Detail on Services)

Name of Hospital, Physician or Provider	Total Provider Charges	(-) Less BCBSM Paid	(-) Less Participating Provider Savings	(-) Less Other Insurance Paid	(=) Equals Your Balance*
UNIV FAM PHYSICIANS WYOM	74.00	9.20		22.88	40.90
	\$	\$		\$	\$
Totals:	74.00	9.20	22.88	40.90	1.02

*Note: The amount in the 'Equals Your Balance' column includes any copayments, deductibles, sanctions and non-covered charges.

Helpful Information

Naturally Blue provides discounts on select alternative medical services and natural products. Call 1-888-718-7011.

Detail on Services Contract Number: 123456789 Patient: SUSAN

Service Date (From/To)	07/10/96	Total Charge	\$ 74.00
Claim Received on:	08/16/96	Amount approved by Medicare for this service ..	51.12
Provider Name:	UNIV FAM PHYSICIANS WYOM	Amount Medicare covered	40.90
Provider Status:	NOT APPLICABLE	Amount considered by BCBSM for this service	10.22
Referring Provider:		Minus copayment	-1.02
Service Type:	OFFICE CALLS	BCBSM processed on 8/22/96 and paid provider	9.20
		Basic \$ 0.00	
		MM \$ 9.20	
Procedure:	OFFICE/OUTPATIENT,ES	Savings because provider participates with Medicare	+ 22.88
		Total Covered	\$ 72.98
Procedure Code:	99214	Your Balance: (Highlighted Amounts)	\$ 1.02
Claim Number:	81537654321		
Explanation Message:	We reduced our payment because your contract requires a 10 percent Major Medical copayment for the service. (YM10)		

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

- **Coordination of Benefits (COB)**

Under COB, insurance carriers work together to make sure you receive the maximum benefits available when you are covered by more than one group health care plan. Your BCBSM health care coverage requires that your benefit payments be coordinated with benefit payments from another group for services payable under both plans.

COB makes sure that the level of benefits between the carriers will cover up to 100 percent of the allowable expenses. COB also makes sure that the combined payments of all plans will not exceed the actual cost approved for your care.

- **How COB Works**

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

Your primary plan is the carrier that is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.

Your secondary plan is the carrier that is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by the carriers.

- **Guidelines to Determine Primary and Secondary Plans**

Contract Holder Versus Dependent Coverage – The plan that covers the patient as the employee (participant or contract holder) is primary and pays before a plan that covers the patient as a dependent.

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

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

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

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

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

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

- **Filing COB Claims**

Remember to ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier's payment statement to the secondary carrier. When you submit claims to BCBSM for reimbursement of the balance, please follow these steps:

1. Obtain an Explanation of Benefits (EOB) or payment statement from the primary carrier.
2. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.
3. If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.
4. Make sure the provider's name and complete address are on your receipts. If the provider is in Michigan, include the provider's Blue Cross Blue Shield of Michigan identification number (PIN). If the provider is located out of Michigan, include the provider's tax ID number.
5. Send these items to:

Blue Cross Blue Shield of Michigan
COB Department, Mail Code B570
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

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

MICHIGAN LABORERS' HEALTH CARE FUND Summary Plan Description

- **Updating COB Information – Your Responsibility**

It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, notify your Fund Office immediately. Blue Cross Blue Shield may periodically ask you to update your COB information. Please help Blue Cross Blue Shield serve you better by responding to requests for COB information quickly.

- **Subrogation**

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

Your right to recover payment from them is transferred to BCBSM.

You are required to do whatever is necessary to help BCBSM enforce their right of recovery.

If you receive payment through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse BCBSM. However, this does not apply if the funds you receive are from additional coverage you purchased in your name from another insurance company.

- **No-Fault Auto Insurance and BCBSM Coverage**

If you or an eligible dependent are involved in a motor vehicle accident, BCBSM will not pay for services related to an injury which is a direct or indirect result of an automobile accident. This applies whether or not you have no-fault automobile insurance. It is important that you discuss this with your auto insurance company.

- **Your Right to Request Review of an Adverse Benefit Determination**

Most questions or concerns about decisions BCBSM makes on claims or requests for benefits can be resolved through a phone call to one of BCBSM's Customer Service Representatives. You can locate the phone number in the top right hand corner of the first page of your Explanation of Benefits statement or in the letter BCBSM sends to notify you that BCBSM has not approved a request for benefits.

In addition, the Employee Retirement Income Security Act of 1974, as amended (ERISA) claims procedure regulations protect you by providing you the opportunity to request review of an adverse benefit determination.

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Summary Plan Description

An adverse benefit determination is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on your eligibility to participate in your employer's health plan. You may request review of an adverse benefit determination on a pre-service claim, an urgent care claim, or a post-service claim.

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

"Urgent care claim" means a claim for medical care or treatment where applying the time periods for non-urgent determinations could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician who knows your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

A claim will be found to be one involving urgent care in one of two ways. If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, BCBSM will treat it as such. Absent a determination by your physician, BCBSM will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

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

To obtain review of an adverse benefit determination, you must follow the review procedures below. These procedures vary, depending on whether you are asking for review of a decision on a pre-service, a post-service, or an urgent care claim.

With the exception of requests for review of adverse benefit determinations involving urgent care claims, which may be made orally, all requests for review must be in writing. Normally, for all three types of claims, you must exhaust applicable review procedures before you can initiate a civil action under section 502(a) of ERISA to obtain benefits.

Review Procedure

A. Review Procedure – Post-service claims

Under the review procedure for post-service claims, you are entitled to a two step appeal process. BCBSM must provide you with a written determination

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within 30 calendar days of BCBSM's receipt of your written requests for review at each level.

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

1. To initiate level 1 review, you or your authorized representative must send BCBSM a written statement explaining why you disagree with their determination. Please include in your request all documentation, records or comments you believe support your position. You must request review no later than 180 calendar days after you receive BCBSM's decision on your claim for benefits. Mail your written request for review to the address found in the top right hand corner of the first page of your Explanation of Benefits statement, or to the address contained in the letter BCBSM sends you to notify you that BCBSM has not approved a benefit or service you are requesting. BCBSM will respond to your request for review in writing within 30 days. If you agree with BCBSM's response, it becomes their final determination and the review ends.
2. If you disagree with BCBSM's response to your request for review at level 1, you may then proceed to level 2. You must request review at level 2 in writing no later than 30 calendar days after you receive BCBSM's determination at level 1.

Mail your request to the address specified in the letter BCBSM sends you to notify you BCBSM has not approved your appeal at level 1.

Again, please provide all documentation, records, and comments that you feel support your position. You will receive a written determination of your level 2 request by the latter of (a) the Plan's next regularly scheduled meeting which is at least 30 days after the date of your level 1 request or (b) 30 days following your request for level 2 review unless the Trustees tell you that they need more time.

3. If you disagree with the final determination, or if the determination at each level is not issued within the 30 day time frame or the review procedures for level 1 or level 2 are otherwise not complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

B. Review Procedure – Pre-service claims

1. The review procedure for pre-service claims is identical to the review procedure for post-service claims, except that BCBSM must provide you with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a two step process. A determination will be issued

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within 15 calendar days of receipt of your request for a level 1 review, and within 15 calendar days of your request for a level 2 review. You still have 30 days after receipt of the level 1 determination to file your level 2 appeal.

2. If you disagree with the final determination, or if the determination at each level is not issued within the 15 day time frame or the review procedures for level 1 or level 2 are otherwise not complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

C. Review Procedure – Urgent care claims

The review procedure for urgent care claims is as follows:

1. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call customer service for assistance.
2. BCBSM must provide you with their decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review. All necessary information, including BCBSM's decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile, or other available similarly expeditious method. If BCBSM's decision is communicated orally, BCBSM must provide you or your authorized representative with written confirmation of BCBSM's decision within two business days.
3. If you disagree with BCBSM's final determination, or if BCBSM fails to issue their determination within 72 hours, or otherwise fails to comply with the review procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits.

In addition to the information found above, the following requirements apply to review of pre-service, post-service, and urgent care claims:

- a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal review procedure.
- b. No fees or costs may be imposed as a condition to requesting review.
- c. Although there are set timeframes within which you must receive BCBSM's final determination on all three types of claims, you have the right to allow BCBSM additional time if you wish.

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- d. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- e. You may submit written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination.
- f. The person who reviews your adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The determination on review will be a new determination; the initial determination on your claim will not be afforded deference on review.
- g. If your request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.
- h. Upon request, the medical experts whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination.
- i. On review, you will be advised of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.
- j. If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion free of charge upon request.
- k. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be advised and provided an explanation of the scientific or clinical judgment free of charge upon request.

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Section 13. Dental Care Coverage

The Fund offers two dental plans: a Standard Dental Plan and an alternative plan which is a Dental Preferred Provider Organization. This section of your booklet explains the two plans. For active eligible participants, there is no additional fee for either the Fund's standard dental plan or DPO. If you seek treatment when you are not eligible for benefits you must pay for the services on the date treatment is rendered.

Dental Benefits are limited to Preventive Services only.

Eligibility Guidelines

The Fund's eligibility provisions are the same regardless of the dental plan you choose. If you or your dependents are eligible for regular hospital-medical coverage as a result of employer contributions, you will also be eligible under the dental plan. You must be eligible by employer contributions or self-payments (which include dental coverage) on the date charges are incurred, in order for any services to be covered.

Standard Dental Plan

Dental care benefits are payable according to a Schedule of Dental Benefits that is available at the Fund Office.

Dental Preferred Provider Organization

Dentemax is an established and large network of dentists. These dentists have agreed to accept the DenteMax fixed fee schedule as full payment (along with your co-payment) for dental services. By using a DenteMax participating provider, you save the Fund and yourself money.

Dental Care Benefits

The following procedures will be covered only for usage by an individual participant or his eligible dependent within the terms specified:

- X-rays every two (2) years and bitewings (includes intraoral, extraoral and bitewings x-rays)
- Prophylaxis (cleaning) or periodontal maintenance every six (6) months

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The annual dental benefit maximum is \$1,000 per participant, per calendar year. Dental Benefits are limited to preventive services only. Maximum amounts payable by procedure code apply to each service. Contact the Fund Office for the dental fee schedule.

Claim Filing

Benefits payable from the Fund will automatically be assigned to your dentist. This means that the Fund will pay your dentist directly for dental services rendered in accordance with the program's schedule of benefits. If his or her fee for a particular service is greater than that payable by the Fund, you may be billed directly for the additional amount by the dentist.

Dental claims should be sent to:

Michigan Laborers' Health Care Fund
6525 Centurion Drive
Lansing, MI 48917

All claims must be filed within one (1) year from the date the service is provided. Claims filed after the one (1) year period will not be paid.

Coordination of Benefits

The benefits under the Dental Program will be subject to the regular coordination of benefit provisions as are applicable under other types of benefits from the Fund.

Claims Incurred in Foreign Countries

The Fund will not pay for any dental claims incurred outside of the United States, Puerto Rico, the American Virgin Islands or American Samoa unless the claim is the result of a covered accident or illness which requires emergency treatment and which occurs while traveling outside such areas.

Exclusions and Limitations

Benefits under the Dental Program will not be payable for:

- Charges for services or supplies to the extent they are provided under any governmental plan or law under which the individual is, or could be, covered

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- Charges for services or supplies furnished by or for the U.S. Government, or any other government unless payment is legally required
- Charges incurred on account of war, declared or undeclared, including armed aggression of services received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar type of group of injury or sickness connected with employment with any employer of loss or theft of dentures or bridgework
- Charges for services or supplies for which the covered person is not required to pay
- Expenses arising as the result of a motor vehicular accident
- Expenses arising as the result of injuries/illnesses sustained in the course of employment for wage or profit
- Services not listed as a covered benefit on the Michigan Laborers' Dental Benefit Fee Schedule
- Services and supplies that are partial or wholly cosmetic in nature
- Expenses for duplication of any appliance to be used as a spare
- Treatment of temporomandibular joint dysfunction, commonly referred to as "TMJ"
- Orthodontics
- \$63 limit for x-rays
- Restorative services

Coverage for removal of "impacted" wisdom teeth is provided through the Fund Office. Please contact the Fund Office for further information.

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Section 14. Burial and Accidental Death and Dismemberment Benefits

The following information explains the burial and accidental death and dismemberment benefits available to you.

Burial Benefits

Burial benefits apply to those persons who are eligible by employer contributions, disability hours, retiree or active self-payments on the date of death (Surviving spouse self-payments do not provide death benefits). Burial benefits are payable in the following amounts:

- Participant – \$5,000
- Spouse – \$2,000
- Dependent Child – \$2,000

Written notice of the death must be given to the Fund Office within one (1) year of the date of death, otherwise no benefits will be payable. No burial benefits are payable if the death of the covered person is the result of felonious activity or aggravated assault.

Accidental Death and Dismemberment Benefits

If you are injured through external, violent or accidental means, on or off the job, while you are eligible for benefits by either employer contributions, active self-payments or disability hours, and the injury causes one of the following losses, the Plan will pay benefits for the losses according to the following schedule:

LOSS OF	
Life	\$5,000
Both hands or both feet	\$5,000
One hand and one foot	\$5,000
One hand or one foot & entire sight of one eye .	\$5,000
One hand or one foot	\$2,500
Entire sight of one eye	\$2,500
Entire sight of both eyes.....	\$5,000

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With reference to hand or foot, "loss" means complete severance through or above the wrist or ankle joint and with reference to eye, means the irrecoverable loss of the entire sight of the eye. Benefits will not be paid for more than one (1) of the losses (the greatest) sustained by the employee as the result of any one (1) accident.

No accidental death and dismemberment benefits are payable if the death or injury of the eligible participant is the result of a felonious activity, aggravated assault or suicide.

Beneficiary

As used herein, "beneficiary" means the person or persons designated to receive any benefits upon the death of an Eligible Employee, Retired Participant, or the legal Spouse of such Eligible Employee or Retired Participant. The designation of a Beneficiary shall be initially made by the Employee when he completes and files a *Participant Data Card* with the Fund Office.

Any Employee may thereafter designate a Beneficiary or change his designated Beneficiary at any time, without the consent or knowledge of the Beneficiary, by filing with the Fund Office a new, completed *Participant Data Card*. A change of Beneficiary will be effective upon receipt in the Fund Office of the newly completed *Participant Data Card*.

If no Beneficiary has been designated, any benefits payable upon the death of an Employee will be paid to his surviving legal spouse. If there is no surviving legal spouse, benefits are paid to his surviving children. If there are no surviving children, benefits are paid to his surviving parents. If there are not surviving parents, benefits are paid to the estate of the deceased Employee.

The Employee shall automatically be deemed to be the Beneficiary for the payment of any benefits upon the death of his legal spouse. The spouse of an Eligible or Retired Participant shall be entitled to designate a Beneficiary under the Plan.

Benefits may be assigned by the designated beneficiary, directly to the Funeral home. Assignment of benefits by any individual(s) other than the designated beneficiary will not be honored.

The Beneficiary must submit written claim for benefits within one (1) year from the date of death.

The designated beneficiary for receipt of death benefits will also be the beneficiary for any medical expenses that had not been paid prior to the date of death.

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Section 15. Glossary – Terms You Should Know

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

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

Custodial, convalescent, rest care or care of the aged

Skilled nursing care or nursing home care

Substance abuse treatment

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

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

Approved Amount – The BCBSM Blue Shield of Michigan maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copayments are deducted from the approved amount.

For prescription drugs, the approved amount is the lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) for a covered drug or service. The drug cost and dispensing fee are set according to the BCBSM contracts with the pharmacy. The approved amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Copayments that may be required of you are subtracted from the approved amount before BCBSM will make their payment.

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

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

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

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

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

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

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

Phase I - a study conducted on a small number of patients to determine what the side effect(s) and appropriate dose of treatment may be for a certain disease or condition.

Phase II - a study conducted on a large number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.

Phase III - a study on a much larger group of patients to compare the results of a new treatment of a condition to a conventional or standard treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Colony Stimulating Growth Factors – Factors that stimulate the multiplication of very young blood cells.

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

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

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

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

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

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

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

Routine nursing care

Training in personal hygiene and other forms of self-care

Care supervised by a physician

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

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

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

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

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

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

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

Opinions of local and national medical societies, organizations, committees, or governmental bodies

Accepted national standards of practice in the medical profession

Scientific data such as controlled studies in peer review journals or literature

Opinions of the Blue Cross Blue Shield Association or other local or national bodies

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

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

Hematopoietic Transplant – A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.

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

High Risk Patient – An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

HLA Genetic Markers – Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

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

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

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

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

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

Network Pharmacies – Pharmacies that have been selected for participation and have signed agreements to provide covered drugs through the Preferred Rx network (in Michigan) or MedImpact network (outside Michigan). Network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

Network Providers – Hospitals, physicians and other licensed facilities or health care professionals who have contracted with Blue Cross Blue Shield to provide services to members enrolled in a BCBSM Preferred Provider Organization (PPO) or Point of Service (POS) health care plan. Network providers have agreed to accept BCBSM approved amount as payment in full for covered services provided under these plans.

Non-Network Pharmacies – Pharmacies that are **not** in the Preferred Rx (in Michigan) or MedImpact (outside Michigan) networks. Non-network pharmacies have not agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

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

Occupational Therapy – A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury, or following surgery

Help the patient learn to apply the newly restored or improved function to meet the demands of daily living or

Design and use splints, orthoses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raised toilet seats).

Out-of-Network Service – Under BCBSM's PPO plans, an out-of-network service is a service **not** performed or referred by a PPO network provider. Under BCBSM's Point of Service (POS) plans, an out-of-network service is a service **not** performed or authorized by the member's primary care physician. This may also include services performed by another POS network provider, if authorization was not provided by the member's primary care physician.

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

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

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

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

Pheresis – Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets, and stem cells).

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

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

Purging – A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.

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

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

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

Refractory Patient – An individual who does not achieve clinical disappearance of the disease after standard therapy.

Relapse – When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient's condition.

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

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

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

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

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

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

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

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

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

Harm a person's physical, mental, social, and economic well-being

Cause the person to lose self-control

Endanger the safety or welfare of others because of the substance's habitual influence on the person

Syngeneic Transplant – A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient's identical twin to transplant into the patient.

T-Cell Depleted Infusion – A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

Tandem Transplant – A procedure in which the patient is given chemotherapy followed by a blood stem cell (peripheral or umbilical cord blood) transplant or bone marrow transplant, and, if the patient's cancer has not progressed, a second round of chemotherapy followed by a blood stem cell or bone marrow transplant. The second round of chemotherapy and transplant is usually performed within six months of the first transplant and if not, it must be approved by BCBSM. Tandem transplants are also

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referred to as dual transplants or sequential transplants. For purposes of transplant benefit coverage, a tandem transplant is considered to be one transplant.

Total Body Irradiation – A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

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

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Notes

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Section 16. Other Plan Information

Information Required by ERISA

The following information is provided in compliance with the Employee Retirement Income Security Act of 1974 (ERISA).

Type of Plan

The Plan provides health care and prescription drug coverage, dental coverage, vision coverage, burial benefits, and accidental death and dismemberment benefits.

Name of Plan Administrator

The Michigan Laborers' Health Care Fund is maintained and administered by a Board of Trustees of which labor and management are equally represented. There are six (6) Labor Trustees and six (6) Management Trustees on the Board. A list of the current Trustees is in the Appendix, "Board of Trustees."

The Board of Trustees has the primary responsibility for decisions regarding the eligibility provisions, type of benefits, administrative policies, management of Fund assets, and interpretation of Fund provisions.

Plan Year

The Plan year operates on a fiscal year basis commencing September 1 and ending on August 31 of the following year.

Identification Numbers

The Michigan Laborers' Health Care Fund been assigned employer identification number **38-6058384** by the Internal Revenue Service and assigned to itself identification number **501** for the Department of Labor.

Type of Administration

Although the Board of Trustees is legally designated as the Fund administrator, they have delegated many of the day-to-day functions to TIC and Blue Cross Blue Shield of Michigan.

- TIC maintains the eligibility records, accounts for employer contributions and performs other routine activities under the direction of the Trustees.
- Blue Cross Blue Shield of Michigan processes claims, and keeps participants informed about Plan changes and performs other routine activities under the direction of the Trustees, for the health care and prescription drug coverage.

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- TIC keeps participants informed about Plan changes and performs other routine activities under the direction of the Trustees for burial benefits and accidental death and dismemberment benefits.

Collective Bargaining Agreements

The Michigan Laborers' Health Care Fund was established and is maintained under the terms of collective bargaining agreements. The agreements set forth the conditions under which the participating employers are required to contribute to the Fund and the rate of contributions. Upon written request, employees may examine the agreements at the Fund Office or at other specified locations. Employees may request a copy of the agreement which will be provided to them at a reasonable charge.

Plan Sponsors

The Fund is maintained under the terms of collective bargaining agreements negotiated by the Union with participating employers. Employers who agree in writing to make contributions to the Fund are considered "plan sponsors." If any employer is not a party to a written agreement then he generally has no legal obligation to contribute to the Fund on behalf of employees. Consequently, to obtain benefits under this Fund, employees must be working for a contributing employer. If there is any uncertainty about whether or not an employer is a contributing employer, your Local Union Office should be contacted.

Source of Contributions

The primary source of financing for the benefits provided under this Fund and for the expenses of Fund operations is employer contributions. The rate of contribution is spelled out in the collective bargaining agreements negotiated by the Union with participating employers. No money is ever deducted from an employee's paycheck to pay for these benefits. However, under the terms of the Fund, participants may make self-payments to retain their eligibility if they are temporarily unemployed or temporarily disabled or not work enough hours to satisfy the eligibility provisions. Participants in the Early Retiree, Total and Permanent Disability, and Retiree Self-Payment Programs are required to make self-payments to maintain eligibility for themselves and their dependents. A portion of Fund assets are invested and this also produces additional Fund income to help defray expenses.

Fund Medium for the Accumulation of Fund Assets

All contributions and investment earnings are accumulated in a trust fund.

MICHIGAN LABORERS' HEALTH CARE FUND

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ERISA Rights and Protections

Participants in the Michigan Laborers' Health Care Fund are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all Plan documents including: insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Trustees. Under ERISA, Trustees may make a reasonable charge for the actual cost of reproducing the documents and other information.
3. Receive a summary of the Fund's annual financial report. The Fund administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
4. In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate this Fund, called "fiduciaries" of the Fund, have a duty to do so with reasonable care and in the exclusive interest of Plan participants and other beneficiaries.
5. No one may take any action which would prevent a participant from obtaining a benefit to which he is entitled under the Fund or from exercising his rights under ERISA.
6. In accordance with Section 503 of ERISA and federal regulations, the Trustees have adopted certain procedures to protect the rights of participants who are not satisfied with the action taken on a claim. If a claim for benefits is denied, in whole or in part, the participant must receive a written explanation of the reason for denial. Then, if the participant is not satisfied with the action on the claim, he has the right to have the Trustees review and reconsider such claim in accordance with the Fund's claim review procedures set forth in Section 4 of this Summary Plan Description.
7. If a participant has any questions about the Fund, he should contact the Trustees by writing to:

Board of Trustees
Michigan Laborers' Health Care Fund
6525 Centurion Drive
Lansing, MI 48917

MICHIGAN LABORERS' HEALTH CARE FUND
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8. Under ERISA, there are steps participants can take to enforce their rights under the Fund. If materials are requested from the Fund and they are not received, or if the participant feels that the Trustees or employees are discriminating against him for asserting his rights under ERISA, he may seek assistance from the nearest Area Office of the United States Department of Labor or he may file suit in a Federal Court. However, the Fund provides appeal procedures, as set forth in Section 4 of this Summary Plan Description, and you must exhaust the Fund appeal procedures before taking other steps.
9. If a participant has any questions about the foregoing statements or about his rights under ERISA which have not been answered in this booklet or by the Fund Office, he should contact the nearest Area Office of the U.S. Labor Management Services Administration, Department of Labor.

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Section 17. Other Important Information

Employer Trustees

Don Bovre, Secretary
Associated General Contractors of America,
Michigan Chapter
2323 North Larch Street
P.O. Box 27005
Lansing, MI 48909

Edgar Boettcher, III
Edgar Boettcher Masonry
Box 6043
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Joel Christensen
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3012 N 7th Avenue, Suite D
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W. A. Hendrick, Jr.
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619 Foxboro
Saginaw, MI 48603

T. Gregory Longpre
1153 West Glenlord Road, #110
St. Joseph, MI 49085-9703

Michael Nystrom
Michigan Infrastructure & Transportation
Association
P.O. Box 1640
Okemos, MI 48805

Union Trustees

Gary Jorgensen, Chairman
Michigan Laborers District Council
302 South Waverly Road, #8
Lansing, MI 48917

Michael Aaron
Local Union 1191
2161 W Grand Boulevard
Detroit, MI 48208

Michael DeVergilio
Local Union 1076
760 Joslyn Avenue
Pontiac, MI 48340

Joseph Gallino
Local Union 1329
P.O. Box 863, North US 2
Iron Mountain, MI 49801

Robert Malcolm
Local Union 959
3080 Platt Road
Ann Arbor, MI 48104

Alex Zurek
Local Union 355
1500 East Columbia Avenue
Battle Creek, MI 49014

MICHIGAN LABORERS' HEALTH CARE FUND
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Alternate Employer Trustees

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Associated General Contractors of America,
Michigan Chapter
2323 North Larch Street
PO Box 27005
Lansing, MI 48906

Dan Emmenecker
J. R. Heineman & Sons, Inc.
1224 North Niagara
Saginaw, MI 48602

Alternate Union Trustees

Dan Husted
Local Union 1075
PO Box 5188
Flint, MI 48505

Dan Minton
Local Union 465
1110 East Second Street
Monroe, MI 48161

Other Fund Contacts

Fund Office

Michigan Laborers' Health Care Fund
6525 Centurion Drive
Lansing, MI 48917-9275

Administrative Manager for the Plan

TIC International Corporation
6525 Centurion Drive
Lansing, MI 48917-9275

BCBSM Customer Service Office

Blue Cross Blue Shield of Michigan
Major Accounts Service Center
600 East Lafayette, X420
Detroit, MI 48226

Vision Service Plan

Eastern Operations Center
P.O Box 2487
Columbus, OH 43216-2487

Legal Counsel - Agent for Service of Legal Process

Christopher P. Legghio
Martens, Ice, Klass, Legghio, & Israel, P.C.
306 South Washington, Suite 600
Royal Oak, MI 48067

Website Addresses

Michigan Laborers Fringe Benefit Funds - www.michiganlaborers.org
Blue Cross Blue Shield of Michigan Home Page – www.bcbsm.com
Blue Cross Blue Shield of Michigan Anti-Fraud – www.bcbsm.com/antifraud/contact.shtml
Vision Service Plans – www.vsp.com