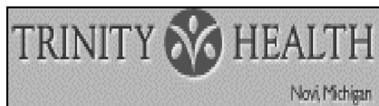

Health Care Handbook for associates of *Trinity Health Corporation*

Exclusive Provider Organization (EPO) Oakland

Blue Cross Blue Shield
Customer Service Directory

We are committed to providing you with excellent customer service. When you have a question or need help, you can call a knowledgeable customer service representative or go to one of the Web sites listed below.

Where to Call or Write for Customer Service:

When writing or calling, please provide your contract number from your Blue Cross Blue Shield ID card.

Telephone inquiries:	866-917-7537

Note: You can get information about your coverage 24 hours a day through our interactive voice response system by calling the telephone inquiry phone number. See the "General Information" section of this handbook for more information about the IVR system.

Written inquires:	Blue Cross Blue Shield of Michigan National Customer Service Center Mail Code B455 600 E. Lafayette Blvd. Detroit, MI 48226-2998
If you suspect fraud, call our fraud hotline:	800-482-3787
Write to the Anti-fraud unit:	Anti-Fraud Unit — Mail Code B759 Blue Cross Blue Shield of Michigan 600 E. Lafayette Blvd. Detroit, MI 48226
Anti-fraud unit Web site:	bcbsm.com/home/health_care_fraud

Network Provider Locator:

800-810-BLUE (2583)	**bcbs.com**

Web Site Address:

Blue Cross Blue Shield of Michigan:	**bcbsm.com**

Member Self Service

This feature allows you to check on a claim you sent to us, get up to date information on your deductibles and out of pocket expenses, view or print EOBs or order a Blue Cross and Blue Shield ("BCBS") ID card. . You can also see the personalized resources that BlueHealthConnection® offers.

Visit my health care benefits	**hcbo.com**

BlueHealthConnection®

Your benefits include BlueHealthConnection, our personalized program designed to help you learn as much as you can about your health. When you have the health information you need, you can make better decisions, which will help you wherever you are.

BlueHealthConnection provides you with educational resources to help you understand and manage a disease and interactive Web resources where you can learn about your health and how to improve it.

Call 24 hours a day:	800-775-BLUE (2583)
Or visit the BlueHealthConnection Web site:	**hcbo.com** (after you login, click **"Links"** located on the left navigation bar)

Decision Support Resources

Using Healthcare Advisor™ , you can access a suite of Web-based resources designed to help you make more informed decisions about your health care. You can research doctors and hospitals, find the cost of common health care services, compare drug treatment options and much more.

To access Healthcare Advisor™, go to:	**hcbo.com** (after you login, click **"Links"** located on the left navigation bar)

Coverage Advisor ™ is designed to help you find the type of health care plan that best fits your lifestyle.

To access Coverage Advisor, go to:	**http://mybenefits.trinity-health.org Choose: "My Health & Welfare" Select: Your Ministry Organization**

For more information on any of these resources, see the section "Making the Most of Your Health Care Plan."

Introduction

Blue Cross Blue Shield of Michigan ("BCBSM") and Trinity Health Corporation ("Trinity Health") are pleased to provide you and your family with this handbook that explains your health care coverage under the Medical Program component of Plan 504 of the Trinity Health Corporation Welfare Benefit Plan ("Plan") that is provided through the BCBS preferred provider organization ("PPO") health care plan.

The Plan described in this handbook is a benefit plan of the Trinity Health. The Plan provides benefits to eligible associates of Trinity Health and the Trinity Health Ministry Organizations that have adopted the Plan (collectively referred to as the "Employer") and their eligible dependents.

When you are well informed about your coverage and your health care benefits, you will have the confidence and security that comes from knowing that health care coverage is available when you need it. When you come across a word you don't understand or that is in **bold**, look in the Glossary at the back of the handbook. It contains the definitions of many words that you might not be familiar with.

This handbook is not a contract or insurance policy. This handbook provides a general explanation of the Plan. While we have tried to describe the Plan as completely and accurately as possible, due to the relatively brief nature of this Handbook and the complexity of the Plan document, some details may not have been described or have been described only briefly. **We strongly urge you to read this Handbook in its entirety.** If you have further questions, or if you would like to review the entire Plan document, copies are available from the Plan Administrator.

This handbook may be an electronic version of the handbook on file with Trinity Health and Aetna Life Insurance Company. In case of any discrepancy between an electronic version of this handbook and the printed version on file with Trinity Health, the terms set forth in the printed version on file with Trinity Health will prevail. In addition, in case of any discrepancy between the handbook (electronic or printed) and the actual Plan document, the Plan document will prevail. To obtain a printed copy of this handbook and/or the Plan document, please contact the Plan Administrator.

BCBSM administers the benefit Plan for your Employer and provides administrative claims payment services only. BCBSM does not insure the coverage nor do we assume any financial risk or obligation with respect to claims. Benefits and future changes in benefits are the responsibility of your Employer. Information concerning members may be reviewed by BCBSM, and may also be reviewed by your Employer, on a limited basis, for specific purposes permitted by law.

The coverage described in this handbook is provided pursuant to a contract entered into between the Trinity Health Corporation Welfare Benefit Plan ("Welfare Benefit Plan"), Trinity Health, as the sponsor of the Welfare Benefit Plan, and BCBSM in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

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Section 1:
General Information

Your Identification Card is Important
As an enrolled member of a BCBS health care plan, you will receive BCBS identification ("ID") cards. Your ID cards allow you to obtain services covered under your health care plan. Only the subscriber's (associate's) name appears on the ID cards. However, the cards are for use by all of the subscriber's eligible dependents.

The numbers on your ID card, especially the contract number, are very important in identifying your type of coverage. The contract number is the alphanumeric number found on your ID card.
Here are some tips about your ID card:

- Make sure you carry the latest card. Using outdated cards may delay payment of claims.
- You may request additional cards, without cost, for your eligible dependents and replace lost or stolen cards by calling your BCBS customer service representative at the toll-free phone number listed on the inside front cover of this handbook. **You can also visit hcbo.com** to order ID cards.
- If your card is lost or stolen, you can still receive services, but you should report the loss of your card immediately to your Employer or to your BCBS customer service representative.

Preventing Fraud
BCBS tries to prevent fraudulent use of your ID card. Only you and your eligible dependents may use the cards issued for your health care plan. Lending your card to anyone not eligible to use it is illegal. Your health care provider may ask for identification other than your ID card. Checking identification helps prevent unauthorized use of your card. If you suspect health care fraud against BCBS, contact our Anti-Fraud Unit at the phone number or address listed on the inside front cover of this handbook. All inquiries are strictly confidential.

Customer Service

If you have questions about your health care plan, please contact your BCBS customer service representative. For your convenience, we have listed our customer service phone numbers and addresses on the inside front cover of this handbook.

To help the customer service representative serve you better, here are some tips to remember:

- Have your contract number ready. It is the alphanumeric number found on your BCBS ID card.
- In addition to your contract number, please provide a daytime telephone number.
- If you are questioning a service, please provide:
  - Patient's name
  - Date the patient was treated
  - ˜ name of doctor or hospital
  - ˜ Type of service
  - Charge for **each** service
- When sending us bills, forms or other papers, please make copies of them. Send the originals to BCBS and keep the copies for your records. Make sure your contract number is on each page.

24/7 Customer Service

When you have a question about claims, deductibles, maximum out of pocket expenses, coordination of benefits, whether a health care provider participates with your health plan, or you need an ID card, you can get the help you need by using our interactive voice response automated servicing system, available, 24 hours a day everyday. You are immediately connected to the system when you dial your customer service telephone number.

Section 2:
Eligibility Guidelines

You are eligible to participate in the Plan if you are a regularly scheduled benefit eligible full-time or part-time **associate**, as described in your Employer's policy that defines associate classifications. Coverage will generally become effective after you satisfy the waiting period described in your Employer's policy that defines associate benefit eligibility.

Shown below is a list of **dependents** that are eligible for coverage under the Plan. Upon election for coverage, you will have 31 days to provide documentation to verify the eligibility of each of your covered **dependents, including your spouse**. The required documentation is set forth in the Trinity Health Dependent Verification Documentation Requirements, a copy of which can be obtained at http://mybenefits.trinity-health.org/auditdocrequirements.pdf. Coverage for your **dependents** will remain in an "ineligible" status until appropriate documentation is provided. Failure to provide appropriate documentation within 31 days will result in the voluntary termination of your election.

NOTE: If you and your spouse are employed by any Employer in a benefits eligible position, you may either both elect individual coverage or one of you may cover the other as a dependent spouse. You and/or your spouse are not eligible to be covered as both an **associate** and a **dependent** under the Plan. In addition, if both you and your spouse are covered as **associates** under the Plan, only one of you may elect coverage for your dependent children.

SPOUSE

Your spouse is eligible for coverage under the Plan provided:

1. The person is legally married to you under applicable State and Federal law and the IRS recognizes the person as your spouse for income tax purposes. A person who is your spouse as a result of a common law marriage is not eligible for coverage under the Plan.
2. The person is not otherwise covered under the Plan or any other group health plan offered by the Employer.

DEPENDENT CHILDREN BY BIRTH, MARRIAGE, ADOPTION, LEGAL GUARDIANSHIP OR QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Dependent children are eligible for coverage under the Plan through the end of the calendar year in which they turn 19, provided they meet all of the following criteria:

1. They are unmarried.
2. They are the natural, legally adopted or court appointed children of either you and/or your legal spouse (a legal spouse is a person who is legally married to you under applicable State and Federal law and who the IRS recognizes as your spouse for income tax purpose; a spouse by common law marriage is not considered your legal spouse for Plan purposes).
3. They are not otherwise covered under the Plan or any other group health plan offered by the Employer.
4. They either:
   - have the same principal place of abode as you for more than half of the taxable year, and they do not provide more than half of their own support for the taxable year (a "qualifying child"); or
   - have gross income for the taxable year, which is less than the exemption amount under Code Section 151(d) ($3,650 for 2009), you provide over half of their support, and they are not anyone else's qualifying child.

DEPENDENT CHILDREN BY BIRTH, MARRIAGE, ADOPTION, LEGAL GUARDIANSHIP OR QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) (Continued)

Dependent children are eligible for coverage under the Plan through the end of the calendar year in which they turn age 24, provided they meet all of the following criteria:

1. They are unmarried.
2. They are the natural, legally adopted or court appointed children of either you and/or your legal spouse (a legal spouse is a person who is legally married to you under applicable State and Federal law and who the IRS recognizes as your spouse for income tax purpose; a spouse by common law marriage is not considered your legal spouse for Plan purposes).
3. They are not otherwise covered under the Plan or any other group health plan offered by the Employer.
4. They are enrolled as full-time students for at least five months of the year.
5. They either:

- have the same principal place of abode as you for more than half of the taxable year, and they do not provide more than half of their own support for the taxable year (also a "qualifying child"); or
- have gross income for the taxable year, which is less than the exemption amount under Code Section 151(d) ($3,650 for 2009), you provide over half of their support, and they are not anyone else's qualifying child.

DEPENDENT CHILDREN BY BIRTH, MARRIAGE, ADOPTION, LEGAL GUARDIANSHIP OR QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) *(Continued)*

Dependent children are eligible for coverage under the Plan through the end of the calendar year in which they turn age 26, provided they meet all of the following criteria:

1. They are unmarried.
2. They are the natural, legally adopted or court appointed children of either you and/or your legal spouse (a legal spouse is a person who is legally married to you under applicable State and Federal law and who the IRS recognizes as your spouse for income tax purpose; a spouse by common law marriage is not considered your legal spouse for Plan purposes).
3. They are not otherwise covered under the Plan or any other group health plan offered by the Employer.
4. They have gross income for the taxable year, which is less than the exemption amount under Code Section 151(d) ($3,650 for 2009).
5. You provide over half of their support for the taxable year.
6. They are not anyone else's qualifying child.

Dependent children who are totally and permanently disabled are eligible for coverage beyond age 26, provided they also meet all of the following criteria:

- They are continuously enrolled in a creditable plan prior to their 19th or 26th birthday, and
- They are deemed legally disabled by mental or physical incapacity (i.e., unable to engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months) prior to their 19th or 26th birthday.

Continuation of Coverage for Dependent Students Taking a Leave of Absence from School due to Illness or Injury
Effective on and after January 1, 2010, an unmarried child who is a full-time student will not cease to be an eligible **dependent** child solely due to the fact that the child takes a medically necessary leave of absence from school (or reduces his or her school hours to part-time status for a medically necessary reason). The medically necessary leave of absence (or reduction of hours) must be verified by written certification from the child's treating physician. The

child must be enrolled in the Plan as an eligible **dependent** immediately prior to the medically necessary leave of absence (or reduction of hours) and the absence must otherwise cause the child to lose coverage under the Plan. The child will continue to be a **dependent** for one year after the first day of any verified medically necessary leave of absence or, if earlier, the date coverage would otherwise terminate under the Plan because the child does not satisfy the other eligibility requirements for **dependent** coverage (e.g., because the child attains age 26).

Qualified Medical Child Support Orders

The Plan will also provide coverage as required by the terms of a Qualified Medical Child Support Order ("QMCSO"). This coverage applies even if you do not have legal custody of the child; the child is not dependent on you for support, and regardless of any enrollment restrictions that may otherwise exist for dependent coverage. If the Plan Administrator receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. Additionally, the Employer may withhold from your paycheck any contributions required for such coverage.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing the Employer to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. The Employer follows certain procedures to determine if a child support notice is "qualified." You may receive a copy of these procedures at no charge. If you have any questions, or would like a copy of the child support order qualification procedures, please contact the Plan Administrator.

Unless the context clearly indicates otherwise, a reference in this Handbook to “dependents” includes both an associate’s spouse and dependent child(ren).

WHO IS NOT ELIGIBLE FOR BENEFITS?

1. Your common law spouse;
2. Your legal spouse and/or dependent child(ren) if covered under the Plan or other group health plan offered by the Employer as an **associate** or **dependent**.
3. Any individual who begins active service in the armed forces of any country, unless coverage is continued as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and
4. Any individual who does not meet the definition of an **associate** or **dependent** as described in the section of the Handbook titled WHO IS ELIGIBLE FOR BENEFITS.

ENROLLMENT PROCEDURE

You may enroll for coverage through your Employer’s benefit enrollment process. For example, your Employer’s benefit enrollment process may require you to complete an enrollment form or enroll electronically. If you want to enroll yourself and/or your eligible **dependents** in the Plan, you must follow your Employer’s benefit enrollment process. Please review your Employer’s policy regarding benefit enrollment to find out your Employer’s benefit enrollment process.

Your “Initial Enrollment Period” is the 31-day period beginning on the date you are first eligible for coverage. If you complete your enrollment within the Initial Enrollment Period, you and your eligible **dependents** will be enrolled in this Plan as described under the section of this handbook titled WHEN WILL COVERAGE BEGIN? You must enroll yourself for coverage, in order for your **dependents** to be eligible for coverage under this Plan.

You and your Employer will share the cost of the coverage you elect under the Plan. Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. Your Employer will determine the

rate of any required contributions in accordance with your Employer's policy. Please see the Plan Provisions Appendix.

If you do not enroll during the Initial Enrollment Period, you and your eligible **dependents** will not be eligible to enroll for coverage under the Plan until the next annual Open Enrollment Period except under the circumstances described in the "Special Enrollment Periods" section below or if you and/or your **dependents** experience a "Change in Status" event (described below). The annual Open Enrollment Period is held during the fall of each year.

WHEN WILL COVERAGE BEGIN?

Follow your specific Employer's benefit enrollment process within 31 days of your date of eligibility. Your coverage will begin in accordance with your Employers policy. Please see Plan Provisions Appendix.

SPECIAL ENROLLMENT PERIODS

Special Enrollment for Coverage Under Medical Program

Under the Health Insurance Portability and Accountability Act ("HIPAA"), special enrollment rights are available to certain eligible **associates** who previously declined coverage under the Plan and wish to enroll themselves and/or one or more of their eligible **dependents**. If you are an **associate** who is eligible to participate in the Plan, you will have a special enrollment right regardless of when you would otherwise be eligible to enroll under the Plan. Therefore, these provisions supplement any other enrollment period otherwise available to you. You will be entitled to special enrollment, if all of the following conditions are met:

1. You did not elect coverage under the Plan for yourself and/or you eligible **dependent** when you were first eligible to do so, because:

- you and/or your eligible **dependent** were covered under a group health plan or had health insurance at the time coverage was previously offered; and
- you stated in writing at the time you declined coverage that the reason you were declining was because you had other similar coverage; and
- you and/or your eligible **dependent** lose such coverage because of a loss of eligibility for that coverage due to:
  - termination of employment in a class eligible for such coverage;
  - reduction in hours of employment;
  - death;
  - divorce or legal separation;
  - the exhaustion of COBRA continuation coverage;
  - the other employer no longer contributing toward the cost of such coverage;
  - the exhaustion of applicable lifetime benefits under the coverage;
  - an individual ceases to be a dependent under the plan;
  - the plan terminates a benefit package option;

- if your coverage is provided through an HMO, you no longer live or work in the HMO's service area (and there is no other coverage available under the plan); or

- the plan no longer offers coverage to a class of similarly situated individuals that includes you and/or your eligible **dependent** (e.g., the plan terminates coverage for all part-time associates but continues coverage for full-time associates, and you are a part-time associate); and

2. You elect coverage not later than 31 days after the date of the loss of coverage for one of the reasons stated above.

Coverage under the Plan for a special enrollee will become effective on the date set forth in your Employer's policy, but no later than the first day of the first calendar month beginning after the date on which you timely enroll.

Special Enrollment for New Dependents

The HIPAA special enrollment provisions also apply if you acquire an eligible **dependent** through marriage, birth, adoption or placement for adoption. If you are an eligible **associate**, you will be entitled and provided that you elect coverage not later than 31 days after such event. You will be entitled to special enrollment, if you meet one of the following conditions:

- **Non-Enrolled Associate**: If you are an eligible **associate** but you have not enrolled in the Plan, you may enroll upon your marriage or upon the birth, adoption, or placement for adoption of your child.

- **Non-Enrolled Spouse**: If you are an eligible **associate** who is already enrolled in the Plan, you may enroll your spouse at the time of his or her marriage to you. You may also enroll your spouse if you acquire a child through birth, adoption, or placement for adoption.

- **New Dependents of an Enrolled Associate**: If you are an eligible **associate** who is already enrolled in the Plan, you may enroll a child who becomes your eligible **dependent** as a result of marriage, birth, adoption, or placement for adoption.

- **New Dependents/Spouse of a Non-Enrolled Associate**: If you are an eligible **associate** but you are not enrolled in the Plan, you may enroll a spouse, or **dependent** child, as applicable, who becomes your eligible **dependent** as a result of marriage, birth, adoption, or placement for adoption. However, you (the non-enrolled **associate**) must also be eligible to enroll in the Plan, and actually enroll in the Plan at the same time.

You must enroll yourself and/or your new eligible **dependent(s)** no later than 31 days after the date of the event that entitles you and/or your eligible **dependent(s)** to the special enrollment period. If you are entitled to special enrollment and enroll within 31 days of the date of the event, coverage will become effective on the date set forth in your Employer's policy; provided, however, that coverage will become effective on the date of the event for birth, adoption or placement for adoption if you timely enroll and, with respect to marriage, coverage will become effective no later than the first day of the first calendar month beginning after the date on which you timely enroll . If you do not timely enroll, enrollment for yourself and/or your new eligible **dependent(s)** must wait until the next Open Enrollment Period, to be effective at the beginning of the next Plan Year (unless another event occurs which would allow you to enroll yourself and/or your new eligible **dependent(s)** prior to such time).

Special Enrollment for Medicaid/Children's Health Insurance Program

Effective April 1, 2009, HIPAA special enrollment rights also apply if (1) you and/or your eligible **dependent** lose Medicaid or Children's Health Insurance Program ("CHIP") coverage due to no longer being eligible for those benefits, or (2) you and/or your eligible **dependent** become eligible for premium assistance in the Plan under a Medicaid program or CHIP. You must enroll due to one of these reasons no later than 60 days after the date of the event that entitles you and/or your eligible **dependent** to the special enrollment period. If you are entitled to special enrollment and you enroll within 60 days after the date of the event, coverage will become effective as of the date

set forth in your Employer's policy, but no later than the first day of the first calendar month beginning after the date on which you timely enroll. If you do not timely enroll, enrollment for you and/or your eligible **dependent** must wait until the next Open Enrollment Period, to be effective at the beginning of the next Plan Year (unless another event occurs which would allow you to enroll yourself and/or your new eligible **dependent** prior to such time).

CHANGE IN STATUS

Once you make your coverage election for a plan year (January 1 through December 31) (or in your initial year of eligibility, for the remaining portion of the plan year), you generally cannot change or revoke your election until the beginning of the next plan year unless you have a qualified change in status (described below). This rule applies whether your election was to opt out of coverage, to begin participation, or to continue coverage by making no other affirmative election.

Qualified Change in Status

A qualified change in status **includes the following events that may impact you or your dependent's eligibility for coverage under the Plan:**

Change in marital status, including marriage, divorce, legal separation, annulment or death of spouse.

- Change in number of **dependents**, including birth, death, adoption, and placement for adoption. .
- Change in employment status of the **associate**, spouse or **dependent** that causes you, your spouse or dependent to either gain or lose eligibility for an employer's benefit program, including commencement or termination of employment, change in worksite that removes the affected individual from a benefit plan's service provider area, commencement or return from leave of absence, or any employment status change that affects the eligibility of the individual to participate in a benefit program or plan of an employer, including a change from part-time to full-time employment or vice-versa, or a change from salaried to hourly pay, or, a strike or lockout.
- Change in residence of the **associate**, spouse or **dependent** that removes the affected individual from a benefit plan's service provider area (such a change entitles you to make a new plan election selecting another coverage option, but generally does not permit you to opt out of coverage entirely unless no other relevant coverage is available).
- **Dependent** meeting or ceasing to meet the Plan's definition of **dependent**, such as attainment of a specified age, ceasing to be a student, or a change in the Plan's eligibility requirements.
- **Cost or Coverage** - A significant change in the cost or coverage of a benefit plan offered to you, your spouse or dependent, including a new benefit option being added, a benefit option being eliminated or significantly curtailed, a coverage change made under a plan offered by the Employer or the employer of your spouse, former spouse or dependent, or a significant increase in the cost of a benefit (such qualified change in status permits you to make a new benefit selection, but does not allow you to revoke coverage entirely, unless no other similar coverage is available).
- You, your spouse or dependent become covered or lose benefit coverage under Medicare or Medicaid, other than for pediatric vaccines.
- A judgment, decree or order requiring **dependent** coverage (e.g., **QMCSO**).
- A special enrollment right you may be entitled to under the provisions of HIPAA.
- You commence or return from an unpaid leave of absence as permitted and regulated by the FMLA.
- An election of coverage by your spouse, former spouse or dependent during an open enrollment period that differs in time from the open enrollment period offered by the Employer

Any election change or revocation you make must be consistent with the qualified change in status. You must change or revoke your election within 31 days after the change in status event occurs. The change or revocation will be effective as soon as is administratively practicable after it is received by the Employer, but in no event earlier than the first pay period beginning after a new election is completed and returned to the Employer. Changes in elections due to a qualified change in status shall only be effective as to contributions and benefits under the Plan on and after the effective date of such change. However, election changes made due to a special enrollment right as

provided by HIPAA may result in coverage being made available retroactively to the date of the qualified change in status.

LEAVES OF ABSENCE

If you are not at work due to an unpaid, Employer-approved leave of absence, period of military service lasting more than 31 days, or any other reason that creates a legal obligation for the Employer to extend coverage under the Plan, you may, at your option, continue coverage in accordance with your Employers leave of absence policy.

If you are absent from work for any paid leave of absence you must continue the coverage you elected under the Plan and your contributions for the coverage will continue to be deducted from your paychecks during the absence.

REHIRED ASSOCIATES

If you terminate employment prior to becoming a participant and an Employer subsequently reemploys you, you must satisfy the eligibility requirements in order to participate in the Plan without regard to any prior period of employment with an Employer. If you terminate employment after becoming a participant and an Employer subsequently reemploys in a position that entitles you to participate in the Plan, you shall have the opportunity to re-enroll in the Plan immediately upon reemployment. You must follow your Employer's benefit enrollment process within 31 days of your reemployment. Your coverage will begin in accordance with your Employers policy. Please see Plan Provisions Appendix. If you do not enroll within 31 days of your reemployment, you will not be able to enroll yourself and/or your eligible **dependents** in the Plan until the next annual Open Enrollment Period except under the circumstances described in the "Special Enrollment Periods" section or if you and/or your **dependents** experience a "Change in Status" event.

WHEN WILL COVERAGE END?

Your (and your dependents') coverage under the Plan will end when the Plan is terminated. In addition, your (and your dependents') coverage under the Plan will end when you no longer meet the eligibility requirements of this Plan or you die. Your coverage and that of your enrolled **dependent(s)** will end on the last day of the pay period during which you cease to be eligible to participate or die or the last day of the pay period in which you make a contribution toward the cost of coverage, if earlier.

In addition, the coverage of your **dependent(s)** will end when they no longer meet the eligibility requirements of this Plan. Their coverage will end of the last day of the pay period during which they cease to be eligible for coverage or last day of the pay period in which you make a contribution toward the cost of their coverage, if earlier.

NOTE: If your coverage terminates and/or if your **dependent(s)** cease to be covered for any of the above reasons, you and/or your **dependent(s)** may be eligible to continue coverage under the Plan. Please refer to the section titled CONTINUATION COVERAGE RIGHTS UNDER COBRA for further information.

When you and/or your **dependent(s)** lose coverage under the Plan, you and/or your dependant(s) (as applicable) will be provided with a Certificate of Creditable Coverage as required by HIPAA. The Certificate of Creditable Coverage will indicate the time period that you or your **dependent(s)** were covered by the Plan, subject to HIPAA's portability requirements. You and/or your **dependent(s)** may also request a Certificate of Creditable Coverage within 24 months of losing coverage under the Plan. If you and/or your **dependent(s)** need to request a Certificate of Creditable Coverage, you and/or your **dependent(s)** can do so by contacting the Plan Administrator. The request must be in writing and must include: (1) the name(s) of the individual(s), (2) the time period to be covered by the Certificate of Creditable Coverage, and (3) a mailing address where the Certificate of Creditable Coverage should be sent.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is a temporary extension of health coverage that can become available to you when you would otherwise lose your coverage under the Plan. It can also become available to the members of your family who are covered under the Plan when they would otherwise lose their coverage. **The information in this Handbook is intended provide notice and explain, in a summary fashion, COBRA continuation coverage, when it may become available to you and your family, what you must do to continue your coverage under the Plan, including what to do to protect the right to receive it.** This information gives you only a summary of your COBRA continuation coverage rights. Both you and your spouse, if any, should take the time to read this information carefully. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." ." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, you, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an associate covered by the Plan, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an associate, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-associate dies;
- The parent-associate's hours of employment are reduced;
- The parent-associate's employment ends for any reason other than his or her gross misconduct;
- The parent-associate becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If your employer offers retiree coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired associate covered under the Plan, the retired associate

will become a qualified beneficiary with respect to the bankruptcy. The retired associate's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the associate, commencement of a proceeding in bankruptcy with respect to the Employer or enrollment of the associate in Medicare (Part A, Part B or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events. For other qualifying events (divorce or legal separation, or because a child is no longer eligible to be a **dependent**), the **associate** or covered **dependent (or any representative)** MUST notify the Plan Administrator. **The Plan requires the associate or covered dependent (or representative) to notify the Plan Administrator within 60 days after the qualifying event occurs. The notice must be sent to the Plan Administrator** at the address listed at the end of this Handbook. The notice must be in writing and must include: (1) the Plan name, (2) the name of the covered associate and each qualified beneficiary impacted by the qualifying event, (3) the type of qualifying event and (4) the date of the qualifying event. If the Plan Administrator is not notified within 60 days after the date of the qualifying event COBRA continuation coverage will not be offered.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered associates may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the associate, the associate's enrollment in Medicare benefits (under Part A, Part B, or both), the associate's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the associate's hours of employment, COBRA continuation coverage lasts for up to18 months. However, if the qualifying event is the associate's termination of employment or reduction in hours of employment and the qualifying event occurs within the 18-month period after the associate becomes enrolled in Medicare, the associate's spouse and dependent children are entitled to COBRA continuation coverage for up to 36 months from the date the associate enrolled in Medicare. There are two additional ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. **You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the later of: (i) the date of the qualifying event (the associate's termination of employment or reduction in hours); (ii) the date of the Social Security Administration determination; and (iii) the date on the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. In addition, you must notify the Plan Administrator of the Social Security Administration's determination before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator at the address listed for the Plan Administrator at the end of this Handbook. The notice must be in writing and must include: (1) the Plan name, (2) the name of the associate and the disabled qualified beneficiary, if different,**

(3) the date of the Social Security Administration's determination of disability and (4) a copy of the Social Security Administration's determination of disability. The associate, the qualified beneficiary or any representative on behalf of the associate or the qualified beneficiary can provide the notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the associate or former associate dies, becomes enrolled in Medicare (under Part A, Part B, or both) (and the former associate's enrollment in Medicare Part A and/or Part B would have been a qualifying event if it occurred before the former associate's termination of employment or reduction in hours of employment), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator at the address listed for the Plan Administrator at the end of this Handbook. The notice must be in writing and must include: (1) the Plan's name, (2) the name of the associate and each qualified beneficiary impacted by the second qualifying event, (3) the nature of the second qualifying event and (4) the date of the second qualifying event. The associate, the qualified beneficiary or any representative on behalf of the associate or the qualified beneficiary can provide the notice.**

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

USERRA CONTINUATION OF COVERAGE

If you perform service in the uniformed services you may elect up to 24 months of continuation coverage under the Plan, as required by the Uniformed Service Employment and Reemployment Rights Act ("USERRA"). The procedures set forth above for electing COBRA continuation coverage apply to this election for continuation coverage. Contact the Plan Administrator for additional information about USERRA continuation coverage.

If You Have Questions

If you have questions concerning the Plan or COBRA continuation coverage, please feel free to contact Aetna or the Plan Administrator. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Associate Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Section 3:
Selecting a Health Care Provider

Your benefits are provided through the preferred provider organization ("PPO") health care plan. This plan is designed to provide you the highest level of benefit payment and limit your out-of-pocket costs when you use physicians, hospitals and other health care specialists that are a part of Trinity Health or the PPO health care provider network.

There are two levels of participation in this provider network. The level of a health care provider's participation impacts the costs for which you will be responsible. The two levels are:

- Trinity Health facilities
- Network providers

Trinity Health Facilities

When you use Trinity Health facilities and satellite locations, you receive the highest benefit payment level. A listing of eligible facilities is available online at bsbsm.com.

Network Providers

Network providers have signed agreements with BCBS, which means they agree to accept our approved payment for a covered benefit as payment in full. You will only pay for the deductibles, copayments and coinsurances required by your coverage.

Ask your physician if he or she participates with the BCBS PPO network in your plan area. If you need help locating a network provider, please call the phone number to locate a BCBS network provider, visit the Web site listed on the inside front cover of this handbook, or by visiting the Human Resources / Organization and Talent Effectiveness Web site http://mybenefits.trinity-health.org

When you go to network providers, you do not have to send a claim to us. Network providers submit claims to BCBS for you, and they are paid directly by BCBS.

Change of Network Status

Your physician is your partner in managing your health care. However, physicians retire, move, or otherwise cease to be affiliated with the BCBS PPO network. Should this happen, your physician will notify you that he or she is no longer in the PPO network.

If you wish, you may continue your medical care with a physician that is no longer with the PPO network; however, you may be responsible for the difference between the BCBS approved amount and the provider's charges, in addition to any deductible, coinsurance and copayment required by your plan.

You can find physicians and hospitals in your area by calling the network provider locator or by visiting the Web site listed on the inside front cover of this handbook. You do not have to notify BCBS when you select or change providers. To make your appointment, just call the physician's office directly.

Emergency Services by Out-of-Network Providers

When you or your covered **dependent(s)** choose a **Network provider**, the Plan will pay as described in the Plan Provisions Appendix.

If you and your covered **dependents** reside in an area where **Network providers** are not available, the Plan will pay benefits at the Network level when services have been referred by a **Network provider**.

If you or your covered **dependents** need emergency treatment for an accidental bodily **injury** or a **life-threatening medical emergency** outside the Network area at a provider that is not a **Network provider**, the plan will pay benefits at the Network level.

If you or your covered **dependents** need emergency treatment for an accidental bodily **injury** or a **life-threatening medical emergency** and seek treatment (via car or ambulance) at the nearest facility that is not a **Network provider**, the plan will pay benefits at the Network level.

If a covered service, supply, course of treatment or procedure cannot be performed by a **Network provider** the plan will pay benefits at the Network level. Any related laboratory tests, x-rays or follow-up visits by the same **Non-Network provider** will be paid at the Network level. It is your responsibility to investigate the availability of a needed provider.

If you or your covered **dependents** use a Network facility for **inpatient/outpatient** services/procedures, but the Network facility uses a **Non-Network provider** for anesthesia, the interpretation of laboratory tests and x-rays and other **medically necessary** services, the plan will pay benefits at the Network level.

If you or your covered **dependents** are admitted to a Non-Network **hospital** through the emergency room, the plan will pay benefits for that confinement at the Network level until you are stable, at that point the plan will pay benefits at the Non-Network level, unless you are transferred to a Network facility.

We realize when an emergency situation occurs; you need to seek care from the nearest provider — who may not always be a network provider. If you receive treatment from an out-of-network provider for a medical emergency or accidental injury, your services will be paid at the in-network benefit level. **The treatment must be for a true emergency as determined by BCBS.** See the “Your Health Care Benefits” section of this handbook to find out what qualifies as a medical emergency.

Referral to Out-of-Network Providers

If you seek or are referred for services from a **Non-Network provider** and such specialty provider and/or covered service, supply, course of treatment or procedure can be performed by a **Network provider**, services will not be covered. Any related laboratory tests, x-rays or follow-up visits by the same **Non-Network provider** will not be covered. It is your responsibility to investigate the availability of a needed provider.

Coverage When You Travel

When you travel across the country or around the world, your health care benefits go with you. The BlueCard® program gives you access to doctors and hospitals everywhere you travel.

Travel Across the United States

Our extensive provider network makes it easy to find participating doctors and hospitals when you travel away from home. Out-of-state participating providers will bill their local Blue plan for any covered services you receive. This means faster payment to the provider and less out-of-pocket costs for you. Here’s how it works:

- **Participating providers** — Present your BCBS ID card to out-of-state participating providers. They will bill their local Blues plan for payment. Your provider also will accept the approved amount or negotiated rate (see “Glossary of Health Care Terms”) as payment in full. You are responsible for any member out-of-pocket costs (deductible, coinsurance and payments) as identified in this handbook. Remember, your out-of-pocket costs are usually calculated on the lower of the provider’s actual charge or the BCBS negotiated rate.

  Note: If a participating provider bills you for charges other than what is required by your plan, remind the provider that he or she should accept the BCBS payment as payment in full.

- **Nonparticipating provider** — If your out-of-state provider does not participate with the local Blues plan, ask if the provider can send the bill directly to us. If not, you will need to get an itemized receipt and send it to us for reimbursement. See the “Filing Claims” section of this handbook for instructions on how to submit a claim.

Travel Outside of the United States

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

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

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

BlueCard®

All BCBS licensees participate in this program. Whenever members' access health care services outside the geographic area BCBSM serves, the claim for those services may be processed through BlueCard and presented to BCBSM for payment. Under BlueCard, when members receive covered health care services within the geographic area served by another BCBS plan ("host plan"), BCBSM will remain responsible to the group for fulfilling BCBSM's contract obligations. However, the host plan will only be responsible, in accordance with applicable BlueCard policies, for providing services such as contracting and other interaction with its participating providers. The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim

The calculation of a member's liability on claims for covered health care services incurred outside the geographic area BCBSM serves and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price BCBSM pays the host plan.

The calculation of the group's liability on these BlueCard claims will be based on the negotiated price BCBSM pays the host plan.

The methods employed by a host plan to determine a negotiated price will vary among plans based on the terms of each plan's provider contracts. The negotiated price paid to a host plan by BCBSM on a claim for health care services processed through BlueCard may represent:

(i) The actual price paid on the claim by the host plan to the health care provider ("actual price")

(ii) An estimated price, determined by the host plan in accordance with BlueCard policies, based on the actual price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the host plan's health care providers or one or more particular providers ("estimated price")

(iii) An average price, determined by the host plan in accordance with BlueCard policies, based on a billed charges discount representing the host plan's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers ("average price"). An average price may result in greater variation to the member and the group from the actual price than would an estimated price.

Host plans using either the estimated price or average price will, in accordance with BlueCard policies, prospectively increase or reduce the price to correct for over- or underestimation of past prices. However, the amount paid by the member and the group is a final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of estimated price or average price may result in some portion of the amount paid by the group being held in a variance account by the host plan, pending settlement with its participating providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to the group and are eventually exhausted by provider settlements and through prospective adjustment to the negotiated prices.

Statutes in a small number of states may require a host plan either:

(1) Use a basis for calculating a member's liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim

(2) Add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the host plan would then calculate a member's liability and the group's liability for any covered health care services consistent with the applicable state statute in effect at the time the member received those services.

Return of Overpayments

Under BlueCard, recoveries from a host plan or from participating providers of a host plan can arise in several ways, including but not limited to anti-fraud and abuse audits, health care provider audits, credit balance audits, utilization review refunds and unsolicited refunds. In some cases, the host plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

BlueCard Fees and Compensation

The group understands and agrees:

1. To pay certain fees and compensation to BCBSM which it is obligated under BlueCard to pay to the host plan, to the BCBSA or to the BlueCard vendors, unless BCBSM's contract obligations to the group require those fees and compensation to be paid only by BCBSM.

2. That fees and compensation under BlueCard may be revised from time to time without the group's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Some of these fees and compensation are charged each time a claim is processed through BlueCard and include, but are not limited to access fees, administrative expense allowance fees, Central Financial Agency fees, and ITS transaction fees. Also, some of these claim-based fees, such as the access fee and the administrative expense allowance fee may be passed on to the group as an additional claim liability. Other fees include, but are not limited to, those for providing an 800-telephone number and for providing PPO provider directories. If the group does not have a complete listing or wants an updated listing of these types of fees or the amount of these fees paid directly by the group, it should contact BCBSM.

Section 4:
Making the Most of Your Health Care Plan

This section provides general information about your total health care package. Your coverage includes the following benefits:

Medical Coverage
Your hospital and medical-surgical benefits are provided through the PPO health care plan. PPO is a cost-sharing plan that provides a wide range of benefits from inpatient hospital care to physician services. Using PPO network providers will limit your out-of-pocket costs. Please see the "Your Health Care Benefits" section of this handbook for more information.

Payment of Benefits
Your coverage consists of services and supplies for which BCBS agrees to pay under the terms of your Employer's coverage documents. Covered services and supplies are called "benefits".

The payment amount for benefits is called the "approved amount." This is the BCBS maximum payment level allowed for the covered services. Deductibles, copayments, coinsurances and sanctions are deducted from the approved amount. **All references to the approved amount in this handbook refer to the approved amount as determined by BCBS.**

Value Added Resources
In addition to quality health care coverage, your plan includes the following resources:
- The Web site, My Health Care Benefits Online, at hcbo.com.
- BlueHealthConnection®
- Healthcare Advisor™
- Coverage Advisor™
- Naturally Blue^{SM}
- How to Receive a Discount

Section 5:
Your Health Care Benefits

This section of your handbook explains the benefits covered by your PPO health care plan. These benefits include coverage for your hospital care and the services you receive from a physician. **Unless otherwise indicated, all benefits described below are subject to any deductibles, copayments, coinsurances or benefit maximums detailed in your Plan Provisions Appendix.**

Plan Deductible

The plan considers the **network rate** allowance for **medically necessary** services and supplies.

Services that are covered by the plan are payable after the annual **deductible** has been satisfied. Please see the Plan Provisions (APPENDIX C) for detailed information regarding the **deductible** amount.

The **deductible** is satisfied on a calendar year basis with expenses from January through December. Any expense applied toward the **deductible** during the last three months of the calendar year may be applied towards the **deductible** for the following year.

When an individual's coverage becomes effective during a calendar year, the **deductible** will apply only to expenses that are incurred after the **coverage effective date**.

Network co-pays and **prescription drug** co-pays <u>cannot</u> be used to satisfy the plan's calendar year **deductible**.

Out-of-Pocket Maximum Expense

This plan shares with you the expense for certain services. Your co-payment is the balance that you must pay of the covered charge for covered benefits when plan payment is at a percentage other than 100%.

This plan is designed to limit your out-of-pocket. The **out-of-pocket maximum** expense limits are for covered services rendered during each calendar year. Please see the Plan Provisions (APPENDIX C) for detailed information regarding your **out-of-pocket maximum** amount.

For services rendered during the remainder of the calendar year after a **covered individual** reaches their **out-of-pocket maximum** expense limit, this plan will pay 100% of the **reasonable and customary** charges for subsequent expenses.

Co-payments <u>not</u> included in the **out-of-pocket maximum** expense limit and <u>not</u> eligible for 100% payment even if the **out-of-pocket maximum** expense limit is met are:

- **Deductibles**
- Amounts over the usual, customary, and reasonable charges (UCR)
- Applicable Penalties
- Coinsurance or co-payments for **prescription drugs**
- Coinsurance for **inpatient** and/or **outpatient** psychiatric care and /or substance abuse care
- Office visit co-payments
- Coinsurance for services related to Temporomandibular Joint Syndrome
- Coinsurance for infertility drugs
- Hospital inpatient **co-pays**

Medical Necessity

A service that you receive from a medical provider must be medically necessary, or a specified preventive service, in order to be payable under your health care plan. The guidelines for determining medical necessity are specified in detail in the "Glossary of Health Care Terms" section of this handbook.

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

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

Health Management Services

The services outlined in this section of the plan are part of BCBS Health Management Services. Together, they ensure that you receive high quality, cost-effective care.

It is important to remember that this plan covers only those procedures, services, and supplies that are medically necessary unless otherwise specified. For a service to be covered it must be considered necessary for the diagnosis or treatment of an illness or injury and the care must be given at the appropriate level. In determining questions of reasonableness and necessity, consideration is given to the customary practices of physicians in the community where the service is provided.

Services which are NOT considered to be **medically necessary** include, but are not limited to:

- Procedures of unproven value or of questionable current usefulness.
- Procedures which could be unnecessary when performed in combination with other procedures.
- Diagnostic procedures which are unlikely to provide a **physician** with additional information when used repeatedly.
- Procedures which are not ordered by a **physician** or which are not documented in a timely fashion in the patient's medical record, or which can be performed with equal effectiveness at a lower level of care facility (e.g., on an **outpatient** basis).

For example, a medically unnecessary **hospital** admission would be one which does not require acute **hospital** bed patient care and could have been provided in a **physician's** office, **hospital outpatient** department, or lower level of care facility without reduction in the quality of care provided and without harm to the patient. Also, a **hospital** admission primarily for observation, evaluation, or diagnostic study which could be provided adequately and safely on an **outpatient** basis is considered to be medically unnecessary.

Case Management

Case management is a service designed to develop a quality plan of care. BCBS **nurses** will partner with you and your **physician** to coordinate your care. They will ensure that you receive high quality, cost-effective care by accessing your condition, evaluating your needs, and monitoring your progress.

If you are diagnosed with a serious **illness** or suffer a serious **injury**, a BCBS **nurse** will review your treatment plan with your **physician**, and will clarify questions that you may have regarding your treatment. You can contact a NGS **nurse** any time you have a question or concern regarding your treatment. The **nurse** will provide you with information about the treatment and will assist you in evaluating your options.

When the patient chooses to follow the recommendations made through case management, the plan may, at its discretion, cover additional expenses of alternative care and supplies when recommended by medical case managers.

If the **Plan Administrator** determines through case management that the treatment plan submitted is appropriate, then the Plan participant must follow this plan of treatment in order to receive benefits under this plan.

Hospital Benefits — Inpatient Care

For an approved hospital admission, your plan will cover the following inpatient hospital services. All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed in your Plan Provision Appendix.

Precertification of Hospital Admissions

A **hospital** stay can be a serious and expensive part of your course of treatment. This Plan has a special program, Pre-Certification of Services, to make sure that you are not hospitalized unnecessarily. If you are admitted to (or registered as a patient at) a **hospital** or a rehabilitation facility, whether for emergency treatment, elective non-emergency treatment, or maternity care in excess of 48 hours for normal deliveries or 96 hours for cesarean delivery, you or a member of your family should call NGS at the number listed on your medical identification card. The call should be made prior to the elective **hospital** admission. It is your responsibility to obtain Pre-Certification of Services.

BCBS **nurse** and your admitting **hospital** review your **inpatient** treatment plan before and during your hospitalization. The objective is to help you obtain all the information you need to make informed decisions. The BCBS **nurse**:

- checks medical necessity of the **hospital** admission and length of stay against generally accepted medical standards, and
- suggests alternative treatment settings, if appropriate.

You will be notified by mail of the approved length of stay. Additional days may be assigned based on medical necessity.

The final decision regarding treatment and hospitalization is yours. Maximum allowable Plan benefits are paid as long as these steps are followed prior to any **inpatient** hospitalization.

If you or a covered **dependent** are admitted to a **hospital** for any reason without prior approval:

- Contact BCBS by telephone within two business days of the admission. The contact may be made by you, a family member, or your **physician**.

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 must 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 considered general medical care:

- **Maternity and nursery care** — Coverage for obstetrical and maternity care includes delivery room costs and ordinary nursery care for a newborn during the mother's hospital stay. After the hospital stay, the newborn is covered as a dependent child, but **only if you add the child to your coverage within 30 days of birth.** Termination of pregnancy **is not covered** regardless of medical necessity.

- **Cosmetic surgery** — Admissions for cosmetic and reconstructive surgery are covered for the correction of birth defects, conditions resulting from accidental injuries or traumatic scars and the correction of deformities resulting from certain surgeries, such as breast reconstruction following a mastectomy.

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

Mental Health Care and Substance Abuse Treatment Days

All **inpatient** services (including partial hospitalization), intensive **outpatient** services, and **outpatient** psychiatric testing for **mental disorders** and/or substance abuse require pre-certification through BCBS. Please note that if pre-certification is not received for these services, benefits will not be payable.

Important: Inpatient mental health care and substance abuse treatment admissions are covered only if they meet BCBS severity of illness and intensity of service criteria. If you are not sure that the criteria will be met, please have your physician call the Blue Cross Blue Shield Mental Health Precertification Unit.

Benefits available under this Plan for the treatment of **mental disorders** and/or substance abuse are payable as described in Plan Provisions Appendix.

Care provided during a mental health or substance abuse treatment admission can include individual and group therapy sessions and family counseling.

Fully licensed psychologists with hospital privileges can be directly reimbursed for the following inpatient services:

- Psychological testing
- Individual psychotherapeutic treatment
- 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

Genetic Testing/Screening and Counseling

Genetic testing/screening is done to look for abnormalities in a person's genes, or the presence/absence of key proteins whose production is directed by specific genes.

Covered individuals must be referred by a **physician** to a **genetic counselor** before testing can occur. You will be asked to sign a consent form before the test is performed. Only one evaluation visit can initially be approved.

Genetic counseling, testing and/or screening is covered when **all** of the following conditions are met.

1. **Covered individual** is referred by a **physician** to a **genetic counselor** before testing
2. Informed written consent is obtained before and after testing/screening
3. The test has been proven valid (regulatory agency approval).
4. Factors exist to justify that a **covered individual** is at increased risk.
5. Knowledge of presence or absence of condition would directly affect medical care, where:
    a. the disease is treatable or preventable
    b. the test results will lead to a marked change in the intensity of surveillance/treatment of that disease.

NOTE: Tests commonly performed on amniotic fluid by a **physician** do not require genetic counseling.

Genetic testing/screening is performed:

1. to determine whether a person has a disorder caused by a genetic defect,
2. to determine whether a person is a carrier of a disorder caused by a genetic abnormality,
3. to determine a person's risk of developing a disease,
4. to predict response to therapy,
5. if there is a history of spontaneous abortions,
6. if a **covered individual** gave birth to a child with a **genetic disorder** or chromosomal abnormality,
7. if there is a family history of certain inherited disorders, or the **covered individual** has symptoms of certain inherited disorders and requires a **diagnosis**,

8. for a dependent child if there is an increased risk of developing a childhood malignancy,
9. for an adopted child(ren), where the family history is unavailable or unknown, for conditions that manifest themselves during childhood and for which preventive measures or therapy may be undertaken during childhood.

Genetic counseling, testing and/or screen may be covered for non-covered individuals when BRCA testing is required to assess the need for Prophylactic Mastectomies or Oophorectomies for a **covered Individual**.

All of the following criteria must be met:

1. the information is needed to adequately assess risk in the **covered individual**;
2. the information will be used in the immediate care of the **covered individual**;
3. the non-**covered individual's** plan (if any) will not cover the test (proof required).

NOT COVERED:

Routine, ongoing, or long-term genetic counseling

Genetic testing to determine the paternity of a child

Genetic testing to determine the sex of a child

Genetic testing to determine one's own genetic predisposition

General population screening for **genetic disorders** (example-cystic fibrosis)

Prenatal genetic screening undertaken with the intention of aborting the child

Genetic testing or screening in children or adolescents, except as provided

Genetic testing/screening for any individual who is not an eligible **employee** or **dependent** as defined in the section titled ELIGIBILITY of this plan

Genetic testing for:

Huntington's Chorea Disease,

Li-Fraumeni syndrome,

Melanoma and melanoma-associated syndromes, and

Ataxia Telanglextasaia-associated susceptibilities.

Surgical procedure and related expenses that are performed as a precautionary measure when there is no presence of cancer or other disease (e.g. preventative mastectomy)

Hospital Services and Supplies

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

- **Anesthesia** — Includes administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service.
- **Blood services** — Includes blood derivatives, whole blood, blood plasma and supplies used for administering the services beginning with the first pint of blood
- **Laboratory and pathology tests** — Includes laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service
- **Drugs** — Includes medicines prescribed and given during a hospital admission

- **Durable medical equipment** — Includes items such as oxygen tents, wheelchairs and other hospital equipment used during the hospital stay
- **Medical and surgical supplies** — Includes gauze, cotton and solutions used during the hospital admission
- **Prosthetic and orthotic appliances** — Includes items that are surgically implanted in the body, such as heart valves
- **Special care units** — Includes operating, delivery and recovery rooms

Your coverage includes the following diagnostic and radiology services:

- **CAT and MRI scans** — Covers scans of the head and body when required for eligible diagnoses and when performed in a facility approved by BCBS
- **Diagnostic tests** — Includes EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury
- **Therapeutic radiology** — Includes radiological treatment by X-ray, isotopes or cobalt for a malignancy
- **Diagnostic radiology** — Includes ultrasound and X-rays required for the diagnosis of an illness or injury

Hospital Benefits — Outpatient Care

The following services are covered when performed in the outpatient department of a participating hospital or, where noted, in a freestanding facility approved by BCBS. All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed in your benefits summary.

Emergency Room Care

You are covered for the treatment of accidental injuries or conditions that BCBS determines are medical emergencies.

- An **accidental injury** is physical damage caused by an action, object, or substance from outside of the body. This includes strains, sprains, fractures, cuts and bruises; allergic reactions, frostbite, sunburn and sunstroke; swallowing poisons and medication overdosing; and inhaling smoke, carbon monoxide or fumes.
- A **medical emergency** is a condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury.

Preadmission Testing

Preadmission testing is covered when performed in the outpatient department of a hospital within seven days of a scheduled hospital admission or surgery. These tests must be valid at the time of admission and must not be duplicated during the hospital stay.

Physical, Occupational and Speech Therapy

Your physical, occupational and speech therapy services are payable when provided in:

- The outpatient department of participating hospitals
- Participating outpatient therapy facilities

In addition, physical therapy services are payable in physicians' offices and offices of independent, licensed therapists.

Important: Payment for therapy is based on the diagnosis and the location. Ask your physician or therapist to call Blue Cross Blue Shield to verify if the treatment meets diagnosis requirements, and if the prescribed therapy will be rendered in a payable location before receiving therapy treatment.

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
- Speech and language pathology services to treat severe congenital disorders.

Your coverage does not pay for:

- Long-standing, chronic conditions such as arthritis
- Health club membership or spa membership
- Inpatient hospital admissions principally for speech or language therapy

Cardiac Rehabilitation

You have coverage for cardiac rehabilitation services. This benefit is payable if it is provided:

- In a hospital-based or freestanding (not owned or operated by a hospital) cardiac rehabilitation center
- By a licensed physician (M.D. or D.O.) or professionals working under the direct supervision of a licensed physician
- Within six months of a diagnosis of acute myocardial infarction, angina pectoris or a prior related professional cardiac service, including coronary artery bypass surgery, percutaneous transluminal coronary angioplasty, cardiac transplantation or heart valve surgery
- For physician prescribed exercises to cardiac patients during phases II and III of their cardiac rehabilitation treatment
- Within the 12 week total time allowed for cardiac rehabilitation

Phase II services include:

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

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

Outpatient Mental Health Care

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

Outpatient Substance Abuse Treatment

Your coverage includes outpatient substance abuse treatment provided at an approved substance abuse treatment facility.

Additional Hospital Services and Programs

Your coverage will pay the approved amount for the following services provided by a participating hospital or an approved facility, as indicated below. All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed in your benefits summary chart.

Chemotherapy

You may receive chemotherapy treatment in a hospital, in the outpatient department of a hospital or in a physician's office.

Benefits include the administration and cost of drugs when ordered by a physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration for use in chemotherapy and provided as part of a chemotherapy program, if the treatment is not considered experimental or investigative. Coverage includes three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.

Hemodialysis

Hemodialysis services to treat acute renal (kidney) failure and end stage renal disease are a benefit. Treatment may take place in the outpatient department of a hospital, in a licensed facility or in the home. Home hemodialysis must be arranged by a physician and services must be billed by a participating hospital that has an approved hemodialysis program. Coverage includes the cost of the equipment, installation, training and necessary hemodialysis supplies.

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

Home Hemophilia Program

The Home Hemophilia Program provides benefits for the necessary medications and supplies used to treat hemophilia in a home setting. All medications and supplies needed for the patient to *self-infuse* at home, including syringes, needles and the antihemophilic factor, must be supplied by a participating hospital. Benefits may also include training to the patient or a family member on how to inject the antihemophilic factor, when the training is provided through a participating hospital. Services are coordinated through the Individual Case Management Program and may not be subject to deductible and coinsurance.

Home Health Care

Your benefits include home health care visits when the patient is referred to and accepted by a participating home health care agency. A physician who submits a detailed treatment plan to the home health care agency and certifies that home health care is medically necessary must prescribe the services.

Home health care benefits include nursing services; physical, occupational or speech therapy; social service and nutritional guidance, medication, supplies and lab work.

Skilled Nursing Care

A convalescent care facility provides skilled, comprehensive inpatient care for either a short or extended period of time. Your coverage includes skilled nursing care in an approved skilled nursing facility, when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve.

Convalescent care benefits cannot be used for custodial care or care for mental deficiency, mental retardation, senile deterioration or cases in which the prognosis is unfavorable.

Human Organ Transplants

The following types of human organ transplants are covered when received at a participating hospital or, where noted, in a BCBS-approved transplant facility. All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed in your benefits summary chart.

Organ and Tissue Transplants

Benefits are payable for services and expenses for transplanting organs and tissues to an eligible recipient when performed in a participating facility. Coverage includes evaluation and surgical removal of the donated organ (including skin, cornea and kidney) from a living or non-living donor. These transplants are subject to the same guidelines as other PPO benefits.

Bone Marrow Transplants

Benefits for **allogeneic** bone marrow transplants are payable only when the bone marrow, peripheral blood stem cells or umbilical cord blood of another person is transplanted into the patient to treat the following conditions and is not considered experimental or investigational:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Aplastic anemia
- Beta thalassemia major
- Chronic myeloid leukemia
- Hodgkin's disease (relapsed and stage III or IV)
- Hurler's syndrome
- Myelodysplastic syndromes
- Myelofibrosis
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency disease
- Sickle cell disease (when complicated by stroke)
- Wiskott-Aldrich syndrome
- X-linked lymphoproliferative syndrome

Allogeneic bone marrow transplants are payable when the donor is an immediate relative (mother, father, sister, or brother) and has four of the six important genetic markers the same as the patient. **Donors outside of the immediate family must have five of the six important genetic markers the same as the patient.**

Note: Human leukocyte antigen genetic markers are specific chemical groupings of many body cells, including white blood cells used to detect the constitutional similarity of one person to another.

Your coverage also includes transplants of the patient's own bone marrow (**autologous**) and transplanting the patient's own peripheral blood stem cells when used to rescue a patient after receiving high doses of chemotherapy. The transplant cannot be considered experimental or investigational. **Only** the following conditions are covered:

- 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 (stage III or IV)
- Medulloblastoma
- Metastatic breast cancer (stage IV)
- Multiple myeloma
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Primitive neuroectodermal tumors
- Rhobdomyosarcoma
- Wilms' tumor

Payable benefits for bone marrow transplants include:

- High dose chemotherapy and total body radiation
- Blood tests on immediate relatives for evaluation as donors if the tests are not covered by the donor's plan
- Harvesting the marrow and peripheral blood stem cells if the donor meets specific genetic marker requirements for **allogeneic** bone marrow transplants; harvesting and storing the marrow and peripheral blood stem cells for a transplant intended to be performed within one year for **autologous** bone marrow transplants
- 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 simulating growth factors
- Hospitalization
- Services you receive as a donor of bone marrow and/or peripheral blood stem cells (e.g., infusion of growth stimulating factors, hospitalization, blood tests and harvesting as indicated above)

Note: We also will pay for similar services related to or for high dose chemotherapy, total body radiation, allogeneic or autologous bone marrow and peripheral blood stem cell transplants to treat conditions other than those listed above, if the services are not otherwise excluded from coverage as experimental or investigational. This benefit does not limit or preclude coverage of antineoplastic drugs when state law requires that these drugs, and the reasonable cost of their administration, be covered.

Your coverage does not pay for:

- Any services related to or for allogeneic bone marrow transplants or peripheral blood stem cell transplants when the donor does not meet the HLA genetic marker matching requirements

- Purging of or positive stem cell selection of bone marrow stem cells or peripheral blood stem cells
- Harvesting and storage costs of bone marrow or peripheral blood stem cells if not intended for transplant within one year
- Health care services provided by people who are not legally qualified or licensed to provide such services
- Services that are not medically necessary (see the “Glossary of Health Care Terms” section for definition of medically necessary)
- Any facility, physician or associated services related to any of the above exclusions
- Services that are experimental or investigational
- Services rendered to a donor when the donor’s health care coverage will pay for such services

Specified Oncology Clinical Trials

Covers antineoplastic drugs to treat stages II and III 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 state 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 and length of stay **must** be medically necessary and preapproved (**no** retroactive approvals will be granted).
- The services must be performed at a National Cancer Institute (NCI) designated cancer center (see the glossary for a definition of designated cancer center) or an affiliate of an NCI designated center.
- The treatment plan, also called protocol, **must** meet the guidelines of the Feb. 19, 1993, American Society of Clinical Oncology statement for clinical trials.
- The patient must be an eligible BCBS member with hospital/medical/surgical coverage.

Important: If the above requirements are not met, the services will not be a covered benefit and you will be responsible for **all** charges.

Covered Services

Covered services are payable when directly related to a bone marrow transplant, peripheral blood stem cell transplant, high-dose chemotherapy or total body radiation.

When preapproved by BCBS, the following services are covered:

- Allogeneic transplants (including syngeneic transplants when the donor is the identical twin of the patient)
  - Blood tests to evaluate donors (if not covered by the potential donor’s health plan)
  - 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. The registry’s bill must be submitted to us by the designated cancer center.
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell phereses) and storage of the donor’s bone marrow and peripheral blood stem cells for a transplant intended to be performed within one year (if not covered by the donor’s health plan)
  - Purging of, or positive stem cell selection of, bone marrow or peripheral blood stem cells
  - High-dose chemotherapy and total body radiation

- Infusion of bone marrow and peripheral blood stem cells

- Autologous transplants
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell phereses) and storage of the donor's bone marrow and peripheral blood stem cells for a transplant intended to be performed within one year (if not covered by the donor's health plan)
  - Purging of, or positive stem cell selection of, bone marrow or peripheral blood stem cells
  - High-dose chemotherapy and total body radiation
  - Infusion of bone marrow and peripheral blood stem cells
- Preapproved hospitalization in an intensive care unit, special care unit, or private room.

Your coverage does not pay for:

- Services performed at a center that is not an NCI designated center or an affiliate of an NCI designated center
- A hospital admission, a length of stay at a hospital, or any service that has not been **preapproved**
- Harvesting (including phereses) and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplantation within one year
- Any other services related to any of the above exclusions
- Items or services, such as investigational drugs, non-health care services and/or research management (such as administrative costs) that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)
- Services rendered as part of a protocol that does not meet the Feb. 19, 1993 ASCO guidelines
- Items that are 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, stationary, stamps, household products, household utilities including cell phone charges, maid service, baby-sitter or day-care services.

Specified Human Organ Transplants

Hospital care for specified human organ transplants performed during the transplant benefit period is covered in full when the transplant is preapproved by Blue Cross Blue Shield and received at a Trinity Health facility or a Blue Cross Blue Shield designated transplant facility. (For kidney, cornea, bone marrow and skin transplants, please reference your applicable benefit summary for program guidelines)

- Benefits apply only to transplants of the:
  - Liver
  - Partial liver (a portion of the liver taken from a cadaver or living donor)
  - Heart
  - Lung(s)
  - Lobar lung (transplantation of a portion of a lung from a cadaver or living donor)
  - Heart-lung(s)
  - Pancreas
  - Simultaneous pancreas-kidney

- Small intestine (small bowel)
- Combined small intestine-liver

- All payable human organ transplant services, except anti-rejection drugs and other transplant related prescriptions, must be provided during the benefit period that begins five days before the transplant surgery and ends one year after the surgery.
- Providers must submit a request to BCBS for preauthorization for all specified organ transplants before a transplant is performed. Authorization for the transplant surgery will be sent to the patient and the transplant facility or the patient's physician (whoever requests the preauthorization).

Note: Call a BCBS customer service representative to confirm a facility's participation status.

When directly related to the transplant we will pay for the following services. Benefits are limited to a $1 million maximum for each type of specified human organ transplant. This maximum is separate from the general lifetime maximum.

- Facility and professional services.
- Anti-rejection drugs and other transplant-related prescription drugs, as needed. Payment will be based on the amount we determine to be reasonable and necessary.
- Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition occurs **during** the transplant benefit period, and is a **direct** result of the organ transplant surgery. We will pay for 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 our certificates.
- Up to $10,000 for travel, meals and lodging directly related to preapproved services. We will pay the cost of transportation to and from the designated transplant facility for an adult patient and one companion eligible to accompany the patient (or two companions if the patient is younger than 18 or if the transplant involves a living related donor). As part of the $10,000 we will pay the reasonable and necessary costs of lodging for the companion(s) eligible to accompany the patient, and meals for the patient and companion(s) eligible to accompany the patient up to a combined maximum of $40 per day.
- The cost of acquiring the organ, which includes surgery to obtain the organ, storage of the organ and transportation of the organ and payment for covered services for a donor if the donor does not have transplant services under any health care plan. The total payment for all services combined for each organ transplant will not be more than the $1 million lifetime maximum.

Benefits are not payable for:

- Non-covered services
- Living donor transplants other than partial liver, lobar lung and kidney transplants that are part of a simultaneous pancreas-kidney transplant
- Anti-rejection drugs that do not have Food and Drug Administration marketing approval
- Transplant surgery and related services the patient receives in a nondesignated facility
- Transportation, meals and lodging costs under circumstances other than those related to the initial transplant surgery and hospitalization
- Any expenses incurred for transportation, meals and lodging after 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, stationary,

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

- Services prior to the patient's transplant surgery, such as expenses for evaluation and testing, if not covered by your hospital/medical/surgical coverage
- Experimental transplant procedures

Physician Benefits

You have coverage for the physician services described below.

Office Visits

Your benefits include visits to a physician's office, outpatient clinic or outpatient department of a hospital for the examination, diagnosis and treatment of general medical conditions. Services include medical care, consultations, medication and injections.

Preventive Services

You have coverage for the following preventive services.

- **Routine physical exam** — You have coverage for one routine physical per member, per benefit period, beginning at the age of 18.
- **Routine gynecological exam** — You have coverage for one routine gynecological exam per benefit period for female members, beginning at age 18.
- **Well childcare —** Your benefits include visits to a physician to monitor the development of a child up to and including the age of 17. Benefits are subject to the following frequency limitations:
  - seven exams in the first 12 months of life;
  - three exams in the second 12 months of life;
  - three exams in the third 12 months of life; and
- an annual physical examination thereafter.
- **Laboratory and screening services** — You have coverage for routine laboratory, diagnostic tests and X-rays related to a routine exam which include but are not limited to:
  - Chemical profile
  - Complete blood count (CBC)
  - Fecal occult blood screening
  - Urinalysis
  - Chest X-ray
  - EKG
  - Sickle cell test
  - TB test
  - PPD (purified protein derivative) test
  - Fasting glucose test
  - CRP (C-reactive protein) test
  - Digital rectal exam

- TSH (thyroid stimulating hormone)
- PFT (pulmonary function test)
- Bone density scan

- **Routine mammograms** — You have coverage for one routine mammogram (breast X-ray) for female members between the ages of 35 and 39. At age 40 and older, one mammogram per benefit period is covered. More frequent mammograms are covered as diagnostic services if requested by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.
- **Pap smear** — You have coverage for laboratory services for one routine pap smear, per benefit period for female members, beginning at age 18. More frequent pap smears are covered as diagnostic services for the following conditions:
  - Previous surgery for vaginal, cervical or uterine malignancy
  - Presence of a suspected lesion in the vaginal, cervical or uterine areas
  - Post-surgery
- **Prostate specific antigen screening —** Your coverage includes one PSA screening laboratory test for male members per benefit period, beginning at age 40.
- **Routine hearing exam –** You have coverage for one routine hearing exam per member, per benefit period.
- **Depression screening -** You have coverage for one depression screening per member, per benefit period, beginning at age 40.
- **Endoscopic procedures** (proctosigmoidoscopy, sigmoidoscopy, colonoscopy, etc.) The first endoscopic procedure, in-network, per calendar year is covered at 100% (routine or medically necessary).
- **Immunizations —** Your coverage also includes the following:

  Pediatric immunizations, which are currently recommended by the United States Center for Disease Control and Prevention, Advisory Committee on Immunizations Practices, American Academy of Pediatrics, and the American Academy of Family Physicians.

  Adult immunizations, including all of the recommended childhood immunizations and all adult immunizations recommended by the CDC and the ACIP.

Allergy Services

Allergy testing and therapy are covered when performed by or under the supervision of a physician. Services include scratch and puncture testing, allergy survey, allergy serum and therapeutic injections.

Chiropractic Services

Your benefits include the following chiropractic services:

- **Office visits —** Covers one per benefit period for established patients
- **Chiropractic Traction —** Number of payable visits is determined by your physical therapy benefit.
- **Chiropractic Manipulation —** Up to 20 medically necessary visits per calendar year.

Maternity Care

You have coverage for obstetrical services including delivery and pre- and postnatal care visits. The initial inpatient examination of the newborn also is covered when performed by a physician other than the delivering provider.

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

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Physician Emergency Care

Emergency care benefits cover physician services for the initial examination and treatment of accidental injuries and conditions determined by BCBS to be medical emergencies. These terms are explained in the "Glossary of Health Care Terms" section.

Inpatient Medical Care

While you are an inpatient, you are covered for an unlimited number of medical visits by a physician for general medical conditions that are not related to surgery or maternity care.

Inpatient Consultations

In complicated situations, the physician in charge of the case may consult another physician for assistance or advice about diagnosis or treatment. Necessary inpatient consultations are covered when the attending physician requests them.

Presurgical Consultation

A presurgical consultation can help you obtain additional information about the benefits and risks of your proposed surgery and inform you of any alternative treatments that may be available. X-rays and laboratory services your doctor may request will be covered according to the level of benefits outlined in this handbook.

The physician's recommendation does not affect the approved amount for the surgery. Whether or not the recommendation from the second physician favors surgery, **you make the final decision about the surgery**.

Surgery

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

- **Multiple surgeries** (two or more surgical procedures during one operative session) are subject to payment limitations:
  - When the surgeries are through **different** incisions, your coverage will pay the approved amount for the primary surgery (the procedure with the higher benefit payment), plus half the approved amount for any additional procedures.
  - When the surgeries are through the **same** incision, your coverage will pay the approved amount only for the primary surgery. (Physician payment for additional surgeries through the same incision is included in the amount paid for the primary surgery.)

  Note: Participating providers accept these approved amounts, less any required deductible, coinsurance and copayment for multiple surgeries as payment in full.
- **Laser surgery** is a benefit when the procedure is not considered experimental or investigative and the payment is not more than that allowed for conventional surgical procedures.
- **Breast reconstruction surgery is covered for**:
  - Reconstruction of the breast on which a 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

- **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 mastectomies.
- **Dental surgery** for the removal of impacted teeth or multiple extractions is covered only when the patient must be hospitalized for the surgery because a concurrent medical condition exists. The inpatient admission for the dental surgery must be considered medically necessary to safeguard the life of the patient.

Ambulatory Surgery Care

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

Technical Surgical Assistance

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

Anesthesia

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

Temporomandibular Joint Syndrome or Jaw-Joint Disorder

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

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

Other than the exceptions noted, benefits are *not* payable for reversible or irreversible medical or dental treatment of the mouth, teeth, jaw, jaw joint, 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 BCBS for approval **before** treatment begins.

Diagnostic and Radiation Services

All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed in your benefit summary chart.

- **Diagnostic radiology** — Benefits include outpatient diagnostic radiology services required for the diagnosis of an illness or injury when performed and billed by a physician. These services may be performed in the physician's office or in the outpatient department of a hospital. Covered services include ultrasound and diagnostic X-rays. MRI and CAT scans of the head and body also are covered when performed for an eligible diagnosis in approved facilities.

- **Laboratory and pathology services** — Laboratory and pathology services performed in the physician's office or in the outpatient department of a hospital and ordered and billed by a physician are covered. This benefit includes laboratory and pathology tests required in the diagnosis of an illness or injury.
- **Diagnostic tests** — Diagnostic tests performed in the physician's office or in the outpatient department of a hospital are covered when performed and billed by a physician. Covered tests include EKGs, EMGs, EEGs, thyroid function tests, and nerve conduction studies required in the diagnosis of an illness or injury.
- **Radiation therapy** — Radiation therapy performed in the physician's office or in the outpatient department of a hospital is covered when performed and billed by a physician. Covered services include radiological treatment by X-ray, isotopes, or cobalt for a malignancy.

Weight Management

The Plan provides for services as described below. For Plan coverage specifics please refer to the Plan Provisions Appendix.

COVERED BENEFITS:

All expenses related to the treatment of morbid obesity that are otherwise payable under the Plan will be considered allowable expenses (e.g. **surgery**, hospitalization, anesthesia, office visits for a **physician**, lab testing, psychotherapy, etc.; services will be payable as described in each respective section of this handbook). For purposes of determining these benefits, the Plan will base the determination of morbid obesity on the patient's Body Mass Index ("BMI") or overweight status. A BMI greater than 40, or more then 80 pounds overweight for a female or more than 100 pounds overweight for a male will be considered indicative of morbid obesity. A BMI greater than 35 but less than 40 will also be considered indicative of morbid obesity where the patient has one or more of the following co-morbid conditions that are either life threatening or which significantly impair a major life function (e.g., mobility, ability to work, ability to self care): severe sleep apnea, Pickwickian syndrome, congestive heart failure, cardiomyopathy, insulin-dependent diabetes or severe musculoskeletal dysfunction. Documentation of the medical treatment of the co-morbid conditions that demonstrates the patient meets these criteria must be provided.

Additionally, the Plan will review patient history for optimal candidacy for any proposed surgical treatment according to current, generally accepted medical practices. For example, this review will consider whether the patient has been unable to lose weight through non-surgical, conventional measures and whether the individual's ability to manage the surgical intervention and required post operative care has been assessed through a psychological evaluation.

The Plan will review if the patient has undergone a **physician** supervised nutrition, exercise and weight loss program for a minimum of six months, within the 12 months immediately preceding the proposed **surgery**, during which the patient was found unable to meet the **physician's** weight loss goals. Unsuccessful weight loss attempts and lifestyle changes will require documentation by medical office progress notes and a letter from the attending **physician** as to why non-invasive weight loss attempts are no longer a standard of care for the patient.

If confirmation is obtained from the attending surgeon that the program the patient will be under includes a complete support team with required follow ups, etc. a psychological evaluation is not required.

Other limitations include:

1. Appendectomies and cholecystectomies in conjunction with surgical treatment of morbid obesity will be considered incidental and not covered unless the individual has an existing condition that requires the additional surgical treatment.
2. Subsequent panniculectomy [**surgery** to remove loose skin] resulting from weight loss will be covered only if it is **medically necessary** as a result a documented history of treatment by a **physician** for related **illnesses** for a minimum of six months where the treated condition is no longer controlled through any other means.
3. Bariatric Surgical intervention beyond one course of treatment per lifetime.

NOTE: Please refer to the sections titled CONSULTATIONS, LABORATORY/PATHOLOGICAL TESTING, X-RAY AND X-RAY INTERPRETATION and OFFICE VISITS for information regarding coverage for consultations, laboratory/pathological tests, x-rays and office visits related to covered weight management procedures.

NOT COVERED:

Prescription drugs without prior authorization

Additional Benefits

Your coverage will pay the approved amount for the following additional benefits. All benefits are subject to any deductibles, copayments, coinsurances or benefit maximums detailed in your benefit summary chart.

Ambulance Services

Ground and air ambulance services required because of an injury or hospital admission are covered. Services must be medically necessary and prescribed by the attending physician. The patient may be transported to and from the hospital, between hospitals, and between hospitals and approved medical facilities. A licensed ambulance company must provide services. This benefit includes the equipment used, mileage and waiting time. Services provided by a fire department, rescue squad or other carrier whose fee is a voluntary donation are not covered.

Durable Medical Equipment

Benefits are covered for rental or purchase (whichever is less expensive) and repair of durable medical equipment appropriate for home use and prescribed by a physician. Examples of durable medical equipment are canes, wheelchairs and walkers.

The equipment must be medically necessary for the treatment of an illness or injury or used to improve the functioning of the patient's body. Equipment primarily for the comfort or convenience of the patient is not covered.

Prosthetic and Orthotic Appliances

Benefits are provided for external appliances to replace a missing part of the body or to correct any defect of form or function of the body. Benefits include temporary appliances, delivery, services and fitting charges.

These appliances must be prescribed by a physician and supplied by a fully accredited facility approved by the American Board of Certification in Orthotics and Prosthetics.

Adjustment or replacement of eligible appliances is payable only when required because of normal wear or growth or a change in the patient's condition. Examples of these appliances are braces and artificial arms and legs.

Prosthetic Appliances Following Mastectomy

Benefits are provided for an external breast prosthesis following a mastectomy when prescribed by a physician. Benefits cover two post-surgical forms and two post-surgical bras every benefit period. Replacements are payable only when required because of a significant change in body weight or when necessary for hygienic reasons.

Oxygen and Other Therapeutic Gases

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

Optical Services Following Cataract Surgery

Your benefits include the examination and fitting of one pair of contact lenses or eyeglasses when prescribed by a physician following cataract surgery. Cataract sunglasses are not covered.

Dental Services

Dental services and appliances required for the treatment of an accidental injury are covered. An external force must have caused the injury. Injuries resulting from biting or chewing are not covered.

Medical Supplies and Dressings

Your coverage includes medically necessary medical supplies and dressings that are used to treat a diagnosed condition.

Non-Surgical Weight Loss / Smoking Cessation Therapy

The plan will cover services for non-surgical weight loss treatment /smoking cessation therapy. These benefits are not subject to **deductible** and **out-of-pocket maximums**. Benefits are payable at 100% up to an annual maximum of $500 and include:

- Outpatient counseling or therapy
- Office visits rendered by a licensed physician for the treatment of weight loss / smoking cessation
- Lab services performed during a course of treatment, and
- Services for weight loss render by a Trinity Health Ministry Organization or national recognized programs such as Jenny Craig, Weight Watchers and LA Weight Loss

NOT COVERED:

- Services administered exclusively in a Web-based forum
- Pharmacotherapy and/or injection expenses associated with smoking cessation or weight loss, unless otherwise covered for an unrelated medical condition
- Charges for food and/or nutritional supplements, unless included in the initial program fee
- Charges for over-the-counter diet aids and/or smoking cessation aids
- Health clubs, exercise equipment
- Services and/or programs not approved in the United States
- Charges in connection with acupuncture, hypnotism, and/or biofeedback training

Private Duty Nursing

A professional nurse on a one-to-one basis covers private duty nursing when the patient's condition requires 24-hour, continuous skilled care. Non-skilled care or care provided by a nurse who ordinarily resides in the patient's home or is a member of the immediate family is not covered.

The services must be prescribed by a physician and provided by a registered nurse or licensed practical nurse. The attending physician must complete a certification statement each month the patient is under care.

Pain Management

BCBS considers pain management an integral part of a complete disease treatment plan. We provide coverage for the comprehensive evaluation and treatment of diseases, including the management of symptoms such as intractable

pain that may be associated with these diseases. Your health care benefits provide for such coverage and are subject to contract limitations.

Prescription Drugs

Prescription drugs that are necessary for the treatment of an **illness** or **injury** of a **covered individual** when prescribed by a **physician** are covered as described below. Drugs furnished during a **hospital confinement** will be payable as described in the section of this handbook titled HOSPITAL SERVICES AND SUPPLIES.

Prescription drugs purchased in a participating pharmacy are covered by the **prescription drug** benefit administered by Medco Health Solutions, Inc. The participating pharmacy will fill the prescription with a generic equivalent, unless a generic substitute is not available. For each new or refilled prescription, you simply pay the **copayment** or **co-insurance** shown in the Plan Provisions Appendix. When drugs are purchased at a pharmacy, the **prescription drug** program will allow up to a 34-day supply. If you need a brand name drug and a generic equivalent drug is available you will be charged the difference in ingredient cost between the brand and generic drug, in addition to the brand copayment.

Maintenance drugs (to treat long-term or chronic medical conditions) can be obtained by mail through the Medco Health Solutions, Inc. This program allows you to save money by receiving a 90-day supply of medication for a low copayment or co-insurance.

COVERED DRUGS:

The following are covered benefits unless listed as an exclusion below

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug.
- Insulin
- Needles and Syringes
- OTC Diabetic Test Strips and Lancets
- Retin-A through age 25
- Tazorac cream through age 25
- Zostavax from age 60
- Pediatric Fluoride Vitamins through age 13
- Legend Pediatric Fluoride Vitamin Drops up to a 50-day supply
- Inhalers, Assisted Devices
- Rhogam

TRADITIONAL PRIOR AUTHORIZATION:

- Retin-A/Avita/Altinac (cream only) age 26 and older
- Tazorac cream age 26 and over
- Growth hormones/Growth Hormone Releasing Hormones
- IVRU – Oral Contraceptives (except Emergency Contraceptives) for females only
- 91 day Pre-packaged Oral Contraceptives up to a 91-day supply for females only
- PDST (Preferred Drug Step Therapy) - For a list of drugs that require PDST, contact Medco customer service
- Transdermal and Intravaginal Contraceptives for females only
- Legend Anti-Obesity Preparations
- Erythroid Stimulants
- Myeloid Stimulants
- Platelet Proliferation Stimulants
- MS Agents
- Tysabri
- Interferons
- Xolair
- Provigil

Note: Drugs for cancer therapy and the reasonable cost of administering them are usually covered. The prescription plan may implement prior authorization rules to determine if the cancer therapy is eligible for coverage under the plan based on the plan rules. Certain off-label uses of cancer drugs may not be eligible for coverage under the plan if there is insufficient published evidence to determine the toxicity, safety and/or efficacy of the cancer therapy for the specific cancer it is prescribed to treat.

EXCLUSIONS:

- The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs".
- Non-Federal Legend Drugs
- Contraceptive jellies, creams, foams, devices, implants or injections
- Emergency Contraceptives
- Retin-A (except cream) age 26 and older
- Non-Sedating Antihistamines/Non-Sedating Antihistamine Combo Products(SPECs: Z2O, Z2Q)
- Zostavax through age 59
- Drug to Treat Impotency
- Mifeprex
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
- Allergy Sera
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.
- Over-the-counter smoking cessation drugs

DISPENSING LIMITS:

- The amount of drug which is to be dispensed per prescription or refill (regardless of dosage form) will be in quantities prescribed up to a 34 day supply.
- Thalomid limited to a 28 day supply.

If you or your **dependent** purchases a drug at a pharmacy that does not participate in the Medco Health Solutions, Inc. program, you or your **dependent** must pay for the prescription in full and submit a claim for reimbursement to Medco Health Solutions, Inc. You will be reimbursed the amount that would have been paid to the pharmacy minus the cash co-payment you would have paid at a participating pharmacy.

Your **prescription drug** co-payments are not eligible expenses in this plan and may not be applied to any **deductible** or **out-of-pocket maximum** expense limits.

NOTE: This plan does not coordinate benefits on **prescription drug** charges that are provided through Pharmacy Benefit Managers.

For questions related to your prescription drug plan, contact Medco Health Solutions Customer Service at 800-849-9080.

Individual Case Management Program (“ICMP”)

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

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

Note: Whenever possible, BCBS will identify more than one provider for services recommended in the plan. The patient and family then have the option to select the provider.

After reviewing the alternative benefit plan documents, the patient and family can decide whether or not to accept the plan. Participation is entirely voluntary.

Once the plan is implemented, participation will be canceled in either of the following situations:

The patient's condition no longer requires the extra benefits documented in the alternative benefit plan.

The total amount paid under the alternative benefit plan exceeds the amount that would be payable under the patient's regular facility coverage.

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

Hospice Care

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

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

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

Levels of Care

The hospice program provides four levels of care:

- **Routine home care** — 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** — Consists of nursing care services provided to patients during crisis periods to enable them to stay in their homes. Such care must be provided for a minimum of eight continuous hours per day.
- **Inpatient respite care** — Consists of short-term inpatient services to allow home care providers short periods of relief. Such care must be provided in an approved facility on a non-routine or occasional basis and in increments of five days or less in any 30-day period.

- **General inpatient care** — Consists of services for pain control and acute and chronic symptom management that cannot be provided in other less intensive settings.

PPO Exclusions and Limitations

In addition to the exclusions and limitations listed elsewhere in this handbook, unless otherwise stated, the following exclusions and limitations apply:

- 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 are not covered
- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location are not covered
- Custodial care, rest therapy and care in nursing or rest home facilities are not covered
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition, such as a heart condition, exists is not covered
- Treatment of temporomandibular joint syndrome and related jaw-joint problems by any method other than as specified in this handbook is not covered
- Any medical care, hospitalization or service provided **before** the effective date of coverage or **after** the coverage termination date is not covered
- Routine hospital outpatient care requiring repeat visits for the treatment of chronic conditions such, as diabetes is not covered
- 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 is not covered
- Items for the personal comfort or convenience of the patient are not covered
- Psychiatric services after determination that the patient's condition will not respond to treatment are not covered
- Psychological tests for vocational guidance or counseling are not covered
- Routine premarital or pre-employment exams are not covered
- Services and supplies that are not medically necessary according to accepted standards of medical practice are not covered
- Treatment of occupational injury or disease that the employer is obligated to furnish or otherwise fund is not covered
- Care and services received under another BCBS plan is not covered
- Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which the member is eligible are not covered. These services are not payable even if you have not signed up to receive the benefits provided by such government-sponsored programs. However, care and services are payable if federal law requires Medicare to be secondary.
- Cosmetic surgery solely for improving appearance, except as specified in this handbook, is not covered
- Treatment of a condition caused by military action or war, declared or undeclared, is not covered
- Services, care, devices or supplies considered experimental or investigative are not covered
- Services for which a charge is not customarily made; services for which the patient is not obligated to pay are not covered

- Dialysis services after 33 months of end stage renal disease treatment are not covered
- Services that are not included in the Employer's coverage documents are not covered
- Charges from a nonparticipating provider that are in excess of the BCBS approved amount are not covered
- Charges for hospital room accommodations over and above the hospital's regular charges covered by your medical benefits are not covered
- Transportation and travel except as specified in this handbook is not covered
- Preparation, fitting or procurement of hearing aids is not covered
- Eyeglasses or contact lenses and vision examinations for prescribing or fitting them (except for aphakic patients) or for soft contact lenses or sclera shells intended for use in the treatment of diseases or injury are not covered (except as specified following cataract surgery)
- Injections for cosmetic purposes are not covered
- Immunizations and vaccines required when traveling out of the country are not covered
- Charges for examinations required by school, camp, licensing or for any other regulatory purpose are not covered
- Hospital admission for weight control is not covered
- Testing more frequently than necessary is not covered
- Dental care and dental appliances except those specified in your Plan Provision Appendix are not covered
- Voluntary sterilization is not covered
- Experimental bone marrow transplants are not covered
- Charges for contraceptive pills, devices, implants and injections, unless **medically necessary**
- Artificial insemination, in-vitro fertilization, fertility drugs (refer to the section titled PRESCRIPTION DRUGS), or embryo transfer procedures are not covered.
- Acupuncture services are not covered
- Gender reassignment is not covered
- Services, care, treatment, and referrals rendered by the covered individual's family, including, but not limited to, the covered individuals' spouse, mother, father, grandmother, grandfather, in-laws, son, daughter, step-children or any person who resides with the covered individual are not covered
- Claims filed later than one year from the date the charge was incurred
- Charges incurred by a surrogate mother
- Termination of pregnancy (abortion)
- GIFT (Gacmete Intrafallopian Transfer), ZIFT
- Charges incurred as a result of committing an assault, felony or any illegal or criminal activity
- Services rendered for treatment of any injury or illness for which benefits are available under Workers' Compensation or Employer Liability Law, and such coverage must be purchased by law, whether or not such coverage is in force, and whether or not such benefits are received by the covered individual. Occupational illness or injury includes those as a result of any work for wage or profit.

Section 6:
Filing Claims

You may file claims for benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An "authorized representative" means a person you authorize, in writing, to act on your behalf. We will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

How to Submit a Claim

A claim must be filed before a benefit payment can be made. There are three (3) types of claims:

1. A “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.

2. An “urgent care claim” means a pre-service claim for medical care or treatment where the time periods for non-urgent predeterminations could seriously jeopardize your life, health, 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.

   If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, we will treat it as such. Absent a determination by your physician, we 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.

3. A “post-service claim” means all other claims that are not “pre-service claims” or “urgent care claims”.

You or your authorized representative generally must file claims in writing with your BCBS customer service office. Addresses are listed on the inside front cover of this handbook. You or your authorized representative may, however, file urgent care claims by telephone, facsimile or through the Web site. If you go to participating providers, you will generally not have to file claims because claims are submitted directly to BCBS for you. However, if you receive medical services or supplies from nonparticipating providers, or you receive care out of the country, you may be required to file your own claims. Please check with your provider to find out if the provider is going to submit a claim on your behalf.

If you need a claim form, contact your Employer or call a BCBS customer service representative.

To file a claim in writing, follow these steps:

1. Obtain an itemized statement from the provider that includes the following information:

   Name of the patient and the subscriber

   Contract number (from your ID card)

   Provider’s name and address

   Provider's federal tax ID number

   Description of services or supplies

   Diagnosis (nature of illness or injury)

   Date of each service or date each supply is received

   Dates of admission and discharge (if admitted to a hospital)

You may include cash register receipts, canceled checks or money order stubs with your itemized receipt, but they may not substitute for an itemized receipt.

Note: If you receive medical services out of the country, you will need to pay the bill and get an itemized receipt. Try to have all receipts written in English and U.S. currency amounts.

2. Complete a separate claim for each family member. Multiple services or supplies for the same patient may be attached to one claim.

3. Attach all itemized receipts and statements to the claim form. Make sure the subscriber's name and contract number from the BCBS ID card are on all receipts and attachments.

4. Review all claims to be sure they are accurate and complete. **Incomplete forms will cause your payment to be delayed.** Be sure to sign and date each claim. Always keep a copy of your claims and receipts because BCBS cannot return them to you.

5. Mail all claims to the address shown on the form. If you do **not** have a claim form, send the itemized receipt to your BCBS customer service office. Addresses are listed on the inside front cover of this handbook.

You or your authorized representative must submit pre-service claims (including urgent care claims) before you receive covered services. Post-service claims must be submitted as soon as possible after you receive covered services or supplies. Generally, if you submit post-service claims beyond the applicable filing limitation, they will be denied. The following filing limitations apply for most post-service claims:

- Twelve months after the date of service for hospital and other facility claim and claims for supplies.
- Twelve months after the date of service for doctor and other medical professional claims.

Explanation of Benefits ("EOBs") and Notification Letters

We will send you a letter to notify you of our decision regarding pre-service claims (including urgent care claims). However, if the claim is an urgent care claim, we may provide you our decision orally and then provide you a letter notifying you of our decision within three (3) days of our decision. With respect to post-service claims, we will send you an explanation of benefits statement after we have processed your claim, including a claim submitted directly to BCBS for you by a provider. The EOB shows you what services have been paid by BCBS and what, if anything, you owe. It is not a bill. Please check the EOB carefully to make sure that you received the services or supplies listed. It is very important that you notify us if you did not receive the services or supplies or if there are any discrepancies.

If your claim is denied, the letter or EOB will explain why all or part of the service or supply is not covered.

The letter or EOB will be given within the following timeframes, depending on the type of claim:

1. Urgent care claims - within 72 hours after receipt of your claim, unless you do not provide enough information for BCBS to determine what benefits are payable under the plan. If this occurs, we will notify you of the deficiency within 24 hours of receiving your claim. You will have a reasonable amount of time, not less than 48 hours, to provide the additional necessary information. We will notify you of our determination as soon as possible, but no later than 48 hours after the earlier of (i) our receipt of the additional information, or (ii) the end of the time period given to you to provide additional information.

2. Pre-Service Claims - within a reasonable time, but no longer than 15 days after receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond our control, but only if we notify you before the end of the first 15 days of the circumstances requiring the extension and the date by which we expect to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to us, but which otherwise fail to follow the procedures for filing pre-service claims, you or your authorized representative will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

3. Post-Service Claims **-** within a reasonable time, but no later than 30 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond our control if we notify you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which we expect to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

4. Ongoing Course of Treatment – if you are receiving an ongoing treatment (i.e., treatment over a period of time or a specified number of treatments) that has been previously approved by the Plan, any reduction or termination of the ongoing treatment is a claim denial. We will notify you within a reasonable time prior to the reduction or termination of services. If you request to extend urgent care beyond the approved period of time or number of treatments, we will notify you of its decision as soon as possible, but no later than 24 hours after receiving your claim, provided that your request was made at least 24 hours in advance of the end of the approved ongoing treatment. If you do not make your claim at least 24 hours before the expiration of the ongoing treatment, then the time frames for urgent care claims (discussed above) will apply. If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a pre-service or post-service claim, as applicable.

Online EOB

Online EOB statements provide the same information as paper EOB statements but allow you to view statements quickly and easily 24 hours a day, seven days a week. You can access your online EOB statements by visiting **hcbo.com**.

Online EOB statements allow you to view statements securely from any personal computer, search for statements by date or patient name, track benefit payments, and download or print statements.

Note: When you sign up to receive online EOB statements, you will no longer receive paper statements through the mail.

What to do if a Claim is Denied

If your claim is denied, in whole or in part, your notification letter or EOB will indicate the reason for the denial.

Your Right to Request Review of an Adverse Benefit Determination

Most questions or concerns about decisions we make on claims can be resolved through a phone call to one of our 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 we send to notify you that we have not approved a request for benefits.

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

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

All requests for review of adverse benefit determinations must be in writing, except requests for review of urgent care claims, which may be made orally. Normally, for all three types of claims, you must exhaust our internal review procedure 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. We must provide you with a written determination within 30 calendar days of our 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 us a written statement explaining why you disagree with our determination as set forth in the EOB statement or the letter we send notifying you that we have not approved your pre-service claim. 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 the EOB statement or the letter we send notifying you that we have not approved your pre-service claim . Mail your written request for review to the address found in the top right hand corner of the first page of your EOB statement or to the address in the letter we send notifying you that we have not approved your pre-service claim. We will respond to your request for review in writing within 30 days, unless we have notified you in writing that we need additional information to complete our review. If you agree with our response, it becomes our final determination, and the review ends.

2. If you disagree with our response to your level 1 appeal, you may then proceed to level 2. You must request level 2 reviews in writing no later than 30 calendar days after you receive our level 1 determination. You have not exhausted our internal review procedure (and, therefore, cannot initiate a civil action under section 502(a) of ERISA to obtain benefits) unless and until you have requested a level 2 review.

   Mail your request for a level 2 review to the address specified in the letter we send notifying you we have not approved your level 1 appeal.

   Again, please provide all documentation, records and comments that support your position. We will provide you a written determination within 30 days of receipt of your request for level 2 review, unless we notify you in writing that additional information is needed for us to complete our review. Our written level 2 determination will be our final determination.

3. If you disagree with our final determination, or if we fail to issue our determination at each level within the 30-day time frame or otherwise fail to comply with the review procedures for level 1 or level 2, 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 we must provide you with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a two-step process. We will issue our determination within 15 calendar days of receipt of your level 1 review request and within 15 calendar days of your level 2 review request. You still have 30 days after receipt of the level 1 determination to file your level 2 appeal.

2. If you disagree with our final determination, or if we fail to issue our determination at each level within the 15-

day time frame or otherwise fail to comply with the review procedures for level 1 or level 2, 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.

2. We must provide you with our decision as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of your request for review. All necessary information will be transmitted to you or to your authorized representative by telephone, facsimile or other available similarly expeditious method. If our decision is communicated orally, we must provide you or your authorized representative with written confirmation of our decision within two business days.

3. If you disagree with our final determination, or if we fail to issue our determination within 72 hours or otherwise fail 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. In writing, you may authorize another person, including but not limited to a physician, to act on your behalf at any stage in the standard internal review procedure.

b. We do not impose any review fees or costs.

c. Although we have set time frames within which to give you our final determination on all three types of claims, you have the right to allow us additional time if you wish.

d. We will provide you, 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 we will consider this information 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 that determination. The determination we make on review will be a new determination; the initial determination we made on your claim will not be afforded deference in the 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, we will consult with a health care professional who has appropriate training and experience in the medical field or specialty involved.

h. Upon request, we will identify the medical experts whose advice was obtained in connection with the adverse benefit determination, even if we did not rely on that advice in making the determination.

i. On review, we will advise you of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.

j. If we rely on an internal rule, guideline, protocol or other similar criterion in making the adverse determination, we will advise you and provide a copy of the rule, guideline, protocol or other similar criterion free of charge upon request.

k. If the adverse benefit determination is due to lack of medical necessity or to experimental treatment, or similar exclusion, we will advise you and provide an explanation of the clinical judgment free of charge upon request.

l. If your health plan provides for any voluntary appeal procedures beyond the level 2 review, we will advise you of those procedures in our level 2 response.

LEGAL ACTION

No legal action can be brought to recover any benefit under the Plan after 3 years from the date you have exhausted our internal review procedure.

Section 7:
Other Information

This section includes helpful information about these important topics:

- Coordination of benefits
- Subrogation and reimbursement
- No-fault auto coverage

Coordination of Benefits (“COB”)

COB is how plans coordinate benefits when you are covered by more than one health care or motor vehicle insurance plan or policy. Your Employer’s health care plan, which is administered by us, requires that your benefit payments be coordinated with benefit payments from another health care or motor vehicle insurance plan or policy for services and/or supplies that may be payable under either plan, so that payment responsibilities will be fair. If you are covered by more than one health care or motor vehicle insurance plan or policy, COB guidelines (explained below) determine which plan pays for covered services first. COB letters of inquiry, which request information about other plans, may be sent on an annual basis in order to keep our records up to date.

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

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

Guidelines to Determine Which Plan is Primary and Secondary

When both this plan, paying as secondary, and the primary plan have a preferred provider arrangement in place, payment will be made up to the preferred provider allowance available to the primary plan.

NOTE: For information regarding coordination with **Medicare**, please refer to the sections titled COORDINATION WITH MEDICARE and MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE.

IF THE CLAIMANT IS AN ACTIVE ASSOCIATE THIS PLAN WILL BE PRIMARY TO:

- a plan covering **the claimant** as a **dependent**,
- a plan covering the **claimant** as a **COBRA** participant,
- a plan covering the **claimant** as a retiree in another group health plan, or
- a plan covering the **claimant** as a **dependent** of a retiree in another group plan.

IF THE CLAIMANT IS THE SPOUSE OF AN ACTIVE ASSOCIATE THIS PLAN WILL BE PRIMARY TO:

- a plan covering the spouse as a **COBRA** participant.

THIS PLAN WILL BE SECONDARY TO:

- a plan covering the spouse as a retiree, or
- a plan covering the spouse as an active associate.

IF THE CLAIMANT IS THE CHILD OF AN ACTIVE ASSOCIATE THIS PLAN WILL BE PRIMARY TO:

- a plan covering the child as a **dependent** of the **associate's** spouse, provided the spouse is also an active employee, if the **associate's** birthday (day and month) is earlier in the year than the **associate's** spouse,
- a plan covering the child as a **COBRA** participant or a **dependent** of a **COBRA** participant,
- a plan covering the child as a **CHIP** participant; or
- a plan covering the child as a **dependent** of a retiree, or

If both parents have the same birth date, the coverage that has been in effect the longest will be primary for the **dependent** child.

THIS PLAN WILL BE SECONDARY TO:

- a plan covering the child as a **dependent** of the **associate's** spouse provided the spouse is also an active employee, if the **associate's** birthday (day and month) is later in the year than the **associate's** spouse.

Notwithstanding the above, when a **dependent** child is covered by more than one plan and there is a court decree, special rules apply.

IF THE CLAIMANT IS A CHILD OF AN ACTIVE ASSOCIATE AND A COURT DECREE DESIGNATES FINANCIAL RESPONSIBILITY OR ESTABLISHES WHICH PARENT MUST PROVIDE PRIMARY COVERAGE AND/OR THE ORDER OF PAYMENT, THIS PLAN WILL FOLLOW THE COURT DECREE

IF RULES ARE NOT ESTABLISHED THIS PLAN WILL PAY IN THE FOLLOWING ORDER -

- the plan that covers the parent who has custody of the child.
- the plan that covers the step-parent who has custody of the child.
- the plan which covers the parent who does not have custody of the child; or
- the plan that covers the step-parent who does not have custody of the child.

If there is a court decree that orders joint custody and does not determine primary status for benefit coverage, the plan's regular provisions establishing the primary status for children of active **associates** will apply.

IF THE CLAIMANT IS A COBRA PARTICIPANT IN THIS PLAN THIS PLAN WILL BE SECONDARY TO:

- a plan covering the **claimant** as an active associate,
- a plan covering the **claimant** as a **dependent** of an active associate,
- a plan covering the **claimant** as a retiree, or
- a plan covering the **claimant** as a **dependent** of a retiree.

If a **claimant** is covered by another plan as a **COBRA** participant then the primary plan will be the plan in effect the longest.

Notwithstanding the above, if a plan has no COB provision, it will always be primary

COORDINATION WITH MEDICARE

Active Associates or Dependents of Active Associates Eligible for Medicare Due to Age

If you are covered under this plan due to your or someone else's current employment with the Employer, and are also eligible for **Medicare** due to age, you may:

- continue your coverage under this plan (to the extent you remain eligible, of course) and defer enrollment in Medicare; or
- continue your coverage under this plan and also enroll in Medicare; this plan would be your primary medical coverage and Medicare would be your secondary medical coverage as long as your coverage under this plan is attributable to current employment with the Employer; or
- drop your coverage under this plan and enroll in Medicare, in which case Medicare would be your primary medical coverage.

Covered Persons Eligible for Medicare Due to Disability

This plan is primary and **Medicare** is secondary if you are eligible for **Medicare** by reason of disability (but not age), and your coverage under this plan is on account of your (or someone else's) current employment with the Employer. If coverage under this plan is not on account of current employment status with the Employer, and you are eligible for **Medicare** solely by reason of disability, **Medicare** is primary and this plan is secondary. Note that in this latter case – where this plan is secondary – this plan will deem you or your **dependent**, to be enrolled in **Medicare** Parts A, B and D even if you or your **dependent** have not so enrolled.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

This plan is primary and **Medicare** is secondary if you are eligible for **Medicare** solely **on the basis of End Stage Renal Disease (ESRD), are not eligible for** Medicare **by reason of age or disability,** and your coverage under this plan is on account of your (or someone else's) current employment with the Employer. However**, this plan is primary only during the first 30 months of such eligibility for Medicare benefits. This 30-month period begins on the earlier of:**

a. the first day of the month during which a regular course of renal dialysis starts; and
b. if you receive a kidney transplant, the first day of the month during which you become eligible for **Medicare**.

If you are eligible for **Medicare** solely on the basis of ESRD, you must be covered by Parts A, B and D. If you are not covered by Parts A, B and D, you must meet the Medicare Alternate Deductible. In addition, this provision does not apply if at the start of your eligibility for this plan you were already eligible for Medicare benefits and this plan's benefits were payable on a secondary basis.

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 Employer immediately. Please help us serve you better by responding to requests for COB information quickly. We will request updated COB information yearly. If COB information such as cancellation of other coverage, switching other coverage carriers or changes in custody or court ordered coverage for dependent children is not updated, claims could be rejected inappropriately or incorrect information may be sent to your health care providers.

If the information you provided on your latest COB letter of inquiry is more than one year old and a claim is submitted under your contract for your spouse or dependent children, the claim will be temporarily held. We will

send you a new letter of inquiry requesting information about other carriers. When you respond, we will update your record. Your claim will then be processed according to the appropriate COB rules.

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

Specific Information about Your COB

Your plan includes non-duplicative payment COB. This means:

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

Filing COB Claims to your Secondary Carrier

You must always (or must always have your health care provider) submit claims to your primary carrier first. Then your or your provider should submit a claim for the secondary balance to BCBSM. If your provider will not submit a secondary claim to BCBSM, then you can submit the claims as follows:

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

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

Subrogation and Reimbursement

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

- Your right to recover payment from them is transferred to the Plan.
- You are required to do whatever is necessary to help the Plan enforce its right of recovery.
- If you receive money through a lawsuit, settlement or other means for services paid under the Plan, you must reimburse the Plan. 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 Coverage

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

- Whether your auto coverage is coordinated or uncoordinated, your auto insurance carrier is primary.
- The Plan will be secondary to your no-fault auto insurance. BCBS will reject auto accident related claims received without proof of primary payment by the auto insurer.

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

Facility of Payment

Whenever payments which should have been made under the Plan in accordance with its provisions have been made under any other plans, the Plan shall have the right, exercisable alone and in its full discretion, to pay over to any organizations making such other payments any amounts it shall deem to be warranted in order to satisfy the intent of this coordination provision, and any amount so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan shall be fully discharged from liability.

Plan payments will be made to the provider whenever there is no evidence showing that the provider has been paid. If the provider has been paid and the **associate** authorizes payment to another individual, the Plan will pay that individual upon receipt of the **associate's** signed authorization.

If an **associate** dies, the Plan will determine payment of claims as follows:

- First, to any providers who have not received payment that would be due under the Plan;
- Second, the **associate's** spouse;
- Third, the **associate's** estate.

Reimbursement of Plan Payments

The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered person in a time of need, however, the Plan may pay covered expenses that may be or become the responsibility of another party, provided that the Plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

1. Assignment of Rights (Subrogation). The covered person automatically assigns to the Plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for any reason, including non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the plan to pursue any claim, right or cause of action that the covered person may have, whether or not the covered person chooses to pursue that claim. The covered person must cooperate with the Plan Administrator and Employer in any respect necessary or advisable to make, perfect or prosecute such claim, right or cause of action, and shall enter into a subrogation agreement with the Plan upon the request of the Plan Administrator or Employer. . By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Reimbursement. If the covered person receives any payment from any party, including an insurer or another group health program, for the same covered expenses, the Plan has the right to recover from, and be reimbursed by, the covered person for all Reimbursable Payments the Plan has paid and will pay from such payment, up to and including the full amount the covered person receives. By filing a claim for and/or accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider) under this Plan, a covered person is deemed to have consented to such right of reimbursement and to have agreed to cooperate with the Plan Administrator and Employer in any respect necessary or advisable to make, perfect or prosecute such claim, right or cause of action, and shall enter into a reimbursement agreement with the Plan upon the request of the Plan Administrator or Employer.

3. Equitable Lien and other Equitable Remedies. The Plan shall have an equitable lien against any right the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the Employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust), whether by judgment, settlement or otherwise, as a result of an exercise of the covered person's rights of recovery for the same covered expenses, up to the amount of the Reimbursable Payments (sometimes referred to as "proceeds"). The lien may be enforced against any party who possesses proceeds representing the Reimbursable Payments including, but not limited to, the covered person, the covered person's representative or agent; third party; third party's insurer, representative, or agent; and/or any other source possessing funds representing the Reimbursable Payments. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the **Plan Administrator**, the plan may reduce any future covered expenses otherwise available to the covered person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

   This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decisions entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S., 204 (1/8/2002); and Sereboff v. Mid Atlantic Medical Services, Inc., 126 Sup. Ct. 1869 (2006). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

   By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider) from the Plan, the covered person agrees that if he or she receives any payment from any third party as a result of an injury, illness, or condition for which benefits are paid by the Plan, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the covered person's fiduciary duty to the Plan.

4. Assisting in Plan's Reimbursement Activities. The covered person has an obligation to assist the Plan in obtaining reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) notify the Plan Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or a condition sustained by the covered person, (b) cooperate fully in the Plan's exercise of its rights to subrogation and reimbursement, (c) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan) or to prejudice the Plan's ability to enforce the terms of this provision, (d) sign any document deemed by the **Plan Administrator** to be relevant to protecting the plan's subrogation, reimbursement or other rights, and (e) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the **Plan Administrator** to enforce the Plan's rights. Failure to provide requested information may result in the termination of coverage under the Plan for the covered person or the institution of court proceeding against the covered person.

5. Overpayments. If a benefit payment is made to or on behalf of any person, who exceeds the benefit amount such person is entitled to receive in accordance with the terms of the Plan, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce, by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

This provision does not affect any other right of recovery the Plan may have with respect to overpayments.

Failure by a covered person to follow the above terms and conditions may result, at the discretion of the **Plan Administrator**, in a reduction from future benefit payments available to the covered person under the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan.

In the event that any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator or its delegate shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting benefits (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider) from the Plan, the covered person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

HIPAA Privacy Compliance

The Plan may have access to certain health information about you and your covered dependents. This information is necessary to administer claims and provide benefits under the Plan. The Plan understands and recognizes the confidentiality and sensitivity of your health information and is committed to protecting this information from inappropriate uses and disclosures.

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Trinity Health Corporation Welfare Benefit Plan (“Welfare Plan”) has adopted certain privacy policies and procedures related to the use and disclosure of your protected health information ("PHI"). You will receive a copy of the Welfare Plan's Notice of Privacy Practices (the "Notice") that outlines how and when the Plan can use or disclose your PHI as well as your rights and protections under the law. If there are material changes made to the Welfare Plan's practices and procedures regarding the use and protection of your PHI, you will receive a revised Notice. In addition, you may receive a copy of the Notice at any time by contacting the Welfare Plan's Privacy Officer at:

Trinity Health Corporation
34605 Twelve Mile Road
Farmington Hills, MI 48331

The Welfare Plan has appointed one or more individuals to oversee the Welfare Plan's compliance with the HIPAA privacy rules and to address complaints. If you have any questions about how the Plan protects your PHI and your question is not answered by reviewing the information in the Notice, if you would like more information about the Welfare Plan’s privacy practices or if you want to make a complaint about the Welfare Plan's privacy activities, contact the individual(s) identified in the Notice.

General Plan Information

Plan Name
The Medical Program under component Plan 504 of the Trinity Health Corporation Welfare Benefit Plan

Type of Plan
This plan is a welfare benefits plan providing medical benefits.

Plan Number
The plan number is 504.

Plan Administrators and Named Fiduciary
The **Plan Administrator**, named fiduciary and agent for service of legal process is Trinity Health, 34605 Twelve Mile Road, Farmington Hills, MI 48331.

Type of Administration:

Benefits under the Plan are self-insured. The following entity is responsible for the day-to-day administration of the Blue Cross Blue Shield of Michigan PPO health care plan option under the Plan described in this summary plan description, including claims processing:

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998
(866) 917-7537

The Blue Cross Blue Shield of Michigan PPO health care plan option under the Plan is effective as of January 1, 2008.

Employer Identification Number
The employer identification number for the Trinity Health is 35-1443425.

Cost of the Plan
You and your Employer share in the cost of providing Plan benefits for you and your eligible **dependents**.

Plan Year
January 1 – December 31.

PLAN IS NOT A CONTRACT OF EMPLOYMENT

Neither this **Summary Plan Description** nor the Plan constitutes or provides a promise or guarantee of employment or continued employment, to any **associate** of Trinity Health or of any participating employer. Nor do these documents change any such employment relationship to be other than employment "at will."

Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the **Plan Administrator's** office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the **Plan Administrator**, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated **Summary Plan Description**. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The **Plan Administrator** is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse or **dependents** if there is a loss of coverage under the Plan as a result of a qualifying event. You or your covered **dependents** may have to pay for such coverage. Review this **Summary Plan Description** and the documents governing the Plan on the rules governing your **COBRA** continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Designation of Fiduciary Responsibility

Trinity Health is the named fiduciary with respect to this plan, within the meaning of Section 402(a)(1) of ERISA. Trinity Health shall exercise all discretionary authority and control with respect to management of this plan, which is not specifically granted to another fiduciary.

Trinity Health may delegate certain of its fiduciary responsibilities under this plan to persons who are not named fiduciaries of the plan. If fiduciary responsibilities are delegated to any other person, except as otherwise required by ERISA, such delegation of responsibility shall be made by written instrument executed by Trinity Health a copy of which will be kept with the records of this plan.

Blue Cross Blue Shield has, by written instrument, been designated as the fiduciary for appeals of adverse benefit determinations for **post-service claims** and **pre-service claims** submitted to the plan. By making this designation, it is Trinity Health's intention that BCBS make final claim determinations and have final discretion in construing the terms of the plan with respect to final claim determinations.

Each fiduciary under this plan shall be solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon such other fiduciary by federal or state law. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsible remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary shall be liable with respect to a breach of fiduciary duty if such breach is committed before it became a fiduciary, and nothing in this plan shall be deemed to relieve any person from liability for his or her own misconduct or fraud.

Plan Modification, Amendment and Termination

Trinity Health, by a duly **authorized representative**, may modify, amend, or terminate the Plan at any time in its sole discretion.

Any such modification, amendment, or termination that affect covered individuals will be communicated to them. If the Plan is terminated, benefits will only be paid for claims incurred before the date of termination.

Administration of the Plan

The **Plan Administrator**, Trinity Health is required to supply you with this Summary Plan Description and to file various reports and documents with government agencies. In its role of administering this Plan, the **Plan Administrator** also may make rulings, interpret the Plan, prescribe procedures, gather needed information, receive and review financial information of the Plan, employ or appoint individuals to assist in any administrative function, and generally do all other things which need to be handled in administering this Plan.

The **Plan Administrator** shall have any and all powers of authority which shall be proper to enable him to carry out his duties under this Plan, including by way of illustration and not limitation (i) the powers and authority contemplated by the ERISA with respect to employee welfare plans, and (ii) full discretionary authority to make regulations with respect to this Plan not inconsistent with this Plan or ERISA and to determine, consistently therewith, all questions that may arise as to the status and rights of participants and beneficiaries and any and all other persons.

The **Plan Administrator** will determine eligibility for benefits under the Plan. The **Plan Administrator** has delegated fiduciary responsibility to BCBS. The Plan shall be governed by and interpreted according to ERISA and the Internal Revenue Code and, where not pre-empted by Federal law, the laws of the state of Michigan.

Plan Funding and Asset Distribution Upon Termination

The Plan is funded through the general assets of the Employer. In the event of Plan termination, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. If the Plan should be terminated, only claims incurred prior to the date of such termination would be paid by the Plan.

State of Michigan Disclosure Requirement

The Plan is a self-funded plan. **Covered individuals** in this plan are not insured. In the event this plan does not ultimately pay expenses that are eligible for payment under this plan for any reason, the individuals covered by this plan may be liable for those expenses.

The **Claims Administrator**, BCBSM, merely processes claims and does not insure that any medical expenses of individuals covered by this plan will be paid.

Complete and proper claims for benefits made by **covered individuals** will be promptly processed. In the event of a delay in processing, the **covered individual** shall have no greater right or interest or other remedy against the **Claims Administrator**, BCBSM, than as otherwise afforded by law.

Section 8:
Glossary — Health Care Terms

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.

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 BCBS maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles, copayments, coinsurance and sanctions are deducted from the approved amount.

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, and must have been approved as a BCBS provider. Approved facilities must be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

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 BCBS.

Associate – An individual who is a regularly scheduled benefit eligible associate as defined in your Employer's policy.

Authorized representative – A **physician** rendering the service for which a bill is submitted, (but not a designee of the **physician**) or a person who a covered **employee** or covered **dependent** has authorized in writing to act on his/her behalf. If the claim is an urgent care **pre-service claim**, the plan will consider a **health care professional** with knowledge of a **claimant's** medical condition as an **authorized representative**.

If a covered **employee** or covered **dependent** wish to authorize another person (*e.g.,* family member) to act on his/her behalf on matters that relate to filing of benefit claims, notification of benefit determinations, and/or appeal of benefit denials, he/she must first notify the **Plan Administrator** of such authorization by providing a completed Notice of Authorized Representative form. The Notice of Authorized Representative form can be obtained from Human Resources.

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

BCBS — Blue Cross Blue Shield

BCBSA — Blue Cross and Blue Shield Association, an Association of independent Blue Cross 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.

BCBSM — Blue Cross Blue Shield of Michigan, a nonprofit, independent company and 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.

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

Claimant – An eligible **employee**, a covered **dependent** or an **authorized representative**.

Claims Administrator – Your plan has different **Claims Administrators** based on the type of claim. The **Claims Administrator** for each type of claim is responsible for claim processing within the time periods listed for initial claims determination as well as for the final decision for any appeal filed in response to an **adverse benefit determination**. Each is independently, responsible for notifying you of the **adverse benefit determination**, based on the type of claim, as well as reviewing any appeal you may make. Your **Claims Administrators** are as follows:

Pre-service claims **and** post-service claims: **(Medical) BCBS, National Customer Service Center, Mail Code B455, 600 E. Lafayette Blvd., Detroit, MI 48226-2998, (866) 917-7537.**

Post-service claims: (Pharmacy) Medco Health Solutions, Inc., P.O. Box 14711, Lexington, KY 45012.

Each Claims Administrator **shall have final discretionary authority to construe the terms of the plan, for purposes of final claims determinations, for those** pre- **and** post-service claims **listed above for which they are designated as the** Claims Administrator**.**

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 on a small number of patients to determine what the side effects 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.

COB — Coordination of benefits, a program that coordinates your health benefits when you have coverage under more than one group health plan.

COBRA — Continuation coverage as required by the Consolidated Omnibus Budget Reconciliation Act of 1985.

COBRA Administrator – The organization responsible for administering COBRA continuation.

Aetna
Individual Billing Administration
151 Farmington Ave., MB 52
Hartford, CT 06156-7522
(800) 429-9526

Coinsurance — The percentage of the approved amount you are required to pay for covered services.

Colony stimulating growth factors – Factors that stimulate the multiplication of very young blood cells.

Copayment — The designated portion of the approved amount you are required to pay for covered services.

Covered individual – An eligible **employee** or **dependent** that is enrolled in the Trinity Health PPO Plan Effective January 1, 2008. (This includes only those people who qualify for enrollment as indicated in the section titled ELIGIBILITY of this handbook.)

Covered services — Services, treatments or supplies identified as payable in your Employer's coverage documents. 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 as a comprehensive cancer center, clinical cancer center, consortium cancer center or an affiliate of one of these centers.

Designated facility — A facility that BCBS determines to be qualified to perform a specific organ transplant.

Designated services – Services that BCBS determines only a noncontracted area hospital is equipped to provide.

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 exam and treatment of conditions resulting from accidental injury.

ESRD — End stage renal disease, 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 investigative — 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. BCBS 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 (BCBSA) 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.

Genetic Counselor – Health care professional with specialized graduate degrees and experience in medical genetics and counseling. It is the genetic counselor's role to provide information to the individual or family regarding the genetic disorder.

Genetic Disorder – A disease caused in whole or in part by a variation or mutation of a gene. **Genetic disorders** can be passed on to family members who inherit the genetic abnormally.

Health care professional – A **physician** or other **health care professional** licensed, accredited, or certified to perform specified health services consistent with state law.

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.

Hospital confinement – The period of time an individual spends in a **hospital** as an overnight bed patient (**inpatient**).
Illness – The condition of being sick or unhealthy as classified in the International Classification of Diseases (ICD-9).

Injury – A sudden, unexpected and unforeseen bodily harm that occurs solely through external bodily contact. (Strains and spasms are considered an **illness** rather than an **injury**.)

Late Enrollee – This is an associate in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the associate did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible associate or dependent may not be considered a Late Enrollee under certain circumstances. See the Special Enrollment Periods.

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.

Medically necessary — A service must be medically necessary in order to be payable by your health care coverage.

Medically necessary **hospital services** are those that are:

- For the treatment, diagnosis or symptoms of an injury, condition or disease
- Appropriate for the symptoms and consistent with the diagnosis
- Not mainly for the convenience of the member or health care provider
- Not generally regarded as experimental or investigative by BCBS

Medically necessary **physician services** are determined by physicians acting for their respective provider types and medical specialty, and are based on criteria and guidelines developed by physicians and other professional providers. Medically necessary physician services are those that are:

- Generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- Essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.
- 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.
- Determined by a physician or professional review according to generally accepted standards and practices, in the absence of established criteria.

- Based on standards of practice established by physicians, for BCBS payment purposes.

Medicare — Pays health care costs for eligible persons age 65 or older. Also pays for people younger than 65 diagnosed with end stage renal disease or entitled to Social Security or Railroad Retirement benefits because of a disability for at least 24 months.

Member — Any person eligible for health care services under the plan. This includes you as the subscriber and any of your eligible dependents listed in BCBS membership records.

Negotiated rate — In most cases, a simple discount arrangement.

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
- Design and use splints, ortheses (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-area hospital — A BCBSM panel or participating hospital that is more than 75 miles from a noncontracted area hospital. It is not in the same area as a contracted or noncontracted area hospital.

Out-of-pocket maximum – The maximum amount of out-of-pocket expenses you have to pay each calendar year for certain covered medical expenses. The limit varies based on your choice of providers.

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

Per claim — A provider's acceptance of the BCBS 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.

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, and coordination and general mobility.

Note: 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).

Physician — A medical doctor, doctor of osteopathy, doctor of podiatric medicine, doctor of dental surgery or doctor of medical dentistry**.**

Plan Administrator – Trinity Health, 34605 Twelve Mile Road, Farmington Hills, MI 48331.

Post-service claim – Any claim for a benefit under this plan that is not a **pre-service claim**. In other words, a claim that is a request for payment under the plan for covered medical services that a **claimant** has already received.

Preapproval — A process that allows you or your health care provider to know if we will cover proposed services before you receive them. If preapproval is not obtained before you receive certain services, they will not be covered.

Pre-service claim – Any claim for a benefit under this plan where the plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

- **Urgent Care Claim: A pre-service claim** may be an urgent care claim if it is for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the **claimant**; or jeopardize the ability of the **claimant** to regain maximum function; or in the opinion of a **physician** with knowledge of the **claimant's** medical condition, would subject the **claimant** to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim and the plan conditions receipt of the benefit for the service, in whole or in part, on approval in advance of obtaining medical care.

  A **health care professional** with knowledge of the **claimant's** medical condition may determine if a claim is one involving urgent care. If there is no such **health care professional**, an individual acting on behalf of the plan, applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine, may make the determination.

Prescription Drug – Those drugs approved by the Food and Drug Administration of the United States which require a written prescription by a physician or dentist and which bear the legend, "Caution: Federal law prohibits dispensing without a prescription."

Professional provider — A medical doctor, doctor of osteopathy, doctor of podiatric medicine, doctor of dental surgery, doctor of medical dentistry 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.

- **Trinity Health Facilities** – Trinity Health hospitals, facilities and satellite locations.
- **Network providers** – Hospitals, physicians and other licensed facilities or health care professionals who have contracted with BCBS to provide services to members enrolled in a PPO health care plan. Network providers have agreed to accept our approved amount as payment in full for covered services.
- **Nonparticipating (Out-of-network) providers** — Providers who are not part of the BCBS PPO provider network. Out-of-network providers have not signed participation agreements with BCBS agreeing to accept the BCBS payment as payment in full. However, nonparticipating professional providers may agree to accept the BCBS approved amount as payment in full on a per claim basis. However, because these providers are not a part of the PPO network, you must pay higher out-of-pocket costs.

Qualified Medical Child Support Order— A court order or court-approved settlement agreement that provides for health benefits for a child of a group health plan participant or enforces one of the mandatory provisions of state law regarding the provision of health insurance to minors in such cases. A QMCSO gives the child the same rights as an associate to receive benefits under a group health plan.

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.

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.

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.

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 associate or COBRA qualified beneficiary who signed the enrollment form for BCBS 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

Surgery – A cutting operation, suturing of a wound, treatment of a fracture, relocation of dislocation, radiotherapy (if used in lieu of a cutting operation) diagnostic and therapeutic endoscopic procedures, laser **surgery**, and injections classified a **surgery** under the CPT.

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.

TRICARE — A Department of Defense health care program for members of the uniformed services and their families. This includes members of the reserves and National Guard who are called to active duty and their families.

We, us, our – Used when referring to BCBS.

You and your – Used when referring to any person covered under the subscriber's contract.