MEBS
Better Decisions. Better Healthcare.

Tawas Area Schools

Medical Summary Plan Description (SPD) for

Non-Certified

Effective June 1, 1992

Revised November 1, 2012

About Your Self-Funded Medical Plan

Your employer may offer several different Plans. Provisions specific to your Plan are detailed in the following chart.

Effective Date	June 1, 1992 Revised February 1, 2010 Revised November 1, 2012 Coinsurance, Rx copay and Step Therapy
Plan Name	Tawas Area Schools Medical Plan
Group Number	138
Employer	Tawas Area Schools 245 West M-55 Tawas City, MI 48763 (989) 984-2250
Employer Identification Number (EIN)	38-6018192
Eligible Employees	Non-Certified with Wrap
Service Requirement	First of the month following date of hire
Minimum Hour Requirement	20 hours per week
Employee Contributions	This Plan requires employee contributions per contract
Open Enrollment Period	The month of September, October and November
Termination of Coverage	Date of termination
Dependent Child Eligibility	On the 26th birthday
Assignment of Benefits	Benefits may be assigned
Coordination of Benefits	This Plan coordinates benefits
Network	Blue Cross and Blue Shield of Michigan PPO
Network Provider Access	Services from a provider for which there is no PPO network, and services from a non-network provider in a geographic area of Michigan deemed a “low access area” by BCBSM for that particular provider specialty, are covered at the in-network benefit level. If you receive care from a non-participating provider, even when referred, you may be billed for the difference between our approved amount and the provider’s charge.

Underlying Plan	Blue Cross and Blue Shield of Michigan CB 15/20%
Prescription Drug Manager	Caremark
Benefit Administrator	MEBS, Inc. 3809 Lake Eastbrook Boulevard Grand Rapids, MI 49546 (800) 968-6327 or (616) 458-6327 Customerservice@mebs.com www.mebs.com
Benefit Period	January 1 through December 31
Plan Year	The records of the Plan are kept separately for each Plan Year. The Plan Year begins on July 1st and ends on June 30th.
Agent for Service of Legal Process	Tawas Area Schools 245 West M-55 Tawas City, MI 48763 (989) 984-2250

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Preventative Care Services		
Health Maintenance Exam (includes chest X-ray, EKG, cholesterol screening and other select lab procedures)	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological Exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap Smear Screening - laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered
Well-baby and Child Care Visits	100% (no deductible or copay) 6 visits, birth through 12 months 6 visits, 13 months through 23 months 6 visits, 24 months through 35 months 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and Childhood Preventive Services and Immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	Covered at 100% (no deductible or copay)	Not covered
Fecal Occult Blood Screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible Sigmoidoscopy Exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate Specific Antigen (PSA) Screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine Mammogram and related reading	100% (no deductible or copay), one per member per calendar year NOTE: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay	60% after deductible, one per member per calendar year NOTE: Not-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
Colonoscopy - routine or medically necessary	100% for routine colonoscopy (no deductible or copay) NOTE: Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay. One routine colonoscopy per member per calendar year	60% after deductible, one per member per calendar year

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services		
Office Visits	Covered - coinsurance required	Covered - 60% after deductible, must be medically necessary
Outpatient and Home Medical Care Visits	Covered - coinsurance required	Covered - 60% after deductible, must be medically necessary
Office Consultations	Covered - coinsurance required	Covered - 60% after deductible, must
Urgent Care Visits	Covered - coinsurance required	Covered - 60% after deductible, must be medically necessary
Emergency Medical Care		
Hospital Emergency Room	Covered - coinsurance required (copay waived if admitted or for an accidental injury)	Covered - coinsurance required (copay waived if admitted or for an accidental injury)
Ambulance Services - must be medically necessary	Covered - coinsurance required	Covered - 80% after deductible
Diagnostic Services		
Laboratory and Pathology Services	Covered - coinsurance required	Covered - 60% after deductible
Diagnostic Tests and X-rays	Covered - coinsurance required	Covered - 60% after deductible
Therapeutic Radiology	Covered - coinsurance required	Covered - 60% after deductible
Maternity Services provided by a physician		
Prenatal and Postnatal Care	Covered - 100% (includes covered services provided by a certified nurse midwife)	Covered - 60% after deductible (includes covered services provided by a certified nurse midwife)
Delivery and Nursery Care	Covered - coinsurance required	Covered - 60% after deductible
Hospital Care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies (NOTE: Nonemergency services must be rendered in a participating hospital.)	Covered - coinsurance required (unlimited days)	Covered - 60% after deductible (unlimited days)
Inpatient Consultations	Covered - coinsurance required	Covered - 60% after deductible
Chemotherapy	Covered - coinsurance required	Covered - 60% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered - coinsurance required (up to 120 days per calendar year per member)	Covered - 80% after deductible (up to 120 days per calendar year per member)
Hospice Care	Covered - 100% (up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically)	Covered - 100% (up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically)
Home Health Care - must be medically necessary	Covered - coinsurance required	Covered - 80% after deductible
Home Infusion Therapy - must be medically necessary	Covered - coinsurance required	Covered - 80% after deductible

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Surgical Services		
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	Covered - coinsurance required	Covered - 60% after deductible
Presurgical Consultations	Covered - 100%	Covered - 60% after deductible
Voluntary Sterilization	Covered - coinsurance required	Covered - 60% after deductible
Human Organ Transplants		
Specified Human Organ Transplants - in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800.242.3504)	Covered - 100%	Covered 100% - in designated facilities only
Bone Marrow Transplants - when coordinated	Covered - coinsurance required	Covered - 60% after deductible
Specified Oncology Clinical Trials	Covered - coinsurance required	Covered - 60% after deductible
Kidney, Cornea and Skin Transplants	Covered - coinsurance required	Covered - 60% after deductible
Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care	Covered - coinsurance required (unlimited days)	Covered - 60% after deductible (unlimited days)
Inpatient Substance Abuse Treatment	Covered - coinsurance required (unlimited days)	Covered - 60% after deductible (unlimited days)
Outpatient Mental Health Care - Facility and Clinic	Covered - coinsurance required	Covered - 80% after deductible
Outpatient Mental Health Care - Physician's Office	Covered - coinsurance required (mental health and substances abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician's office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay)	Covered - 60% after deductible
Outpatient Substance Abuse Treatment - in approved facilities only	Covered - coinsurance required (mental health and substances abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician's office) will be treated and processed like an office visit, subject to the fixed dollar office visit	Covered - 80% after deductible

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Other Covered Services		
Outpatient Diabetes Management Program (ODMP)	Covered - coinsurance required	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 60% after deductible
Chiropractic Manipulation Treatment and Osteopathic Manipulation Treatment	Covered - coinsurance required (up to a maximum of 24 visits per member per calendar year)	Covered - 60% after deductible (up to a maximum of 24 visits per member per calendar year)
Outpatient Physical, Speech and Occupational Therapy	Covered - coinsurance required (limited to a combined maximum of 60 visits per calendar year per member)	Covered - 60% after deductible (limited to a combined maximum of 60 visits per calendar year per member)
Durable Medical Equipment	Covered - coinsurance required	Covered - 80% after deductible
Prosthetic and Orthotic Appliances	Covered - coinsurance required	Covered - 80% after deductible
Private Duty Nursing	Covered - 50%	Covered - 50%
Prescription Drugs		
Copays:	Retail	Mail Order
Generic	$7.00	$14.00
Formulary	$35.00	$70.00
Non Formulary	$70.00	$140.00
Bio-Techs/Injectables	Covered	Covered
Contraceptives	Covered	Covered
Lifestyle Medications	Covered	Covered
	This plan requires 25% copay at pharmacies not in-network	
Step Therapy	Before filling your first prescription for some brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. If our records show you have tried the generic medication, we will authorize the prescription. If our records do not show you have tried the generic medication, you may have to pay the entire cost of the brand-name drug, or your doctor obtains prior authorization. This applies to both retail and mail order.	

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Member's Responsibility		
Deductibles	None	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year NOTE: Out of network deductible amounts also apply toward the in network deductible
Fixed Dollar Copays (Copays apply once the deductible has been met.)	None	None
Percent Copays (Coinsurance apply once the deductible has been met.)	50% of approved amount for private duty nursing; 5% of approved amount up to $750 per member, $1,500 two or more members each calendar year.	50% of approved amount for private duty nursing; 40% of approved amount for most other covered services.
Copay dollar maximums - applies to copays for all covered services - including mental health and substance abuse services - but does not apply to fixed dollar copays and private duty nursing percent copays.	$750 for one member, $1,500 two or more members, each calendar year	$5,000 for one member, $10,000 for two or more members each calendar year NOTE: Out of network copays also apply toward the in network maximum
Dollar maximums	None	None

Riders
XVA- Excludes benefits for voluntary abortion
MHP 2- Mental Health benefits

Dear Member:

We are pleased to provide you with this updated Summary Plan Description (SPD), which also serves as the Plan Document.

The Plan offers medical and, if indicated on the ***Summary of Benefits***, prescription drug benefits to eligible members. Since benefit plans can be technical and sometimes hard to understand, we have tried to describe your benefits in this booklet as completely as possible and in everyday language. This booklet includes:

- An ***About Your Plan*** section, which includes basic administrative information.
- **Eligibility** information that tells you when you are eligible and can enroll for coverage, who in your family is eligible, what you need to do to continue eligibility, when coverage ends and what you need to do when coverage ends.
- A ***Summary of Benefits***, which summarizes the benefits available through the Plan.
- **Detailed information** about the medical and, if indicated on the ***Summary of Benefits***, prescription drug benefits provided, including what is ***not*** covered.
- **Claims and appeals** information that explains how to file a claim, how benefits are coordinated with other coverage and third parties and what to do if your claim is denied.
- **General Plan information** that provides legally required information about how the Plan operates.
- **Definitions** of key terms used throughout this booklet.

If you have any questions about your benefits, you can view them online anytime, or contact the MEBS, Inc. customer service staff.

- MEBS office hours: 7:30 a.m. to 5:00 p.m., Monday through Friday
- MEBS toll-free phone: (800) 968-6327
- MEBS email: customerservice@mebs.com
- MEBS customer service fax: (616) 458-3495
- MEBS online: www.MyMEBS.com

- When you contact MEBS, be sure to provide your name and identification number.
- Be sure to keep your information on file with MEBS up to date. For example:
  - Notify MEBS (and your employer) as soon as possible if your home address changes.
  - Notify MEBS (and your employer) within 30 days of the date you gain or lose a dependent for any reason (for example, if you get married, divorced or have a child).
  - Send a copy of any Social Security Award letter and/or Medicare card to MEBS (and your employer) as soon as possible if you or a dependent becomes eligible for Social Security and/or Medicare.

The Plan is here to help you meet your health care needs. However, it is your responsibility to know what your benefits are and how to use them. Please read this booklet thoroughly and share it with your family members.

Sincerely,
MEBS, Inc.
3809 Lake Eastbrook Boulevard
Grand Rapids, MI 49546
(800) 968-6327 or (616) 458-6327
customerservice@mebs.com
www.mebs.com

Important Notice

This SPD/Plan Document is meant to help you understand Plan benefits as of the effective date listed in this booklet. This edition, which includes all changes since the last edition, replaces and supersedes any previous SPD/Plan Document.

Any reference in this booklet to a coverage not listed in this booklet does not apply. This document and supplemental documents, serve as the Plan's controlling legal documents. These documents are used to determine eligibility for benefits and to interpret the benefits described in this booklet. However, if there is any conflict or difference between this booklet and any official documents and/or policies, the official documents and policies will control.

The official documents under which this booklet is issued may be amended or discontinued at any time by the Plan Sponsor and Plan Administrator. The Plan Sponsor and Plan Administrator are authorized, at any time and on such basis as deemed appropriate, at their sole discretion, to amend, modify, add to or eliminate any provision or benefit from the Plan. Any changes may be made by formal Plan amendment, resolution and/or other methods that may be permissible. The Plan Sponsor and Plan Administrator also reserve the right to terminate the Plan, at any time and for any reason, under the conditions of the official documents and/or policies. You will be notified of any change in writing.

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Employee Eligibility

You are eligible for coverage as of the date:

- The Plan is in effect for your employer;
- You are in a class of employees eligible for Plan coverage;
- You are actively at work and meet the minimum hours per week and service requirements shown in the ***About Your Plan*** section, which are based on your collective bargaining agreement and your employer's personnel policies; **and**
- You complete an enrollment form authorizing your employer to deduct the required contribution amount from your paycheck, if applicable.

When you are eligible you will be asked to complete an enrollment form and authorize payroll deductions, if applicable.

When You First Become Eligible

Your eligibility is based on your eligible class and the service requirements for your class, as stated above.

You must complete an enrollment form ***within 30 days*** after the date you first become eligible for coverage. If you do not, you may not enroll for coverage until a later open enrollment period. However, you may be eligible for a special enrollment in certain situations; see the ***Changes in Status – Special Enrollment*** section for more information.

GINA provides that group health plans and health insurance issuers cannot adjust premiums or contribution amounts for a plan, or any group of similarly situated individuals under the plan, based on genetic information of one or more individuals in the group. GINA prohibits a plan from collecting genetic information (including family medical history) from an individual prior to or in connection with their enrollment in the plan, or at any time for underwriting purposes.

The Plan will not deny, limit or cancel health care coverage for you or your dependents based on genetic information.

Effective Date of Coverage

Your effective date of coverage is the date you meet the initial eligibility requirements for coverage (as described above). The Plan will not cover any expenses you and/or your dependents incur before this date.

Please note that no benefits will be paid until you submit a completed enrollment form.

Dependent Eligibility

In general, eligible dependents include your:

- ***Spouse,*** from whom you are not divorced or legally separated (a divorced or otherwise legally separated spouse may be considered your dependent if you are required by a court order or ruling to provide health care benefits).
- ***Dependent children,*** which include your natural children, stepchildren, legally adopted children (including children placed for adoption) or legal guardianship (a copy of the court order appointing guardianship must be submitted with the enrollment form) and any other children required to be covered by a Qualified Medical Child Support Order or other court order or ruling, who:
    - Have not reached age 26. See the ***About Your Plan*** section for the when coverage ends.
    - Are any age if they are totally and permanently disabled, either physically or mentally, as long as they became disabled before age 19 are incapable of self-sustaining employment. The children's disability must be certified by a physician.

      Note: If your dependent child is now eligible for coverage, but was not eligible before the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, you will be allowed to reenroll at the beginning of the new plan year after September 23, 2010.

      Note: If your dependent child is eligible for coverage as a full-time student but is unable to maintain full-time student status due to a medically necessary leave, his or her coverage may continue for up to one year or, if earlier, to the date on which coverage would otherwise end under the Plan.
- ***Principally Supported Children,*** including children who are not your or your spouse's offspring, but who:
    - Are related by blood or marriage;
    - Are not married;
    - Are under age 19 as of December 31;
    - Are a member of your household;
    - Are claimed as a dependent on your most recent federal income tax return or qualify in the current tax year for dependency status; and
    - You provided support for at least nine consecutive months before requesting the addition of the child. (Following this period, there is a 90-day waiting period for coverage to begin.) You must complete an enrollment and change form and submit a notarized affidavit stating the date principal support began.
- ***Sponsored Dependents,*** who are dependents who live with you or who are related to you by blood or marriage and who depend on you for more than half of their support, as defined by the U.S. Internal Revenue Code. You must submit and have an application approved by MEBS before a sponsored dependent is eligible for coverage.

Effective Date of Coverage

Your dependent's coverage will begin on the date your coverage begins, as long as you enroll your dependents at the same time you enroll. If you do not enroll your dependents when you are first eligible, you may enroll them during any later open enrollment period.

If you need to add a new dependent, you may do so. However, you must enroll your new dependent within 30 days of the date he or she first becomes eligible to have coverage. If you do not enroll your new dependent within 30 days, you must wait for an open enrollment period to enroll your new dependent.

Please note that no benefits will be paid until you submit a completed enrollment form for your dependents.

Enrollment

Open Enrollment

Each year the Plan has an open enrollment period. This is your opportunity to enroll yourself and/or your dependents for coverage. Your open enrollment period is listed in the ***About Your Plan*** section; in addition, your employer may let you know when this period is.

Identification Cards

Once enrolled, you will receive a Plan ID card from BlueCross BlueShield of Michigan (BCBSM). You will also receive a benefit verification card from MEBS and/or a prescription drug card from the pharmacy benefit manager, if applicable.

Your ID card contains important information, such as the effective date of coverage, your group number and the contract number. Please show your identification card(s) at the time of service.

Only you and your dependents may use the card. Don't lend your card to anyone else; this is illegal and subject to investigation for possible fraud. If you lose your card, you can still use your coverage, but you must report the loss immediately to your employer or MEBS.

Change in Status – Special Enrollment

In general, you may only enroll yourself and/or your eligible dependents when you are first eligible for coverage or during the open enrollment period. However, you may be eligible for a special enrollment due to:

- **Other Coverage Change.** If you decline enrollment for yourself and/or your dependents because you have other coverage, including Medicare, you may be eligible for a special enrollment when you and/or your dependents lose this other coverage. You must submit a written enrollment form and authorize payroll deductions, if applicable, within 30 days after the other health coverage ends. If you do not enroll within 30 days, you will have to wait until the next open enrollment period to enroll for coverage.
- **New Dependents.** If you have a new dependent due to marriage, birth, legal guardianship, adoption or placement for adoption, you may be eligible for a special enrollment for yourself and/or your dependents. You must submit a written enrollment form and authorize payroll deductions, if applicable, within 30 days of the marriage, birth, adoption or placement for adoption. If you do not enroll within 30 days, you will have to wait until the next open enrollment period to enroll for coverage.

- **Newborn children.** If you have a new dependent due to birth, your newborn is covered from the moment of birth. You must submit a written enrollment form and authorize payroll deductions, if applicable, within 30 days of the birth to have coverage continue for more than the first 30 days of life. You are eligible for a special enrollment for yourself and/or your dependents. If you do not enroll your newborn within 30 days, you will have to wait until the next open enrollment period to enroll for coverage.
- **State Children's Health Insurance Program (SCHIP) Coverage Change:** SCHIP provides free or low-cost health care services for eligible children. If your child is covered under this Program, you may be eligible for a special enrollment for yourself and your dependents when your dependent child loses this coverage or when you become eligible for a contribution subsidy for SCHIP coverage. You must submit a written enrollment within 60 days after the SCHIP coverage ends or of becoming eligible for the contribution subsidy. If you do not enroll within 60 days, you will have to wait until the next open enrollment period to enroll for coverage.
- **Medicaid Coverage Change:** If you or your dependent is covered under Medicaid, you may be eligible for a special enrollment for yourself and your dependents when you or your dependent loses Medicaid coverage or when you become eligible for a contribution subsidy for Medicaid coverage. You must submit a written enrollment within 60 days after the Medicaid coverage ends or of becoming eligible for the contribution subsidy. If you do not enroll within 60 days, you will have to wait until the next open enrollment period to enroll for coverage.

How Benefits Are Paid

Benefits are provided from two sources under the Wrap Plan:

- A high-deductible plan fully-insured through BlueCross BlueShield of Michigan (BCBSM) and
- This plan that covers benefits in the deductible portion of the BCBSM high deductible plan.

In a fully-insured plan, premiums are paid to an insurance company that then pays benefits. In a self-insured plan, benefits are paid from the organization's operating income, but MEBS is responsible for administering the benefit payments.

Most of your benefits are paid through the BCBSM portion of the plan. However, this Wrap Plan provides additional benefits, reimbursing certain expenses (such as your deductible and amounts over the BCBSM copayment) and some other expenses not covered by the BCBSM component. These combined benefits can be found in the ***Summary of Benefits***, and represent the *total* of covered expenses reimbursed.

If you have any questions or concerns about your benefits or EOB, contact MEBS:

- On the internet at www.mebs.com;
- By e-mailing Customer Service at customerservice@mebs.com; or
- By calling Customer Service at (800) 968-6327.

In-Network Providers

This Plan includes a network of participating providers administered by BlueCross BlueShield of Michigan (BCBSM). In-network providers include hospitals, doctors, specialists and other health care professionals who have negotiated rates with BlueCross BlueShield. These negotiated fees are generally less than the provider usually charges. Many health care providers in Michigan participate with BCBSM and accept the BCBSM allowed amount as full reimbursement for covered services.

You always have the final say about the providers you and your family use. While the amount you pay may vary, the same general range of services and treatments are covered. However, there are some benefits that are only covered when you use an in-network provider. These are shown on the ***Summary of Benefits***.

To use an in-network provider:

- Find an in-network provider near you by contacting MEBS or BCBSM by visiting their web sites at www.mebs.com or www.bcbsm.com. There is a wide range of providers available and they vary by location and type of practice or service.
- Choose an in-network provider and schedule an appointment. Since providers participating in the network change occasionally, check that the provider is in the network when you call to make your appointment.
- At the time of your appointment be sure to show your Benefit Verification card.

If you use an in-network provider, he or she will bill BCBSM directly; you need only pay the deductible and/or copayment amount. If you use an out-of-network provider, you may have to file your own claims and you will have to pay any amount that is more than the Plan's allowed amount.

Network Provider Access

MEBS follows the BCBSM guidelines regarding provider access unless otherwise specified in the ***About Your Plan*** section of this summary plan description.

How Your Medical Benefits Work

The Plan's medical benefits are designed to help protect you and your family against unexpected and/or large medical expenses. Medical benefits cover a wide range of services and supplies, including hospital, doctor and other health care expenses.

In general, this is how medical benefits work each benefit year:

- **Deductible.** The deductible is the amount of expenses that you and/or your dependents must pay before the Plan begins paying for certain covered services. The ***Summary of Benefits*** includes the deductible amount and when the deductible applies.
    - *Carry-Over Deductible Provision.* Although a new deductible applies each calendar year, some plans include a carry-over deductible provision. See the ***Summary of Benefits*** deductibles and copays section. Under this provision, expenses incurred and applied to a deductible in the last three months of a benefit year will also be applied toward the deductible for the next year. This may only occur if you do not have sufficient expenses before the last three months of the benefit year to meet your deductible for that year.
    - The annual deductible applies to each individual. With a family maximum, once it is reached, no further deductibles apply to any covered family member. For example, if your family's covered expenses reach the family maximum before you meet your individual deductible, you do not need to meet your individual deductible before the Plan begins to pay benefits for you.
    - Only expenses you incur for covered services, excluding copayments, apply toward meeting the annual deductible.
- **Copayment.** A copayment is a flat dollar or percentage amount you pay for certain covered services after you meet your deductible, if applicable. The ***Summary of Benefits*** includes information on when a copayment is required. The copayment is separate from the deductible, and your copayments do not apply toward your annual deductible.
- **Out-of-Pocket Maximum.** The Plan limits the amount of expenses you pay each benefit year for covered services. Once the copayment amounts you pay reach the annual out-of-pocket maximum, the Plan pays 100% of most covered services for the remainder of the benefit year. If there is a family maximum, once your family's expenses reach the family maximum, the Plan pays 100% for most covered services for all covered family members for the remainder of the benefit year.
    - Not all amounts you pay apply toward meeting your out-of-pocket maximum, for example, the out-of-pocket maximum does not include deductibles and certain copayments, such as for private duty nursing and non-covered services.
    - Some covered services may never be paid at 100%, even once you meet your out-of-pocket maximum, such private nursing.
- **Benefit Maximums.** Certain covered services are limited to a specific benefit maximum, which is the maximum the Plan will allow. Any maximums are listed on the ***Summary of Benefits***.

Pre-Authorization

Pre-authorization helps you receive quality care in a way that uses valuable health care resources as wisely as possible. To make it work, you need to become involved in the decisions about your care. Authorization is required as follows:

- **Pre-admission authorization** is required before admission for inpatient hospital services. In-network hospitals will take care of this for you. If an admission is not pre-authorized, the hospital or your physician must request a retroactive review before BCBSM will consider approving payment for the stay. However, with a retroactive review, you will not know before the admission if the care will be considered a covered expense.
- **Emergency hospital admission authorization** is required within 48 hours of an emergency admission. This will let you, your doctor and the hospital know the number of days approved, based on BCBSM's criteria for medical necessity.
- **Additional hospital days' authorization** is needed if your doctor asks to extend your stay in the hospital. The request should be made, by phone or in writing to BCBSM, within 48 hours of your scheduled discharge when possible. BCBSM will advise the hospital or your doctor if, based on medical necessity, the additional days are approved. If the additional days are not approved, you must pay for all charges, including physician and ancillary charges, related to the days that were not approved.

You are responsible for all charges resulting from an admission where services are not pre-authorized or where you were given written or verbal notice of denial of benefits before (or during) the admission.

Individual Case Management Program

The Individual Case Management Program (ICMP) can help you if you are diagnosed with a serious illness or injury. It is tailored to meet unique medical needs and is designed to give you and your family members' flexibility and direct involvement in how your health care is managed.

You must get approval from BCBSM before you can use the program. The payment of benefits will be based on a review of your medical status, current treatment plan, projected treatment plan, long-term cost implications and the effectiveness of care.

Eligibility for and termination of ICMP benefits are made on a case-by-case basis. The following medical conditions may be considered for ICMP:

- Pancreatitis;
- Major head trauma;
- Spinal cord injury;
- Amputations;
- Multiple fractures;
- Severe burns;
- Neonatal high-risk infants;
- Severe stroke;
- Multiple sclerosis;
- Amyotrophic lateral sclerosis;
- Acquired immune deficiency syndrome;
- Crohn's disease; and
- Cancer.

Medical Benefits

The following sections describe the medical benefits available under the Plan. Refer to the ***Summary of Benefits*** for information on what the Plan pays and all limits that apply.

Preventive Services

Preventive services are only covered when provided by in-network providers. Preventive services include:

- **Health maintenance exam**, which includes a comprehensive history and physical examination.
- **Gynecological exam**, which includes a history and examination.
- **Pap smear screening,** including laboratory services only. More frequent pap smears may be covered than listed on the ***Summary of Benefits*** under 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.
- **Well-baby and child care** to monitor the development and well being of children, as listed on the ***Summary of Benefits***.
- **Immunizations,** as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics, as follows:
  - Diphtheria, Tetanus and Pertussis (DTP) vaccine (up to five doses).
  - Measles, Mumps and Rubella (MMR) vaccine (up to two doses of each).
  - Tetanus immune globulin and antitoxin.
  - Polio vaccine (up to six doses).
  - Diphtheria toxoid (Dt).
  - Hepatitis B vaccine (up to three doses).
  - Chicken pox vaccine.
  - Influenza type B (HIB) (up to four doses).
  - Human papillomavirus (HPV).

  This list may be updated periodically; contact MEBS to ask about immunizations not listed above.

- **Adult Immunizations,** as recommended for adults by the Advisory Committee on Immunizations Practices (ACIP). The list of immunizations is updated periodically and a complete list can be found at www.cdc.gov or by contacting MEBS Customer Service. Covered immunizations include:
  - Flu Shots
  - Hepatitis A and B
  - Human papillomavirus (HPV) (between the ages of 19 and 26)
  - Meningococcal
  - Measles, mumps and rubella (MMR)
  - Pneumococcal
  - Tetanus, diphtheria and pertussis (if member's history of vaccination is uncertain)
  - Varicella
  - Zoster (for age 60 and over)
- **Fecal occult blood screening.**
- **Flexible sigmoidoscopy exam.**
- **Prostate Specific Antigen (PSA) screening.**
- **Chemical profile.**
- **Complete blood count.**
- **Urinalysis.**
- **Chest x-ray.**
- **EKG.**
- **Colonoscopy** routine or medically necessary (subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and/or copay)
- **Routine Mammography Screening** one per year (refer to the ***Summary of Benefits*** for limitations).

Physician Office Services

- **Office visits** for medical care, including therapeutic injections in a physician's office for examination, diagnosis and treatment of any disease or illness.
- **Outpatient and home visits** for medical care, including therapeutic injections in a patient's home or hospital outpatient department for examination, diagnosis and treatment of any disease or illness.
- **Office consultations** for medical care, including therapeutic injections in a physician's office for examination, diagnosis and treatment of any disease or illness.

Emergency Medical Care

- **Hospital emergency room services**, which include hospital and physician charges for the initial examination and treatment of accidental injuries and life threatening medical emergencies when an approved diagnosis is provided.
- **Urgent care center** visits for the examination, diagnosis and treatment of an illness or injury.
- **Ambulance services** by professional ground and air ambulance service to the nearest hospital qualified to treat the member's condition. Ambulance services must be medically necessary.

Diagnostic Services

- **Laboratory and pathology** for the examination of blood, tissue, urine and other body fluids.
- **Radiology**, which includes diagnostic and therapeutic x-rays, radioactive isotopes, cobalt, ultrasound and CAT scans of the head and body.

Maternity Services

- **Pre- and post-natal** physician or certified nurse-midwife care, including delivery, pre- and post-natal care of the mother and routine newborn nursery care during the mother's stay.

As required by the Newborn's and Mother's Protection Act of 1996, the Plan does not restrict benefits for any covered hospital length of stay in connection with childbirth for the mother and/or newborn child to less than 48 hours after a normal vaginal delivery or less than 96 hours after a caesarean section.

Hospital Care

- **Inpatient care** in a semi-private room, which includes meals, special diets and general nursing care for general medical conditions and hospital services and supplies.
- **Inpatient consultations** of a consulting physician in the diagnosis and treatment of a condition.
- **Chemotherapy**, which includes:
    - Chemotherapy provided in a hospital, outpatient facility or doctor's office.
    - Administration and cost of FDA-approved drugs if the treatment is not considered experimental or investigative.
    - Administration and cost of drugs that are FDA approved for treatment of a disease other than the disease for which it is being administered if:
        - The drug is ordered by a physician for treatment of a specific malignant disease
        - Current medical literature confirms the drug as effective for the specific malignant disease

        - The drug is recognized by oncology organizations as generally accepted treatment
        - You have given informed consent for the use of the drug for treatment.
    - Three follow-up visits within 30 days of the last chemotherapy treatment to monitor the effects of chemotherapy.

Alternative Hospital Care

- **Skilled nursing care** when the patient is suffering from or gradually recovering from an illness or injury. The patient's physician must prescribe skilled nursing care. Benefits are not payable for custodial care, care for senility or mental retardation.
- **Home health care** when a patient is referred to and accepted by a participating home health agency that provides medically necessary services. Services must be prescribed by the attending physician who certifies that the member is confined to the home due to illness as an alternative to hospital confinement. The services are available based on a 30-day period. The period may be renewed with certification from the physician. Covered services include:
    - Part-time skilled nursing care (full-time care is not included) provided by a registered nurse or a licensed practical nurse.
    - Medical care provided by a home health aide or nurse assistant under the direct supervision of a registered nurse.
    - Medical supplies other than drugs and medicines requiring a written prescription from a physician.
    - Rental of medical equipment (not to exceed the purchase price).
    - Physical therapy, occupational therapy, speech therapy, social service guidance and nutritional guidance provided by a participating home health agency.
    - Hospital services and supplies related to the injury or illness that required or would have required the hospital confinement and that would normally be provided by a hospital.

    Meals and general housekeeping services are not covered.
- **Hospice care**, which is care by an agency or facility that is primarily involved in providing care to terminally ill individuals so they may spend their final days at home or in an approved special hospice facility. A terminally ill individual is one with a life expectancy of six months or less as certified in writing by the attending physician. Hospice care is designed to replace inpatient hospital care. All hospice services must be arranged through a BCBSM-approved hospice provider to be covered. When a member is accepted into an approved hospice program, they are covered for up to 28 pre-hospice counseling visits. When elected, four 90-day periods are provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management). Covered hospice services include:
    - Physician services by a member of the hospice interdisciplinary team.
    - Nursing care provided by or under the supervision of a registered nurse.

- Medical social services by a qualified social worker under the direction of a physician.
- Counseling services provided to the terminally ill member, family members or other persons caring for the member at home.
- Medical appliances and supplies, including drugs and biologicals provided in relation to the pain management of the member's terminal illness.
- Durable medical equipment provided by qualified aides and homemaker services under the general supervision of a registered nurse.
- Home health aide services provided by qualified aides and homemaker services under the general supervision of a registered nurse.
- Physical therapy, occupational therapy and speech language pathology services provided for purposes of symptom control or to enable the member to maintain activities of daily living and basic functional skills.
- Bereavement counseling for the individual's family after the death.
- Hospice professional services for physician care when provided in relation to palliation and management of the terminal illness and related conditions. Benefits under this subsection are exclusive of physician services provided under the hospice program services.
- Home care services (refer to the ***Summary of Benefits*** for limitations).
- Facility inpatient services provided by a participating hospice inpatient unit provide occasional respite care when necessary to relieve family members or others caring for the patient and short term, general inpatient care when the member is admitted for pain control or symptom management (refer to the ***Summary of Benefits*** for limitations).
- *Hospice Exclusions and Limitations.* Hospice benefits do not include:
  - Services other than those furnished by the hospice program and provided primarily in connection with the diagnosis causing terminal illness.
  - Services of a hospice program other than the hospice program designated by the member, unless provided by arrangement made by the member's designated hospice program.
  - Services that are not part of the plan of care established by the hospice program.

Surgical Services

- **Surgery**, which includes all related surgical services, anesthesia and surgical assistance for the diagnosis and treatment of diseases and injuries.
- **Surgery-related pre-and post-operative medical care** by the surgeon.
- **Multiple surgeries** (two or more surgical procedures during one operation), subject to payment limitations:
  - When surgeries are through different incisions, the approved amount is paid for the primary surgery (the procedure with the higher benefit payment) and one half of the approved amount is paid for any additional procedures.

- When surgeries are through the same incision, the approved amount is paid for the primary surgery only.

- **Voluntary sterilization** for both male and female patients regardless of medical necessity (refer to the ***Summary of Benefits*** for any limitations that may apply).
- **Cosmetic or reconstructive surgery** for the correction of birth defects, functional abnormalities resulting from accidental injuries, correction of deformities resulting from severe trauma or cancer surgeries, such as breast reconstruction following mastectomies.

As required by the Women's Health and Cancer Rights Act of 1998, reconstructive surgery after a mastectomy is covered the same as any other medical and surgical benefits, including:

- All stages of reconstruction of the breast on which the mastectomy is performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthetic devices and treatment of physical complications at all stages of the mastectomy, including lymphedema (swelling associated with removal of lymph nodes).

Human Organ Transplant

Specified human organ transplants are covered in designated facilities only. These are coordinated through the BCBSM Human Organ Transplant Program ((800) 242-3504) or you can contact MEBS for more information.

- **Liver, heart, lung, pancreas and heart-lung** transplants, which include:
  - Procurement, surgical storage and transportation costs of donated organs.
  - Anti-rejection drugs.
  - Transportation to and from the transplant facility (including travel expenses for an additional person when a living organ donor is involved).
- **Kidney, cornea, skin and bone marrow transplants**, which includes:
  - Services and expenses for transplantation of organs and tissues when performed in an in-network facility.
  - Evaluation and surgical removal of the donated part from a living or non-living donor.
- **Allogenic bone marrow transplants** are payable only when the bone marrow of another person is transplanted into the patient for specific conditions.

Other Services

- **Allergy testing and therapy**, including scratch and puncture tests, ultrasound and radiotherapy treatment and injections.
- **Chiropractic spinal manipulation, cervical traction and other modalities** as listed on the ***Summary of Benefits***.
- **Outpatient physical, speech and occupational therapy** provided for rehabilitation. Therapy must be:
  - Prescribed by a physician.

- Given under the supervision of a physician or by an appropriate licensed therapist.
- Given for a condition expected to improve within a reasonable and generally predictable period of time.

Examples of covered therapy include, but are not limited to:

- Physical therapy prescribed to restore the use of legs.
- Physical therapy used to accelerate the healing of an acute injury or illness involving muscles or joints.
- Speech therapy to restore speech following a stroke.

Therapy benefits are not payable for:

- Long-standing, chronic conditions, such as arthritis.
- Health club or spa memberships.
- Developmental conditions or learning disabilities.
- Congenital or inherited speech abnormalities for members over age six.
- Inpatient hospital admissions principally for speech or language therapy.
- Inhalation therapy and hyperbaric oxygenation therapy.

- **Durable medical equipment**, which includes the reasonable charge for rental or purchase of durable medical equipment prescribed by a physician for the basic equipment plus medically necessary special features.
- **Prosthetic and orthotic appliances**, which include the reasonable charge for external prostheses and orthotic appliances prescribed by a physician. The device must be furnished by a supplier fully accredited with the American Board for Certification in Orthotics and Prosthetics.
- **Private duty nursing** when the patient's condition requires 24-hour continuous skilled nursing care by a registered nurse on a one-to-one basis. Services must be prescribed by your physician and provided by a registered or licensed practical nurse. Your physician must complete a ***Certification Statement*** for each month that private duty nursing care is required. Non-skilled nursing care or care provided by a nurse who ordinarily resides in a patient's home or is a member of the immediate family is not covered. Although a physician must prescribe private duty nursing, it does not guarantee payment.
- **Diabetes coverage**, in compliance with Michigan laws that require coverage for certain diabetic prescription drugs, supplies, equipment and self-management training. Services must be medically necessary and prescribed by an M.D. or D.O. Benefits include:
  - Syringes and needles for insulin purposes only.
  - Test strips for glucose monitors.
  - Visual reading and urine testing strips.
  - Lancets.
  - Spring-powered lancet devices.

- Insulin pumps and medical supplies required for the use of the pump.
- Blood glucose monitors and blood glucose monitors for the legally blind.
- Outpatient diabetes management, which is an interactive self-management program and collaborative process involving patients with diabetes, their physicians and certified diabetes instructors. Appropriate training should provide members with the knowledge and skills needed to care for themselves on a day-to-day basis, manage diabetic crises and make any lifestyle changes needed to manage the disease successfully. Outpatient self-management and training services may be covered only if the physician who is managing the member's diabetic condition certifies that such services are needed.

Mental Health and Substance User Disorder Treatment

- **Inpatient mental health and substance use disorder care** when provided in approved day or night care centers, including:
  - Services provided by facility staff.
  - Prescribed medications.
  - Electroshock therapy administered by or under the supervision of a physician.
  - Psychological testing.
  - Individual and family counseling.
- **Outpatient mental health treatment** when provided in an approved facility or by a physician or fully licensed psychologist, including individual and group therapy, psychological testing, convulsive therapy treatment and family counseling.
- **Outpatient substance use disorder treatment** provided in an approved facility or by a physician or fully licensed psychologist.

See the ***General Plan Exclusions and Limitations*** section for information on what is not covered.

Prescription Drug Benefits

Prescription Drug Benefits can play an important role in your overall health. The Plan provides prescription drug benefits through a pharmacy benefit manager, which offers a:

- Retail pharmacy program, for your short-term medication needs; and
- Mail order program, for your long-term, maintenance medication needs. Maintenance drugs or medications are medications that are prescribed for longer than 90 days at a time and that are typically used to treat lifelong or chronic conditions.

With the cost of prescription medications rising faster than many other health care expenses, prescription drug benefits include cost-saving features, including a:

- Generic drug requirement; and
- Formulary/Preferred Medications.

Generic Drug Requirement

Many prescription drugs have more than one name; a generic name and a brand name. By law, both generic and brand name medications must meet the same standards for safety, purity and effectiveness. A generic usually serves the same purpose as the original medication, because it is simply a brand name medication that is no longer protected by a patent. This means it costs less because you aren't paying for the original research costs to develop the medication or the brand name advertising and packaging.

With the generic drug requirement, with the exception of insulin, all prescriptions will be filled with a generic equivalent. This does not apply if there is no generic equivalent available for your medication, if your doctor indicates "Dispense as Written" (DAW) on the prescription or if you specifically request the brand name medication. However, if you ask for the brand name medication, you may pay more.

When your doctor indicates DAW, you may be responsible for the difference in cost between the brand name medication and the generic equivalent in addition to paying your brand name drug copayment; refer to the ***Summary of Benefits***.

Formulary/Preferred Medications

Often several types of medications can be used to treat the same condition. To ensure high quality care and to help manage costs, the Plan's pharmacy benefit manager has a list of preferred brand name medications, known as a formulary. Medications on the formulary list are selected based on their medical effectiveness and cost. The medication *must* be clinically equivalent or superior to the alternative medication in the same category of drugs. This list is subject to change; so check with your pharmacy benefit manager for the most up-to-date listing.

Covered Expenses

Covered prescription medications include:

- Medications that must, by federal law, bear the legend "CAUTION: Federal law prohibits dispensing without a prescription."
- Compound medications of which at least one ingredient is a federal legend drug.
- Injectable insulin, including needles and syringes.
- Other medications that, under applicable state law, may only be dispensed upon prescription by a physician.

Types of medications that may be covered include:

- Generic drugs or medications, which are medications that are produced by more than one pharmaceutical company.
- Brand name drugs or medications, which are medications under patent with the Food and Drug Administration (FDA) and only manufactured by one pharmaceutical company.
- Multisource drugs or medications, which are medications that are available as generic and brand name medications.

Refer to the ***Summary of Benefits*** for information on what the Plan pays and all limits that apply.

Retail Pharmacy Program

The retail pharmacy program is designed to help you meet your short-term prescription needs. Prescriptions filled through the retail pharmacy program are limited to a 34-day supply or 100 capsules at one time.

Through the Plan's pharmacy benefit manager, you have access to a network of retail pharmacies (participating pharmacies) where you can have your prescription filled at negotiated rates. A listing of participating pharmacies is available from your employer or MEBS.

When you are eligible, you receive a prescription drug Benefit Verification card. When you have a prescription filled at a participating pharmacy, simply show your Benefit Verification card along with your prescription and pay your copayment. The Plan pays the rest. The amount you pay depends on the type of medication as shown on the ***Summary of Benefits***. Please note that if you have prescription drug coverage under more than one plan, generally the pharmacy will charge you the lowest copayment amount.

When you use your prescription drug Benefit Verification card to have your prescription filled at a participating pharmacy, benefits are automatic, and you do not need to file a claim. If you have your prescription filled at a non-participating pharmacy, you must pay for the prescription when you pick it up and then file a claim for reimbursement (see the ***Prescription Drug Claims*** and ***Claims and Appeals*** sections for more information).

Mail Order Program

If you have a chronic condition (long-term illness) that requires the same medication for a long time (i.e., diabetes or high cholesterol), using the mail order program can save you time and money. Through the mail order program, you can have up to a 90-day supply of medication filled at one time. Plus, your doctor can authorize up to three refills. Copayment amounts are listed on the ***Summary of Benefits***.

For more information about using the mail order program, refer to the materials provided by the pharmacy benefit manager.

Prescription Drug Claims

If you do not have your prescription filled at a participating pharmacy and need to file a claim, be sure to have your pharmacist provide you with an itemized statement/receipt indicating:

- Your name and contract number;
- The full name of patient for whom the prescription was filled;
- The pharmacy's name, address and telephone number;
- The prescription number;
- The prescription quantity and number of days supplied;
- A description of the medication, including the strength of the drug; and
- The price of the prescription.

Prescription drug claims should then be filed the same as any other claim, as shown in the ***Claims and Appeals*** section, and will be processed as post-service claims.

Exclusions and Limitations

In addition to exclusions and limitations listed elsewhere in this booklet, no payment will be made for the following items unless indicated in the ***Summary of Benefits***:

- Drugs costing less than the required copayment.
- Drugs requiring a prescription by state law, but not federal law.
- Drugs that are experimental, investigative or not FDA approved for the condition they are being prescribed.
- Any medication that is consumed at the time or place of the prescription order.
- Administration of drugs.
- More than a 34-day supply, except for specified maintenance drugs that are covered in 100-unit doses or through the mail order program, if applicable.
- Refills not authorized by a physician.
- Refills dispensed after one year from the date of the original prescription.

- Medications covered by workers' compensation or available without charge from any government program.
- Medications provided while an inpatient or outpatient and covered under medical benefits.
- Cosmetic medications, such as Rogaine or Propecia, unless otherwise listed as covered.
- Over-the-counter and nutritional supplements, except those included elsewhere.
- Self-care products, such as elastic stockings, Eldoquin, Botox and allergy serum.
- Contraceptive devices, unless included elsewhere.
- Contraceptives, including extended cycle, Transdermal, emergency kit and oral contraceptives (refer to the ***Summary of Benefits*** for limitations).
- Lifestyle medications are medications used to treat various lifestyle situations, such as obesity and smoking (refer to the ***Summary of Benefits*** for limitations).
- Biotech or genetically engineered medications drugs are medications that involve the use of human DNA properties (cells, tissue and genes) and manipulation of them with bacteria or yeast to create a therapeutic drug. There are no chemical compounds found in these drugs. Refer to the ***Summary of Benefits*** for limitations.

General Plan Limitations and Exclusions

Only benefits listed as covered are considered covered expenses. Generally, benefits are only available when resulting from a non-occupational injury or illness, unless specifically listed otherwise as covered. In addition to any exclusions listed elsewhere in this booklet, no payment will be made for:

- Services paid by Medicare as the primary benefit plan.
- Services covered in full by another plan.
- Services provided before the effective date of this Plan.
- Services provided after Plan coverage ends.
- Services that are not medically necessary.
- Treatment of mental health extending beyond the period needed or beyond the period where favorable outcomes can result.
- Health tests unrelated to previously diagnosed conditions except as otherwise listed as covered.
- Charges determined to be unreasonable.
- Experimental or investigative services and treatment.
- Weight reduction by diet control.
- Services that are not health care services (such as personal and convenience items, completion of forms, cost of transportation, except ambulance service).
- Services and supplies not prescribed by a physician.

- Services provided by persons not qualified or licensed.
- Services provided by employer facilities.
- Services for occupational injury or illness.
- Services available without cost, through the government or under a government health plan (with the exception of Medicaid).
- Services resulting from military action or war, declared or undeclared.
- Custodial care, rest therapy or care in nursing or rest home facilities.
- Hospitalization principally for observation or diagnostic evaluation, physical therapy, x-ray or laboratory tests.
- Pre-marital or pre-employment examinations and related services unless otherwise listed as covered.
- A service rendered by a doctor who ordinarily resides in the same household with the member or who is part of the member's immediate family (i.e., children, parent or spouse).
- Artificial insemination, in-vitro fertilization or any other fertilization procedure to ensure pregnancy.
- Acupuncture unless otherwise listed as covered.
- Voluntary abortion, unless otherwise listed as covered.
- Hearing aids unless otherwise listed as covered.

Limitations

In addition to exclusions listed elsewhere in this document, the following services are limited under the Plan:

- In-hospital dental treatment and other related professional services are covered only for multiple extractions, removal of one or more unerupted teeth, alveoplasty or gingivectomy when a concurrent hazardous medical condition exists.
- Cosmetic surgery benefits are limited to correction of congenital anomalies, conditions resulting from accidental injuries or traumatic scars and for the correction of deformities resulting from cancer surgery and mastectomies.
- Eyeglasses and related services are not covered unless the member lacks natural lenses.
- Treatment of Temporomandibular Joint Syndrome (TMJ) and related jaw-joint problems by any method other than direct surgery on the jaw joint, arthrocentesis (injections) or x-rays are not covered.

Claims and Appeals

Types of Claims

Claims are divided into:

- ***Pre-Service Claims***, which are claims for benefits where approval is required before you get care. Benefits will not be denied if it is not possible to get advance approval or if the process would jeopardize your life or health.
- ***Pre-Service Urgent Care Claims***, which are claims for care or treatment, as determined by the Plan, that would:
  - Seriously jeopardize your life, health or ability to regain maximum function if normal pre-service standards were applied; or
  - Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a physician with knowledge of your condition.
- ***Concurrent Care Claims***, which are claims that are reconsidered after initially approved (such as recertification of the number of days of an inpatient stay) and the reconsideration results in reduced benefits or a termination of benefits.
- ***Post-Service Claims***, which are claims for benefits where you have already received the services for which the claim is being submitted.

Filing a Claim

Many providers will file claims for you. If your provider does not, follow the steps listed in this section. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed.

In-network providers and many other providers will submit claims for you. Be sure to show your Benefit Verification card to your provider so they will know where to submit the claim. If your provider does not submit your claim for you, then you must do so. When you need to submit a claim, follow the steps listed below to make sure your claim is processed as quickly as possible:

Step 1: When you receive covered services or supplies, be sure your bill or statement shows the:

- Provider's name and address;
- Full name of the patient (no nicknames);
- Date of service;
- Charges, listed separately for each service;
- Description of services;
- Diagnosis; and
- Identification number from your Benefit Verification card.

Step 2: Obtain the appropriate claim form, which is one that has been approved by the Health Insurance Association of American (HIAA). BCBSM only accepts claims on their approved Member Application for Payment (MAP) form. The MAP form is available on the MEBS web site www.mebs.com.

Step 3: Complete the claim.

- Make sure to provide all requested information.
- Use a separate claim form for each member.
- Review the form to insure accuracy; incomplete forms will be returned to you, which will cause a delay in payment.
- Make a copy of the claim for your records; originals cannot be returned to you.
- Be sure to sign and date the form.

Step 4: Submit the form to the address listed on your Benefit Verification card.

- Be sure to enclose the original bill or statement with the form; cash register receipts, cancelled checks and money order stubs are not acceptable.
- If you or your dependent have coverage under any other plan (including Medicare), be sure to include information on the other coverage, including any Explanation of Benefits (EOB) if the other plan paid first.

Filing a Claim Outside of Michigan

The Plan requires out-of-state providers bill their Local Plan for services they render. Participating providers receive reimbursement from their Local Plan for services they render to members enrolled with other plans. Payment is based on the Local Plan's reimbursement schedule, and participating providers accept it as full reimbursement, leaving members liable only for the contractual deductible and copays.

Non-participating providers are also required to bill the Local Plan for services they render to members enrolled with other plans. Payment is generally issued to the member. Out-of-state non-participating providers expect full payment from their patients.

Inpatient mental health care and substance use disorder treatment admissions are covered only if they meet Severity of Illness and Intensity of Service criteria. Your physician must call the Blue Cross Blue Shield of Michigan Mental Health Precertification Unit at 1-800-762-2382 to precertify all hospital admissions for mental health and substance use disorder for both in Michigan and outside of Michigan.

Claim Filing Deadlines

Claims can be filed by you, your dependent, your beneficiary or someone authorized to act on your or their behalf. However, claims should be submitted as soon as possible, but no later than 15 months after the expense was incurred. If a claim is not submitted within this 15 month period, it will be denied.

Assignment of Benefits

Benefits are assignable unless otherwise indicated in this document. The Plan is not responsible for the validity or sufficiency of any assignment. The Plan will direct benefits to the provider or member based on the BCBSM assignment.

Explanation of Benefit (EOB)

Whenever a claim is processed, you will receive a printed summary, called an Explanation of Benefits (EOB). An EOB is an itemized statement that shows what action has been taken on a claim; it is not a bill. It is provided to help you understand how expenses were paid and that the information received by the Plan was correct. An EOB is for your information and files. When you receive an EOB, you should review it to verify that it is accurate; be sure to contact MEBS to report any inaccuracies.

You will receive an EOB from Blue Cross and Blue Shield directly. This only represents their handling of the claim and you should receive a second EOB from MEBS within a few weeks. The MEBS EOB will reflect the total benefit of your plan.

Anti-Fraud Telephone Hot-Line: Always check your bills and your EOBs. If you believe there is illegal use of your Benefit Verification card and/or benefits, please call the Anti-Fraud Hot-line at (800) 482-3787 (toll-free in Michigan).

Claim Decisions

Once your claim is submitted, it will be reviewed to determine if you are eligible for benefits and the amount of benefits payable, if any, will be calculated. All claims are processed promptly, when complete claim information is received. Determinations will be made as soon as administratively possible as follows:

- **Pre-Service Claims.** An initial determination will be made within 15 days of receipt of the claim.
    - If more time is needed due to matters beyond the Plan's control, you will be informed, within this 15-day deadline, that an extension of up to 15 additional days is needed.
    - If more information is needed to process your claim, you will be notified within 15 days of receipt of the claim. You will then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, you will be notified of a determination within 15 days.
- **Pre-Service Urgent Care Claims.** A determination will be made within 72 hours from receipt of the claim. Notice of a decision on an urgent care claims may be provided verbally within 72 hours and then confirmed in writing within three days after the oral notice. If more information is needed to process the claim, you will be notified within 24 hours of receipt of the claim. You will then have up to 48 hours to respond. You will be notified of a determination within 48 hours of the later of receipt of the additional information or the end of the 48-hour period for you to provide the additional information.

- **Concurrent Care Claims.** A determination will be made as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated if possible.
    - If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as the claim is received at least 24 hours before the approved treatment ends.
    - If a concurrent care claim does not involve urgent care treatment or is filed less than 24 hours before the previously approved period or number of treatments runs out, the claim will be processed according to the type of claim involved.
- **Post-Service Claims.** An initial determination will be made within 30 days of receipt of the claim.
    - If more time is needed due to matters beyond the Plan's control, you will be informed, within this 30-day deadline, that an extension of up to 30 additional days is needed.
    - If more information is needed to process your claim, you will be notified within 30 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, you will be notified of a determination within 15 days.

If an extension is needed, the extension notice will include the reasons for the extension and the date a decision is expected.

If a Claim Is Denied

If a claim is denied (in whole or in part), you (or your beneficiary) will receive a written notice, within the timeframes described above, that includes:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A description of any additional information or material needed to properly process the claim and an explanation of why it is needed;
- A copy of the Plan's review procedures and periods to request a appeal the decision, including a:
    - Description of the expedited review process of urgent care claims, if applicable; and
    - Statement that you may bring a lawsuit under ERISA after appealing the denial; and
- If applicable, a statement that a copy of any:
    - Rule, guideline, protocol or similar criteria on which the claim is denied is available at no cost upon request, if applicable; or
    - Scientific or clinical judgment relating to medical necessity, experimental treatment or similar exclusion or limit on which the claim is denied is available at no cost upon request.

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling MEBS. However, if a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered.

Appealing a Denied Claim

If a claim is denied (including if the claim is denied based on eligibility) or you disagree with the amount of the benefit, you may have the initial decision reviewed. You must follow and exhaust the Plan's appeals procedure before you file a lawsuit under ERISA (the federal law governing employee benefits) or initiate proceedings before any administrative agency.

Written requests for an appeal should be sent as soon as possible to MEBS at:

MEBS, Inc.
3809 Lake Eastbrook Boulevard
Grand Rapids, Michigan 49546
(800) 968-6327 or (616) 458-6327
www.mebs.com
customerservice@mebs.com

Requests for an urgent care claim appeal may be made verbally or sent by fax.

If the claim is denied or if you are otherwise dissatisfied with a Plan determination, a written appeal must be filed within 180 days from the date of the decision.

Your written appeal should explain the reasons you disagree with the decision and any other information requested in the denial notice. When filing an appeal you may:

- Submit additional materials, including comments, statements or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol or other similar criteria on which the denial was based; and
- Request a copy of any explanation of the scientific or clinical judgment on which the denial was based if the denial was based on medical necessity, experimental treatment or similar exclusion or limitation.

Appeal Decisions

If an appeal is filed on time, following the required procedures, a new, full and independent review of the claim will be made. The new decision will not consider the initial decision. An appropriate Plan fiduciary will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information provided. If the request for review involves a claim for benefits that are provided by the insurance company, that company will make the review and final decision.

A determination on appeal will be made within certain timeframes for the different types of claims as follows:

- **Pre-Service Claims.** A determination will be made within 15 days of receipt of the appeal.
- **Urgent Care Claims.** A determination will be made with 72 hours of receipt of the appeal.
- **Concurrent Care Claims.** A determination will be made, if possible, before termination or reduction of the benefit.
- **Post-Service Claims.** A determination will be made within 30 days of receipt of the appeal.

Written notification of the decision will be provided within five days after a determination is made. However, oral notice of a determination on an urgent care claim may be provided sooner. The written notice will include all required information, including a statement that you may bring a lawsuit under ERISA after the denial of an appealed claim. However, no legal action may begin until 60 days after notice has been provided that the appeal is denied. In addition, any legal action must begin within two years the claim originated.

Authorized Representatives

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide written notification authorizing this representative and comply with the Plan's procedures. Written notification must be received before a determination is made. The Plan will not address any representative unless it is absolutely sure that he or she is your representative. You or your representative may review the pertinent records and documents.

You may have, at your own expense, legal representation at any stage of the review process. If any Plan provision is determined to be unlawful or illegal, the illegality will apply only to the provision in question and will not apply to any other Plan provisions.

External Review Process

Once you have exhausted our internal appeals process, you or your authorized representative has the right to request an external review from the Commissioner of Financial and Insurance Services. This is provided through Public Act 251, the Patient's Right to Independent Review Act.

- Send a written request for an external review to the Commissioner within 60 days of the date you either received our decision, or should have received. Mail your request, including the necessary forms that we will provide you to:

  OFIR Consumer Services
  P.O. Box 30220
  Lansing, MI 48909-7720

- If your request is found to be appropriate for external review, the Commissioner will assign an independent review organization to conduct the review.

- You will be given the opportunity to provide additional information to the Commissioner within seven (7) days after you submit your request for an external review. We must provide information and documents considered in making our final decision to the independent review organization within seven (7) business days after we receive notice of your request from the Commissioner.
- The independent review organization will recommend within 14 days whether the Commissioner should maintain or reverse our decision. The commissioner must decide within seven (7) business days whether or not to accept the recommendation and will notify you.

If your request for external review is related to non-medical issues, and is otherwise found to be appropriate for external review, the Commissioner's staff will conduct the external review.

The Commissioner's staff will recommend whether the Commissioner should maintain or reverse our decision. The Commissioner will notify you of the decision.

Expedited External Review Process

- If a physician confirms, orally or in writing, that the normal time frame for completion of an expedited internal grievance would seriously jeopardize your health or maximum function, and if you have filed a request for an expedited internal grievance, you may request an expedited external review from the Commissioner.

  Mail your request, including the necessary forms that we will provide you to:

  OFIR Consumer Services
  P.O. Box 30220
  Lansing, MI 48909-7720

  Or, call this toll free number: 1.877.999.6442.
- Immediately after receiving your request, the Commissioner will decide if it is appropriate for external review and will assign an independent review organization to conduct the review. If the independent review organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Commissioner should maintain or reverse our decision.
- The Commissioner must decide within 24 hours whether or not to accept the recommendation and will notify you. This decision is the final administrative remedy under the Patient's Right to Independent Review Act.

Medical Judgments

If a claim or appeal is denied based on a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the judgment; and
- Was not consulted (or does not report to the person who was consulted) in connection with the original denial of the claim.

You may request the identity of any medical experts consulted in making a determination of your claim.

Physical Examinations and Autopsy

The Plan has the right, at its own expense, to have a physician of its choice examine you as often as is reasonably necessary while a claim is pending. The Plan also has the right to have an autopsy done at its own expense, if it is not forbidden by law.

Incompetence

If the Plan determines that a person entitled to benefits is unable to care for his or her affairs because of illness, accident or incapacity (either physical or mental), payment that would otherwise be made to that person will be made to that person's appointed legal representative. If no legal representative has been appointed, payment will, at the discretion of the Plan, be made to that person's spouse, child or such person who has care and custody of that person.

Release of Information

As a member, you authorize providers to provide the Plan, upon request, with information relating to services that you are or may be entitled to under the Plan. This authorization allows the Plan to examine records with respect to the services and to provide information requested. All information related to treatment remains confidential except for the purpose of determining rights and liabilities arising under the Plan.

Right of Recovery

The Plan has the right to reimbursement for benefits provided or paid for which you were not eligible under Plan terms. Reimbursement is due and payable immediately upon Plan request. In addition, the Plan has the right to reduce or refuse payment of future benefits to recover any reimbursement. The acceptance of premiums or other fees or the providing or paying of benefits by the Plan does not constitute a waiver of the Plan's rights to enforce this provision in the future. This provision is in addition to, and not instead of, any other remedy available to the Plan at law or in equity.

Subrogation

If you incur expenses due to a bodily injury or illness caused by negligence or wrong of a third party and benefits are payable under this Plan, you will receive benefits. However, the Plan has the right to recover any payment it made on behalf of any eligible member from a liable party. You must execute the necessary documents or perform any other act required to secure this Plan right.

If any amounts are recovered from the third party, whether by judgment, settlement or otherwise, you, your dependents or your personal representative must reimburse the Plan for the total amount of benefits paid. The amount to be reimbursed will not exceed the proceeds of any recovery after the deduction of reasonable and necessary expenditures, including attorney's fees, incurred in effecting such recovery.

Coordination of Benefits

When "you" is used in this section it refers to each member covered under this Plan and any other plan.

This Plan is designed to help you meet certain health care costs. However, this Plan coordinates its coverage with any coverage you may have under any other plan, as defined in the ***Definitions*** section. Specifically, that means that this Plan will either pay:

- Regular benefits in full if this Plan is determined to pay first; or
- If this Plan is not required to pay first, a reduced amount that, when added to benefits paid by any other plan, equals 100% of allowable expenses under this Plan.

If you are subject to any cost containment provisions under any other plan that is primary, any cost containment sanction imposed by that plan will not be payable as a benefit or a secondary balance by any of the other secondary plan(s).

Order of Payment

If you are covered under any other plan, Plan reimbursements are coordinated with your other coverage, with one plan paying first. The plan that pays benefits first (the primary plan) determines benefits first, regardless of payment from any other plan. Other plans then pay secondary, in accordance with this Plan's guidelines.

If this Plan is the primary plan, it will pay its benefits as if there were no other plan. If this Plan is secondary, it will pay its benefits in accordance with Plan guidelines, except that this Plan will pay no more of a covered expense than, when added to the part(s) payable by the other plan(s), equals 100% of the allowable expense under this Plan.

Which plan pays first is based on the following rules:

- Any other plan that does not have a coordination of benefits provision determines benefits first, before this Plan.
- The plan covering a member as an employee pays first before a plan covering the member as a dependent. If a member is covered as an employee under this Plan and any other plan, then:
    - Benefits of the plan that covers the member as an employee who is neither laid off nor retired (or as that member's dependent) are determined before those of a plan that covers the member as a laid off or retired employee (or as that member's dependent). If the other plan does not have this rule, and as a result the plans do not agree on the order of payment, this rule does not apply.
    - The plan that has covered the member for the longest continuous time pays first.
- *If a dependent child is covered by more than one plan and the parents are **not** divorced or legally separated,* the plan that covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year pays first. If the other plan does not have this birthday rule and as a result the plans do not agree on the order of payment, coordination will be determined under the rules of the other plan.

- *If a dependent child is covered by more than one plan and the parents **are** divorced or legally separate and there is:*
    - A court decree that specifically states which parent is responsible for the child's health care expenses, the plan of that parent will pay first; this supersedes any other order below; or
    - No court decree, then:
        - The plan of the parent with custody pays first;
        - If the parent with custody is married, the plan of the stepparent with custody pays next; and
        - The plan of the parent without custody pays next.

If a dependent spouse or child is also covered as an employee member, the Plan's coordination of benefits provisions may also apply.

Coordination with Medicare

Medicare is a multi-part program:

- ***Medicare Part A,*** officially called *Hospital Insurance Benefits for the Aged and Disabled,* primarily covers hospital benefits, although it also provides other benefits.
- ***Medicare Part B,*** officially called *Supplementary Medical Insurance Benefits for the Aged and Disabled*, primarily covers physician's services, although it, too, covers a number of other items and services.
- ***Medicare Part C,*** called *MedicareAdvantage,* is Medicare's managed care offering. If you are covered by an HMO, the Plan will presume that you have complied with the HMO rules necessary for your expenses to be covered by the HMO.
- ***Medicare Part D,*** called *Medicare Prescription Drug Coverage,* is Medicare's prescription drug coverage that is offered through private companies to Medicare-eligible individuals.

The Plan follows the Medicare Coordination of Benefits (COB) rules before any other plan COB rules. If, based on these rules, this Plan is primary over Medicare, then this Plan pays benefits first. When this Plan is not primary over Medicare, then Medicare benefits are determined and paid first. After that, the Plan pays benefits so that combined Medicare and Plan benefits do not exceed 100% of this Plan's allowable expenses.

If you are eligible for Medicare and it is determined that this Plan has secondary responsibility, benefits will be paid on that basis even if you have not enrolled in Medicare Part A and/or B. Therefore, it is very important to enroll in Medicare Parts A and B when you become eligible for Medicare.

When Eligibility Ends

Your eligibility for coverage will end on the first of the following dates:

- On the first day of the month for which employer contributions on your behalf are no longer current; however, your coverage may be reinstated as of the first day of the month for which contributions resume, as long as you are otherwise eligible;
- On the first day of the month for which your contribution is not current (i.e., it is over 30 days past due); however, your coverage may be reinstated as of the next open enrollment period if required contributions are made at least 30 days in advance, as long as you are otherwise eligible (if you are on an approved FMLA leave, your coverage will continue for 90 days; if your leave extends beyond 90 days, coverage may be reinstated when you return to work);
- On the day you are no longer a member of a class of eligible employees, due to termination of employment or for any other reason;
- On the day that the class of employees to which you belong is no longer eligible for coverage; or
- The date the Plan ends.

Your dependent's eligibility ends when your eligibility ends or sooner if your dependent no longer meets the Plan's definition of a dependent.

See the ***About Your Plan*** section for more information on when your coverage ends. In addition, you may end your coverage at any time, either due to a status change or during any open enrollment period. You must provide written notice indicating why you are ending coverage.

When Coverage Ends

If your or your dependent's coverage ends, you and/or your dependent may be eligible to continue coverage by applying and paying for COBRA continuation coverage. See the ***COBRA Continuation Coverage*** section for more information.

When coverage, including COBRA coverage, ends, you and/or your dependent will be provided with a certificate of creditable coverage, free of charge, within 14 days after coverage ends. The certificate will include the:

- Date the certificate was issued;
- Name, address and identification number of the member(s);
- Plan name providing the certificate;
- Name of any dependents to whom the certificate applies;
- Plan waiting/affiliation period;
- Date that creditable coverage began and ended or will end; and
- Name, address and telephone number of the Plan Administrator.

This certificate may help reduce or eliminate any pre-existing condition limitation under a new group health care plan. You or your dependent may ask for a certificate at anytime while covered under the Plan or within 24 months of the date your coverage ends.

COBRA Continuation Coverage

When "you" is used in this section it refers to each person covered under the Plan who is or may become a qualified beneficiary, which is someone eligible for COBRA. The Plan's COBRA continuation coverage notice, available from MEBS, provides a more complete description of your COBRA rights.

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, you and your dependents may be eligible to temporarily extend your coverage under the Plan when it would otherwise end. COBRA may not apply to qualifying churches, certain government entities or companies with fewer than 20 employees. To continue coverage, you and/or your dependents must pay the full cost of that coverage (your share plus the employer's share, if any) plus a 2% administrative fee. **You and your dependents should take the time to read this section carefully. Your rights and responsibilities under the law are summarized below; a more complete description is provided in the Plan's COBRA notice.**

Who Is Eligible to Elect COBRA

In general, to elect COBRA coverage, you and your dependents must have been covered under the Plan on the day before the event that caused coverage to end. Each qualified beneficiary who elects COBRA will have the same Plan rights as other Plan members or beneficiaries, including open enrollment and special enrollment rights.

You and/or your dependents may be eligible to elect COBRA coverage if your coverage ends due to a qualifying event. Qualifying events include:

If you are an employee member:	*If you are a covered spouse:*	*If you are a dependent child:*
• Your hours of employment are reduced. • Your employment ends for any reason other than your gross misconduct.	• 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. • You become divorced or legally separated from your spouse. Also, if your spouse reduces or eliminates your coverage in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation. • Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).	• Your parent-employee dies. • Your parent-employee's hours of employment are reduced. • Your parent-employee's employment ends for any reason other than his or her gross misconduct. • Your parent-employee becomes divorced or legally separated. • You stop being eligible for coverage under the Plan as a "dependent child." • Your parent-employee becomes entitled to Medicare benefits (Part A, Part B or both).

More Information about Who May Be a Qualified Beneficiary

- **Children.** A child born to, adopted by or placed for adoption with a member employee during a COBRA coverage period is considered a qualified beneficiary and will automatically be covered if the member employee is a qualified beneficiary who has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee member. To be enrolled in the Plan, the child must satisfy Plan eligibility requirements (for example, regarding age). COBRA coverage provides the Plan coverage provided to similarly situated members.
- **Alternate Recipients under QMCSOs.** A child of an employee member who is receiving benefits under the Plan pursuant to a QMCSO received by the employer during the member employee's employment is entitled to the same rights to elect COBRA as a dependent child of the employee member.

Notification of Qualifying Events

MEBS must be notified of any qualifying event for you to be eligible for COBRA coverage. Your employer will notify MEBS if the qualifying event is the:

- End of employment;
- Reduction in hours of employment; or
- Death of the employee.
- Parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both)
- If the Plan provides retiree health 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 the employer sponsoring the plan, and that bankruptcy results in the loss of coverage or any retired employee covered under the Plan, the retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

For all other qualifying events, **you** must notify your employer, in writing, within 60 days after the later of the date:

- Of the qualifying event; or
- On which the qualified beneficiary loses or would lose coverage due to a qualifying event.

Electing COBRA Continuation Coverage

- **How to Elect COBRA.** To elect COBRA, you must mail or hand-deliver written notice of your election to your employer. Oral communications regarding COBRA coverage (including in-person or telephone statements) and electronic communications (including e-mail and faxed communications) are not acceptable COBRA elections and will not preserve your COBRA rights.

- **Deadline for COBRA Elections.** Your election must be provided to your employer no later than 60 days after the date of your COBRA election notice. If mailed, your election must be postmarked by this date or if hand-delivered, your election must be received by your employer by this date. If written notice is not provided by this due date, you will lose your right to elect COBRA.
- **If You Reject COBRA.** If you reject COBRA before the due date, you may change your mind as long as your provide the election notice before the deadline for COBRA elections.
- **Premium Payments.** You do not have to send any payment with your election notice (additional payment information is included later in this section).
- **Independent Election Rights.** Each qualified beneficiary has an independent right to elect COBRA. For example, your spouse may elect COBRA even if you do not. COBRA may be elected for only one, several or for all dependent children who are qualified beneficiaries. You or your spouse (if eligible) may elect COBRA on behalf of all of qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within then 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA coverage.
- **Coverage.** Qualified beneficiaries may be enrolled in one or more Plans (for example, medical, dental or vision) at the time of a qualifying event. If you are entitled to a COBRA election due to a qualifying event, you may elect COBRA under any or all health care Plans that you were covered under on the day before the qualifying event. For example, if you were covered under medical, dental and vision on the day before a qualifying event, you may elect medical only, dental only, vision only or any combination of these benefits.
- **Entitlement to Medicare.** When you complete the election form, you must notify your employer if any qualified beneficiary is entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting your election form, you must immediately notify your employer of the date of Medicare entitlement.
- **If You Have Other Coverage or Medicare.** You may elect COBRA even if you have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail later in this section, your COBRA coverage will end automatically if, after electing COBRA, you become entitled to Medicare benefits or become covered under other coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Considerations in Deciding Whether to Elect COBRA

When deciding whether to elect COBRA, consider:

- Election of COBRA may help you avoid having pre-existing condition exclusions of other plans if you have more than a 63-day gap in health coverage.
- You will lose the guaranteed right to purchase individual health insurance policies that do not impose a pre-existing condition provision if you do not get COBRA coverage for the maximum period available to you.

- You have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum period available to you.

Length of COBRA Continuation Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the maximum coverage period for several reasons, which are described in the ***Termination of COBRA Continuation Coverage Before the Maximum Coverage Period*** section.

- **18 Month Maximum Coverage Period.** Coverage can generally continue for up to 18 months if Plan coverage is lost due to the end of employment or reduction in the hours of employment.
- **36 Month Maximum Coverage Period.** Coverage can generally continue for up to 36 months if Plan coverage is lost due to:
    - The death of the employee member;
    - The employee member's divorce or legal separation;
    - A dependent child's losing eligibility as a dependent child; or
    - The end of employment or reduction in hours of employment and the employee member becomes entitled to Medicare less than 18 months before the qualifying event. In this instance, only coverage for qualified beneficiaries other than the employee who lose coverage as a result of the qualifying event can continue for up to 36 months. For example, if an employee member becomes entitled to Medicare eight months before the date on which employment ends, COBRA coverage for the spouse and children can last up to 36 months after the date of Medicare entitlement (this is equal to 28 months after the date of the qualifying event, which is 36 months minus 8 months). This COBRA coverage period is available only if the employee member becomes entitled to Medicare within 18 months **before** the termination or reduction in hours.

Extension of Maximum Coverage Period

If the qualifying event was an employee member's termination of employment or reduction in hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your employer of a disability or second qualifying event to extend the COBRA coverage period. **If you do not provide notice of a disability or second qualifying event, you will lose your right to extend the COBRA coverage period**, as described below:

- **Disability Extension.** If a qualified beneficiary is determined by the Social Security Administration to be disabled and the employer is notified in a timely fashion, you and all other qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA

coverage due to an employee member's termination of employment or reduction in hours. The disability must begin some time before the 60th day of COBRA coverage and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To be eligible for this extension, you must notify your employer, in writing, of the Social Security Administration's determination of the qualified beneficiary's disability within 60 days after the latest of the date:

- Of the Social Security Administration's disability determination;
- Of the employee member's termination of employment or reduction in hours; or
- On which the qualified beneficiary loses or would lose Plan coverage due to the employee member's termination of employment or reduction in hours.

You must also provide this notice within 18 months after the member employee's termination of employment or reduction in hours to be entitled to a disability extension.

To provide notice, you must use the Plan's ***Notice of Disability*** form and follow all required procedures. If the required procedures are not followed or if the notice is not provided as required, no disability extension of COBRA coverage will be available. A copy of this notice and the required procedures is available from your employer or MEBS.

- **Second Qualifying Event Extension.** An extension of coverage is available to spouses and dependent children receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following an employee member's termination of employment or reduction in hours. The maximum COBRA coverage period, including any extension for a second qualifying event, is 36 months. Theses qualifying events may include the death of employee member, divorce or legal separation from the employee member or a dependent child's ceasing to be eligible for coverage as a dependent. These events are a second qualifying only if they would have caused the qualified beneficiary to lose Plan coverage if the first qualifying event had not occurred. This extension is not available when an employee member becomes entitled to Medicare.

  To be eligible for this extension, you must notify your employer in writing of the second qualifying event within 60 days of the later of the date:

  - Of the second qualifying event; or
  - On which the qualified beneficiary would lose Plan coverage due to the second qualifying event if it had occurred while the qualified beneficiary was covered under the Plan.

  To provide this notice, you must use the Plan's ***Notice of Second Qualifying Event*** form and follow all required procedures. If the required procedures are not followed or if the notice is not provided as required, no extension of COBRA coverage will be available. A copy of this notice and the required procedures is available from your employer or MEBS.

Cost of COBRA Continuation Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The required amount will not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated Plan member or beneficiary who is not receiving COBRA coverage. Your COBRA premium amount may change from time to time during your COBRA coverage period and will most likely increase over time. You will be notified of any COBRA premium change.

Claims for reimbursement will not be processed or paid until you have elected COBRA and made the first payment. If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Payment for COBRA Continuation Coverage

- **How Premium Payments Must Be Made.** All COBRA premiums must be mailed or hand-delivered to the address shown on your election notice.
- **When Premium Payments Are Considered to Be Made.** If mailed, your payment is considered to be made on the date that it is postmarked. If hand-delivered, your payment is considered to be made when it is received at the address shown on your election notice. You are not considered to have made any payment if your check is returned due to insufficient funds or otherwise.
- **First Payment for COBRA coverage.** If you elect COBRA, you do not have to send any payment with your election. However, you must make your first payment no later than 45 days after the date of your election. The date of your election is the date your election form is postmarked if mailed or received at the address shown on the election notice if hand-delivered.

  Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise ended through the end of the current month. Also, as discussed below, you will have to pay your premium before the next due date to continue uninterrupted coverage. You are responsible for making sure that the amount of your first payment is correct. You may contact your employer to confirm the correct amount.
- **Monthly Payments for COBRA Coverage.** After you make your first payment for COBRA coverage, you are required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be included in the election notice provided to you at the time of your qualifying event. Each monthly payment is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage will continue for that month without any break. **You will not receive periodic notices of payments due; it is your responsibility to pay COBRA premiums on time.**

- **Grace Periods for Monthly COBRA Premium Payments.** Although monthly payments are due on the first day of each month, you are given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day for the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and you may have to resubmit it once your coverage is reinstated. **If you do not make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.**

Termination of COBRA Continuation Coverage Before the Maximum Coverage Period

COBRA coverage will automatically end before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of the other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied);
- A qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
- The employer ceases to provide any group health plan for its employees; or
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.
- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

COBRA coverage may also end for any reason the Plan would terminate coverage of a member or beneficiary not receiving COBRA coverage (such as fraud).

If You Become Entitled to Medicare or Obtain Other Coverage

After electing COBRA, you must notify your employer in writing within 30 days if a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other coverage (after any pre-existing condition exclusions of that other plan have been exhausted or satisfied). You must use the Plan's ***Notice of Other Coverage, Medicare Entitlement or Cessation of Disability*** form and follow the required procedures. A copy of this notice and the required procedures is available from your employer or MEBS.

COBRA coverage will end (retroactively, if applicable) as of the date of Medicare entitlement or as of the date other coverage begins (after exhaustion or satisfaction of any pre-existing condition exclusions). You are required to repay the Plan for any benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other coverage. However, any premium you paid for COBRA coverage after the termination date will be refunded to you, net of any repayments you may owe.

If a Qualified Beneficiary Is No Longer Disabled

If a disabled beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify your employer in writing within 30 days after the Social Security Administration's determination. To provide notice, you must use the Plan's ***Notice of Other Coverage, Medicare Entitlement or Cessation of Disability*** form and follow the required procedures. A copy of this notice and the required procedures is available from your employer or MEBS.

If the Social Security Administration's determination that a qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will end (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination. You are required to repay the Plan for any benefits paid after the termination date, regardless of whether or when you provide notice that the disabled qualified beneficiary is no longer disabled. Any premium you paid for COBRA coverage after the termination date will be refunded to you, net of any repayments you may owe.

Important

- **If You Have Questions.** Questions concerning the Plan or your COBRA rights should be directed to your employer or MEBS.
- **Keep the Plan Informed of Address Changes.** To protect your family's rights, you should keep your employer and MEBS informed of any changes in your address or the address of family members. You should also keep a copy, for your records, of any notices you send to your employer.
- **Plan Contact Information.** For information about the Plan and COBRA coverage, contact your employer or MEBS, as listed in the ***About Your Plan*** section. The contact information for the Plan may change from time to time.

Trade Adjustment Assistance (TAA)

Note: Only you can know if you are eligible for the TAA program; this information is being provided for informational purposes only.

The Trade Act of 1974 established the TAA program to assist workers employed by a firm who lose their jobs or whose hours of work and wages are reduced as a result of increased imports or shifts in production to foreign countries.

The TAA program provides an array of reemployment and retraining services. Workers who believe they have been adversely affected by foreign trade, or others acting for those workers, may petition the U.S. Department of Labor (DOL) for a determination of eligibility. Workers certified as eligible to apply for TAA may receive reemployment services, training in new occupational skills, a job search allowance when suitable employment is not available in the workers' normal commuting area, a relocation allowance when the worker obtains permanent employment outside the commuting area and Trade Readjustment Allowances (TRA) while the worker is in training.

Health Coverage Tax Credit (HCTC)

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the TAA program, you may be eligible for both a new opportunity to elect COBRA coverage and a HCTC.

If you and/or your dependents did not elect COBRA coverage during your election period, but are later certified by the DOL for the TAA program, you may be entitled to an additional 60-day COBRA coverage election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA coverage later than six months after your Plan coverage ended.

Eligible TAA program individuals can either take a tax credit or get advance payment of a percentage (currently 80%) of premiums paid for qualified health insurance, including COBRA coverage. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Family and Medical Leave

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth, adoption or placement with you for adoption of a child;
- The care of a seriously ill spouse, parent or child;
- Your serious illness; or
- A qualifying urgent need for leave because your spouse, son, daughter or parent is on active duty in the armed services in support of a military operation.

In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member. The service member must be:

- Your spouse, son, daughter, parent or next of kin;
- Undergoing medical treatment, recuperation or therapy for a serious illness or injury incurred in the line of duty while in military service; and
- An outpatient or on the temporary disability retired list of the armed services.

Your eligibility for FMLA leave and benefits are determined by your employer. Generally, you are eligible for a leave under FMLA if you:

- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within a 75-mile radius.

Contact your employer to determine if you are eligible for FMLA leave. During your leave, you will maintain your Plan coverage on the same basis as other similarly situated members. Your eligibility will be maintained until the end of the leave, as long as your employer properly grants the leave under the federal law and your employer makes the required notification and payments are made on your behalf. If you and your employer have a disagreement over your eligibility and coverage under FMLA, the Plan will have no direct role in resolving the dispute.

If you take FMLA leave and do not return to work at the end of the leave, you (and your spouse and dependent children) may be eligible for COBRA coverage. See the ***COBRA Continuation Coverage*** section for more information.

Military Service

If you lose coverage because you enter into active military duty covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994, you and your dependents are eligible to continue your coverage as long as you pay the cost to continue that coverage.

Your rights under COBRA and USERRA are similar but not identical. Any COBRA election you make will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in the ***COBRA Election Notice*** also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

How Long USERRA Coverage May Last

When you take military leave, USERRA coverage for you (and covered dependents for whom you elect coverage) begins the day after you (and covered dependents) lose coverage under the Plan, and it can continue for up to 24 months. However, USERRA coverage will end earlier if:

- A premium payment is not made within the required time;
- You do not return to work within the period required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA due to a dishonorable discharge or other conduct specified in USERRA.

Your right to continue coverage under USERRA will end if you do not notify your employer of your intent to return to work within the period required under USERRA following the completion of your military service by either reporting to work (if your military service was less than 31 days) or applying for reemployment (if your military service was for more than 30 days). The deadline for returning to work, depending on the period of military service, is as follows:

Period of Service	Return-to-Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight hour rest period or, if that is unreasonable or impossible through no fault of your own, as soon as is possible.
More than 30 days but less than 181 days	Within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, the first day on which it is possible to do so.
More than 180 days	Within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight hour rest period or, if that is unreasonable or impossible through no fault of your own, as soon as possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Same as above depending on length of service period, except that that period begins when you have recovered from your injury or illness rather than on completion of your service. The maximum period for recovering is limited to two years, but the two-year period may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above periods.

COBRA and USERRA coverage are concurrent. This means that COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to 18 months (it may continue for a longer period and is subject to early termination, as described in the ***COBRA Continuation Coverage*** section.) In contrast, USERRA coverage can continue for up to 24 months, as described above.

Premium Payments for USERRA Continuation Coverage

If you elect to continue your coverage (or spouse or dependent children's coverage) under USERRA, you pay the same rate as COBRA. However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount you would pay as an active employee for that coverage.

General Plan Information

The following information, along with the information included in the ***About Your Plan*** section, applies to the benefits described in this Summary Plan Description (SPD)/Plan Document.

Benefit Administrator

While the Plan is established, funded, maintained and sponsored by the Plan Sponsor and Plan Administrator, MEBS, Incorporated has been contracted to provide administration services.

Only employees of MEBS are qualified to answer questions about eligibility, benefits and certain other Plan provisions. However, any insurance companies providing coverage are qualified to answer questions about benefits as well. If you have a question, contact:

MEBS, Inc.
3809 Lake Eastbrook Boulevard
Grand Rapids, MI 49546
(800) 968-6327 or (616) 458-6327
customerservice@mebs.com
www.mebs.com

If you would like to see or receive copies of additional documents relating to the Plan, contact MEBS. You may be charged a reasonable fee to cover the cost of reproducing any materials you request.

The Benefit Administrator:

- Does not guarantee or warrant that this is an insured plan. The Plan Sponsor and Plan Administrator assume all responsibilities for insuring or providing benefits on behalf of members.
- Does not insure, reinsure or fund the Plan. If the Plan Sponsor or Plan Administrator elects not to reinsure the Plan, and ultimately not fund expenses that are eligible for payment for any reason, you may be liable for those expenses.
- Merely processes claims and does not insure eligible Plan expenses nor guarantee that eligible expenses will be paid.
- Will promptly process complete claim submissions. If there are delays in processing claims, you have no rights to interest or other remedies against the Benefit Administrator, except as otherwise provided by law.

Plan Year

The Plan's fiscal records are maintained on a plan year basis. The plan year is listed in the ***About Your Plan*** section.

Plan Funding

Benefits may be provided on a self-funded and/or an insured basis by contributions from employers and, in some cases, by employees. Contributions are used to pay any insurance premiums and finance any self-funded benefits. Assets are held by the Plan Sponsor for members. The Plan Sponsor is responsible for the management of assets; but may, from time to time, use the service of an investment manager to invest assets.

Any self-funded benefits are provided through the Plan Sponsor. If, for any reason, the Plan does not pay eligible expenses under any self-funded portion of the Plan, you may be liable for these expenses.

Employer agreements determine the amount of contributions and employees on whose behalf an employer contributes. You may request, in writing, from MEBS, the name and address of a particular employer and whether an employer is participating.

Legal Action

You must wait 60 days after getting written proof of a loss from a claim before initiating legal action against the Plan. In addition, no legal action may be brought more than two years after the earlier of the:

- Expiration of the time within which proof of loss is required; or
- Two years after the filing of a claim.

Michigan Public Act 350

As a Plan member, you may be entitled to legal rights under the Michigan Public Act 350 of 1980, which is a state law governing insurers in Michigan. If you would like more information please contact MEBS.

Agent for Service of Legal Process

If legal disputes involving the Plan arise, any legal documents should be served on the agent for service of legal process. The agent is listed in the ***About Your Plan*** section.

Eligibility

Eligibility requirements are described in this SPD/Plan Document. Circumstances that may cause you to lose eligibility are also explained. Note that your coverage does not constitute a guarantee of employment and you are not vested in any benefits described in this booklet. In addition, no benefits are assignable or transferable, other than assigning benefits to a health care provider.

This Plan does not take the place of or affect any requirement for coverage by workers' compensation insurance.

Plan Interpretation and Determination

The Plan Administrator and in some cases, the individuals or organizations that have been designated by the Plan Administrator have the responsibility to interpret and apply Plan provisions and to determine eligibility for coverage and benefits. To carry out this responsibility, the Plan Administrator will:

- Determine whether an individual is eligible for any Plan benefit.
- Determine the amount of Plan benefits, if any, a member is entitled to.
- Determine or find facts that are relevant to any claim for Plan benefits.
- Interpret all Plan provisions.
- Interpret all provisions of this Summary Plan Description/Plan Document.
- Interpret the provision of any collective bargaining agreement or written participation agreement involving or impacting the Plan.
- Interpret the provisions of any trust agreement governing Plan operation.
- Interpret all provisions of any other document or instrument involving or impacting the Plan.
- Interpret all of the terms used in this Plan and any other previously mentioned agreement, document and instrument.
- Amend, modify or discontinue all or part of the Plan whenever conditions so warrant.

Any Plan Administrator determination and/or interpretation will:

- Be subject to the appeals process on any member claiming Plan benefits and on all employees, employers, unions and parties who have executed any agreement with the Plan Administrator or the union.
- Be given respect in all courts of law to the greatest extent allowed by applicable law.
- Not be overturned or set aside by any court of law unless the court finds that the Plan Administrator or their designee, acted in an arbitrary and/or capricious manner.

Plan Amendment or Termination

The Plan Sponsor and Plan Administrator have the right to change, modify or terminate all or any part of a Plan at any time, in accordance with all official documents, the Employee Retirement Income Security Act and subject to any applicable labor agreements. If any changes are made to the Plan benefits, you will be notified, in writing.

Although it is intended that the Plan remain in effect, the Plan Sponsor and Plan Administrator reserve the right to terminate this Plan at any time. Any funds remaining in the Plan at termination will be distributed for members' benefit in a manner determined by the Plan Sponsor and Plan Administrator. You will be notified, in writing, if the Plan or any part of the Plan ends.

Your ERISA Rights

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

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the MEBS office, your employer or other specified locations (as applicable), such as worksites and union halls, all documents governing the Plan. These include any insurance contracts, collective bargaining agreements and copies 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 (EBSA).
- Obtain, upon written request, copies of documents governing the operation of the Plan. These include any insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and current Summary Plan Description/Plan Document. A reasonable charge may be required for the copies.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself and your eligible spouse and/or dependents if there is a loss of coverage as a result of a qualifying event. You or your dependents may have to pay for this coverage. You will be provided with more information regarding your COBRA coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under a group health plan if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from the Plan when:
    - You lose Plan coverage, including the loss of coverage due to reaching an overall Plan lifetime maximum;
    - You become entitled to elect COBRA coverage; or
    - Your COBRA coverage ends.

    You may request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called Plan fiduciaries, have a duty to do so prudently and in the interest of you and other Plan members 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 benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision (without charge) and to appeal any denial, all within certain time schedules. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claim and appeal procedures.

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

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

Assistance with Questions

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

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

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

Disclosures to Authorized Persons

Effective February 19, 2010 the following provisions also apply.

Members of the Plan Sponsor's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI).

HIPAA implemented regulations to restrict the Plan Sponsor's ability to use and disclose PHI. The Plan Sponsor has access to PHI from the Plan only as permitted as described here or as otherwise required or permitted by HIPAA.

- **Use and Disclosure of PHI to Plan Sponsor.** Plan may disclose PHI to the Plan Sponsor only to the extent necessary for Plan Sponsor to perform the following Plan Administrative functions:
    - Reconciling billing statements.
    - Enrollment/disenrollment.
    - Plan administrative purposes, such as quality assurance, claims processing, auditing and monitoring.
    - Summary Health Information may be requested for the purpose of:
        - Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
        - Modifying, amending or terminating the Plan.
- **Plan Sponsor Certification.** The Plan agrees that it will only disclose PHI to the Plan Sponsor upon receipt of a certification that this addendum has been adopted and the Plan Sponsor agrees to abide by such conditions. Plan Sponsor is subject to the following:
    - ***Prohibition on Unauthorized Use or Disclosure of PHI.*** The Plan Sponsor will not use or disclose any PHI received from the Plan, except as permitted in the Plan's privacy rules or as required by law.
    - ***Subcontractors and Agents.*** The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide PHI to agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Plan Sponsor.
    - ***Permitted Purposes.*** The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other of Plan Sponsor's benefits or employee benefit plans.
    - ***Reporting.*** The Plan Sponsor will report to the Plan any impermissible or improper use or disclosure of PHI not authorized by the Plan documents of which it becomes aware.
    - ***Access to PHI by Participants.*** The Plan Sponsor will make PHI available to the Plan to permit participants to inspect and copy their PHI contained in the designated record set.

- ***Correction of PHI.*** The Plan Sponsor will make a participant's PHI available to the Plan to permit participants to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and Plan Sponsor will incorporate amendments provided by the Plan.
- ***Accounting of PHI.*** The Plan Sponsor will make a participant's PHI available to permit the Plan to provide an accounting of disclosures.
- ***Disclosure to Government Agencies.*** The Plan Sponsor will make its internal practices, books and records related to the use and disclosure of PHI available to the Plan and to the Department of Health and Human Services (DHHS) or its designee for the purpose of determining the Plan's compliance with HIPAA.
- ***Return or Destruction of Health Information.*** When the PHI is no longer needed for the purpose for which disclosure was made, the Plan Sponsor must, if feasible, return to the Plan or destroy all PHI that the Plan Sponsor received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
- ***Minimum Necessary Requests.*** The Plan Sponsor will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical and technical safeguards that reasonable and appropriately protect the confidentiality, integrity and availability of the electronic protected health information, and it will ensure than any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware.

- **Adequate Separation.** The Plan Sponsor represents that adequate separation exists between the Plan and Plan Sponsor so that PHI will be used only for Plan administration. The following employees or persons under the control of the Plan Sponsor have access to participants' PHI for the purposes set forth above: Superintendent, Payroll and Benefits, and Administrative Asssistant.

- **Adequate Separation Certification.** The Plan requires the Plan Sponsor to certify that the employees identified above are the only employees that will access and use participants' PHI. The Plan Sponsor must further certify that such employees will only access and use PHI for the purposes set forth above. In the event that any of the above specified employees do not comply with the provisions of this section, that employee will be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures. In addition, the Plan Sponsor will ensure that the provisions of this Section are supported by reasonable and appropriate security measure to the extent that the designees have access to electronic PHI.
- **Reports of Non-Compliance.** Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the MEBS Privacy Officer at (800) 968-9682.

Definitions

Terms defined in this section are used throughout this booklet.

Actively at Work or Minimum Hour Requirement

When a member employee is on the job (other than absences due to a medical condition or medical treatment) and physically able to perform his or her regular full time duties for a regularly scheduled work day. The number of hours that must be worked each week to meet the minimum hour requirement, if any, is listed in the ***About Your Plan*** section.

Approved Amount

For a covered service this is the lower of the:

- Maximum payment level; or
- Provider's billed charge.

Approved Facility

A hospital or clinic that:

- Provides medical and other services, such as substance use disorder treatment, rehabilitation, skilled nursing care or physical therapy;
- Meets all applicable local and state licensing and certification requirements; and
- Has entered into an agreement with BlueCross BlueShield to provide services.

Benefit Administrator

MEBS, Inc.
3809 Lake Eastbrook Boulevard
Grand Rapids, MI 49546
(800) 968-6327 or (616) 458-6327
www.mebs.com

Benefit Period or Benefit Year

A 12-month period during which any, and all, eligible expenses incurred by a member are subject to the Plan provisions, as listed in the ***About Your Plan*** section.

BlueCross BlueShield of Michigan or BCBSM

Blue Cross Blue Shield of Michigan, a non-profit independent company managed and controlled by a Board of Directors comprised of a majority of community-based public and subscriber members.

Carry-Over Deductible Provision

Eligible expenses incurred and applied toward a deductible during the last three months of a benefit year that may be applied toward the following year's deductible.

Copayment

The portion (fixed dollar amount or percentage) of a provider's and/or facility's approved amount that a member is required to pay for covered services.

Covered Service

A service, treatment or supply identified as payable by the Plan. Covered services must be medically necessary, unless stated otherwise.

Deductible

The amount of out-of-pocket expenses for covered services a member pays before the Plan begins to pay benefits for certain covered services. Only amounts covered under the Plan may be applied toward the deductible.

Dependent

See the ***Dependent Eligibility*** section.

Doctor, Provider or Physician

A physician licensed to practice medicine and perform surgery.

Plan benefits will not be denied solely because charges are for medical care or services that are not provided by a physician as long as the care or services are legally provided by a person qualified as a licensed, consulting psychologist or provided by a person licensed to practice, and acting within the scope of his or her license, chiropractic medicine, dentistry, optometry or podiatry.

Durable Medical Equipment

Equipment that is:

- Able to withstand repeated use;
- Primarily and customarily used to serve a medical purpose; and
- Not generally useful to a person in the absence of illness or injury.

Eligible Charge

The charge actually made to the member for an eligible treatment or service to the extent that the charge is within the Maximum Payment Level (MPL) fee schedule established by MEBS and/or BCBSM.

Emergency First Aid

The initial exam and treatment of a condition resulting from injury.

Employee

An individual employed by an employer. An independent contractor is not considered an employee.

Employee Member

An employee who has met the eligibility requirements for Plan coverage. An independent contractor is not considered an employee member.

Employee Member Effective Date

The date this Plan's benefits become effective for an employee member.

Employer

The employer listed in the ***About Your Plan*** section.

Experimental and/or Investigative

A service, procedure, treatment, device or supply that has not been:

- Scientifically demonstrated to be safe and effective for treatment of a condition; or
- Approved by the applicable governing entities.

BlueCross BlueShield of Michigan makes this determination based on a review of established criteria.

Extended Care Facility

An institution or a distinct part of an institution that:

- Is primarily engaged in providing, for a fee, room and board, skilled nursing care and related services;
- Is primarily engaged in providing skilled nursing care and related services for persons convalescing from sickness and injury under 24-hour supervision of a physician or a registered nurse;
- Has the services of a physician available at all times;
- Has other nursing personnel as may be necessary to provide continuous care of patients;
- Requires each patient be under the care of a physician;
- Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
- Maintains a daily clinical record for each patient;
- Complies with all licensing and other legal requirements; and
- Is recognized and approved as an extended care facility by BlueCross BlueShield of Michigan.

In no event does this include an institution or part of an institution that is used primarily as a:

- Rest facility;
- Facility for the care and treatment of mental diseases, tuberculosis, the aged, blind or deaf;
- Facility for the care of drug addicts or alcoholics; or
- Facility of custodial or educational care.

Home Health Agency

A public or private agency or organization, including a sub-division, that:

- Is primarily engaged in providing skilled nursing care and other therapeutic services;
- Has policies established by associated professional personnel, including one or more physicians and one or more registered nurses to govern the services provided under the supervision of a physician or nurse;
- Maintains clinical records on all patients;
- In cases where state and local law provide for the licensing of an agency or organization of this nature, is licensed or approved by the state or local law as meeting the standards established for licensing; and
- Is recognized and approved as a home health agency by BlueCross BlueShield of Michigan.

In no event does this include an agency or organization that is engaged primarily in the care and treatment of mental health.

Hospice

An agency or facility that is primarily involved in providing care to terminally ill individuals designed to replace inpatient hospital care. Services may be provided in a hospice facility or in the home. All hospice services must be arranged through a BlueCross BlueShield of Michigan approved hospice provider.

Hospital or Facility

An institution for the:

- Care and treatment of sick and injured persons that is under the supervision of a medical staff of physicians and has organized facilities for diagnosis, treatment, major surgery and 24-hour nursing services by registered nurses;
- Treatment of tuberculosis exclusively that is under the supervision of a medical staff of physicians and has 24-hour nursing service by registered nurses; or
- Treatment of mental health exclusively, other than an institution primarily for custodial and not therapeutic care, that is under the supervision of a medical staff of physicians and has 24-hour nursing service by registered nurses.

A hospital or facility must be recognized and approved as a hospital or facility by BlueCross BlueShield of Michigan (BCBSM) to be covered at the in-network provider rate.

Illness or Sickness

A disease, disorder or condition (including pregnancy, childbirth and any related conditions) that requires treatment.

Injury

Any physical damage caused by an action, object or substance outside the body. Examples include, but are not limited to:

- Strains, sprains, cuts and bruises;
- Allergic reactions caused by an outside force, such as bee stings or other insect bites;
- Frostbite, sunburn and sunstroke;
- Swallowing poison;
- Medication overdose; and
- Inhaling smoke, carbon monoxide or fumes.

Inpatient

A bed patient confined in a hospital for whom a room and board charge is made by the hospital.

Maximum Payment Level or MPL

The fee schedule developed between BlueCross BlueShield of Michigan and their provider community (doctors, hospitals, etc.). MPL determines the maximum fees the Plan will pay.

Medical Necessity or Medically Necessary

A covered service that is:

- 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; and
- Not generally regarded as experimental or investigative by BlueCross BlueShield of Michigan (BCBSM).

Medical necessity is determined by physicians acting for BCBSM based on criteria and guidelines developed for BCBSM by physicians acting for their respective provider types. Medical necessity is based on:

- If the covered service is accepted as necessary and appropriate for the patient's condition (i.e., it is not mainly for the convenience of the patient or physician).
- In the case of diagnostic testing, the results are essential to and are used in the diagnosis and management of the patient's condition.

Member

An employee member and an employee member's dependents who meet the Plan's definition of a dependent and are eligible for Plan coverage.

Mental Health Disorder

Any illness that is defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), including substance use disorder, which is a dependence or addiction to alcohol, psychiatric drugs or medications. Mental health disorders typically include treatment provided by psychiatrists, psychologists, social workers or other licensed therapists using psychotherapy and or psychotropic drugs.

Nursing Home or Convalescent Care Facility

A facility for the accommodation of convalescent patients or other persons who are not acutely ill that:

- Provides skilled nursing care and related medical services; and
- Is operated in connection with a hospital or under the general direction of a physician.

This does not include a facility that is not capable of caring for five or more patients at the same time or that is in existence primarily for the care and treatment of alcoholism, drug addiction, mental health, the aged, blind, deaf or mentally deficient.

A nursing home must be recognized and approved by BlueCross BlueShield of Michigan, unless the member applies for and receives prior approval.

Occupational Therapy

Treatment consisting of specifically designed therapeutic tasks or activities to:

- Improve or restore a patient's functional level when there has been a loss in the function of muscles or joints due to illness or injury; and
- Help the patient learn to apply the newly-restored or improved function to meet the demands of daily living.

Occupational therapy must be:

- Prescribed by a patient's attending physician;
- Provided by or under the supervision of a physician or a licensed occupational therapist;
- Provided in conjunction with payable physical therapy treatment; and
- Provided for a condition with the potential for significant improvement in a reasonable and generally predictable period of time.

Other Plan

For coordination of benefits provisions, any plan provided by any employer or any other plan required by law that provides medical benefit.

Out-of-Pocket Maximum

The predetermined amount a member must pay in a benefit year before the Plan begins covering most covered services at 100%. This does not apply to private duty nursing care.

Physical Therapy

Treatment for a patient whose muscles do not function due to illness or injury to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. Treatment is designed to improve muscle strength, joint motion, coordination and general mobility. Physical therapy must be:

- Prescribed by the patient's attending physician;
- Given by or under the supervision of a physician or a licensed physical therapist; and
- Given for a condition that is capable of significant improvement in a reasonable and generally predictable period of time.

Plan

This Plan of medical and prescription drug benefits.

Plan Administrator

The Employer when the plan is funded by the employer listed in the Plan Name in the ***About Your Plan*** section. When this does not apply the Plan Administrator will be the Public Employee Trust.

Plan Effective Date

The date this Plan became effective.

Plan Payment

A portion of a provider's or facility's charge that the Plan will pay. The Plan payment can be reduced by a member's deductible, copayment and ineligible amounts in excess of the allowable charges.

Plan Sponsor

The Employer that sponsors the Group Health Plan, and certifies the health information will be protected as outlined in HIPAA.

Plan Year

The 12-month period over which billing and claims records are maintained, which is used for filing government forms.

Provider Network

A network of providers who have agreed to accept a scheduled fee. The provider network is listed in the ***Summary of Benefits*** section.

- **In-Network Provider, Preferred Provider or Participating Provider.** A hospital, physician or other licensed facility or health care professional who has contracted with BlueCross BlueShield of Michigan (BCBSM) to provide services to members and accepts BCBSM payment as full reimbursement for covered services.
- **Out-of-Network Provider, Non-Preferred Provider or Non-Participating Provider.** A hospital, physician or other licensed facility or health care professional who has not signed an agreement with BlueCross BlueShield of Michigan.

Professional Provider

Any of the following:

- Doctor of Medicine (M.D.);
- Doctor of Osteopathy (D.O.);
- Podiatrist (D.P.M.);
- Chiropractor (D.C.);
- Fully-licensed psychologist (PhD);
- Clinical Licensed Master's Social Workers (LMSW)
- Dentist (D.D.S. or D.M.D.).

Qualified Medical Child Support Order or QMCSO

A court order that recognizes the right of an alternate recipient (child) to receive Plan benefits. A QMCSO is usually issued in a divorce where an employee member or the former spouse is ordered by the court to continue to provide medical support for their child (ren). A QMCSO may not require the Plan to provide a type or form of benefit not otherwise provided to eligible dependent children.

As required by with federal law, the Plan will recognize a QMCSO mandating health care coverage for certain dependent children. When the Plan Administrator receives an order that may be a QMCSO, it will review the order and make a determination as to the order's qualified status. The member and possible alternate recipient will then be notified by the Plan Administrator of the determination.

Reasonable Fee or Usual, Reasonable and Customary (UCR) Fee

The usual charge made by a provider for a like service in the absence of coverage. This fee will not be more than the prevailing charge, as determined by the Plan Administrator, for care of a comparable nature made by providers of similar training and experience, within the area in which the service is actually provided.

"Area" means the municipality (or in the case of a large city, the subdivision) in which the service is actually provided or a greater area as is necessary to obtain a representative cross section of charges for a like service.

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.

Screening Services

Procedures or tests that are ordered for a patient that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a routine physical are considered screening.

Service Requirement

The amount of continuous time an employee member must be actively employed in a covered class with the employer before he or she is eligible for Plan coverage. The service requirement is listed in the ***About Your Plan*** section.

Skilled Nursing Care

Nursing care that is under the supervision of a registered nurse 24 hours a day.

Speech Therapy

Active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery if it is part of a rehabilitation program and is part of the physical therapy benefit.

Speech therapy must be:

- Referred by the attending physician;
- Given by a certified speech pathologist; and
- Provided for a condition expected to be significantly improved in a reasonable period of time.

Substance Use Disorder

The taking of alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and/or economic well-being;
- Cause a person to lose self-control; or
- Endanger the safety or welfare of others because of the substance's habitual influence on the person.

Surgery or Operation

A surgical procedure involving suturing, electrocauterization, removal of stone or foreign body by endoscopic means or injection of sclerosing solution.

Therapy

Physical, occupational and speech therapy, which may be provided on an inpatient or outpatient basis at an approved hospital, approved outpatient physical therapy facility, doctor's office or independent physical therapist.

Wrap Plan

An Employer funded Health Reimbursement Arrangement linked to the Employer's Health Plan to cover qualified out-of-pocket medical expenses.

Voluntary Abortion

This Plan excludes benefits for surgery, treatment and medication which results in, or is intended to result in, a voluntary abortion.

Exception to this Rider

This Rider does not apply if the abortion is performed to

- Prevent or treat a serious medical condition in the patient **and**
- Treatment of the medical condition that warrants the abortion cannot be safely postponed until the fetus is normally able to live outside the uterus
- Prevent the death of the mother upon whom the abortion is performed

Summary of Material Modification

Change beginning (January 1, 2013)

Summary of Benefits

Additional Preventive Services for Women with no out-of-pocket costs for the member when services are provided by an In-Network provider.

- Well Woman visits to obtain preventive services for women under 65.
- Breast feeding support, counseling and the cost of renting breastfeeding equipment.
- FDA-Approved contraceptive methods (except for over-the-counter items), sterilization, education and counsel for women with reproductive capability.
- Screening and counseling for Domestic and interpersonal violence.
- Screening for gestational diabetes pregnant women between 24-28 weeks and those at the first prenatal visit for pregnant women at higher risk of diabetes.
- Human immune-deficiency virus (HIV) screening and counsel.
- High-risk human papillomavirus (HPV) DNA test every 3 years for women with normal cytology results beginning at age thirty (30).
- Sexually Transmitted Infections (STI) counseling.

IMPORTANT: *Please include this addendum with your existing summary plan description (SPD). Should you have any questions regarding this benefit change, please contact MEBS' Customer Service Department at (800) 968-6327.*

Summary of Material Modification

Benefit Change beginning October 15, 2012

The diagnoses for Autism Spectrum Disorder (ASD) include autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified. Children through age 18 with ASD have more coverage.

These benefits do not require prior approval. Your Plan's copay, coinsurance, deductibles and cost sharing may apply.

- Physical therapy for ASD treatment
- Speech therapy for ASD treatment
- Occupational therapy for ASD treatment
- Nutritional counseling for ASD treatment
- Mental health services for ASD diagnoses and treatment
- Medical services for ASD diagnoses and treatment

Applied Behavior Analysis benefit with Autism Spectrum Disorder (ASD) diagnosis requires prior approval.

- Any participating provider (in-network provider) may diagnose ASD.
- The diagnoses of the ASD must be confirmed by an Approved Autism Evaluation Center (AAEC). You may locate an approved AAEC on your network provider's website or by calling customer service at 1-800-968-6327.
- The AAEC must provide a treatment plan including the recommendation for applied behavior analysis, a specialized treatment for autism.
- Applied behavior analysis must be performed by a Board-Certified Behavior Analyst (BCBA) for the treatment to be payable.
- The BCBA must have approval before providing applied behavior analysis services.
- The BCBA may be either an in-network or out-of-network provider.

Benefits are subject to these limits

- Birth through age 18 (to the 19th birthday).
- $50,000 annual limit for applied behavior analysis.
- Benefits that exceed the dollar or age limit will be reviewed for medical appropriateness and may be covered if medically necessary.

For more information about Michigan's autism law visit www.mi.gov/autism

IMPORTANT: *Please include this addendum with your existing summary plan description (SPD). Should you have any questions regarding this benefit change, please contact MEBS' Customer Service Department at (800) 968-6327.*