To All Plan Participants:

This Summary Plan Description benefit book provides a summary of the health and welfare benefits provided for you and your family under the Michigan Electrical Employees' Health Plan. The book also includes information about employee benefits, eligibility and self-payment rules, Plan changes that were made after your last book was printed, and other important information.

The Trustees of your Health Plan constantly work to provide you with the best health care coverage possible within the financial means of the Health Plan.

The Plan Office staff and the Blue Cross Blue Shield of Michigan (BCBSM) staff do their best to answer your questions, to see that your claims are paid as promptly as possible, and to notify you of important information.

Be sure to read this booklet carefully (have your spouse read it, too) and keep it with your other important papers for future reference.

Sincerely,
Board of Trustees
Michigan Electrical Employees' Health Plan

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INTRODUCTION

DOING YOUR PART

As a participant in this Plan you have certain responsibilities in order to protect your eligibility and to receive your benefits from the Plan.

1. **Read this book** to familiarize yourself with your eligibility rules, benefits, etc.
2. **Submit a Participant Data Form -** One of your most important responsibilities is to see that the Plan Office always has current information about you and your dependents. This information is necessary in order for you to get your I.D. cards, for BCBSM to verify coverage for benefits, and for the Plan Office to send you COBRA coverage notices when required as well as other important information, such as notices about changes in your Plan.
   - You must fill in a Participant Data Form immediately and return it to the Plan Office if you are a new covered employee.
   - Periodically, a new Participant Data Form must be filled in and returned to the Plan Office in order to update the Plan Office records.
   - You must get a new Participant Data Form from the Plan Office or at www.meehp.com, fill it in, and return it to the Plan Office immediately if there is any change in address for you or a dependent, or if there is a change in your family status because of marriage, birth or adoption of a child, death, divorce or legal separation, or a child losing dependent status.
3. **Use your I.D. cards -** You and your spouse should each carry a BCBSM I.D. card (which shows the IBEW symbol). Any time you receive medical care or fill a prescription, show the card to the hospital, doctor, pharmacy, etc.
4. **Keep copies of all bills and EOBs -** It is very important that you always keep one or more copies of all bills and Explanation of Benefits (EOB) forms when you submit the originals to BCBSM and/or to the Plan Office.

HELP CONTROL PLAN COSTS

Hospital expenses are the largest cost to your Health Plan. Try to cut down on hospital inpatient days. Ask your doctor to help you to receive medical care cost-effectively. BCBSM can help you and your doctor arrange for the alternative methods of care and cost-saving procedures listed below.

Be sure to note the types of care listed below which require that you call BCBSM for help and of the types of care which must be arranged by BCBSM. If it states below that BCBSM must make the arrangements for the care and you don't have it arranged by BCBSM, you may not receive any benefits for the incurred charges.

- **Outpatient treatment and surgery -** When possible, have your doctor arrange for surgery or treatment on an outpatient basis instead of on an inpatient basis.
- **Get second surgical opinions -** A second surgical opinion can help you obtain more information about a proposed surgical procedure and the advisability of having the surgery. There is no cost to you for second opinions.

  To arrange a second surgical opinion appointment, you must call the BCBSM Referral Center at (313) 225-0700 (Detroit) or 1 (800) 832-6789 (rest of Michigan). (See page 35 for more information about second surgical opinions.)
- **For prescription drugs,** use the pharmacies participating in the BCBSM Drug Card Program or order long-term or maintenance drugs through the Medco mail-order pharmacy. Also, when a prescription drug is necessary, ask your doctor to prescribe from the Formulary list whenever possible and prescribe generic drugs when possible.
- **Use home nursing care** instead of staying longer in the hospital. BCBSM must make the arrangements for the home nursing care—call BCBSM customer service toll-free at the number on the inside front cover.
- **Use skilled nursing facility care** if you are well enough to leave the hospital but aren't well enough to go home. BCBSM must make the arrangements for the skilled nursing facility care—call BCBSM cus-

tomer service at the number on the inside front cover.

- **Use hospice care** for terminal conditions. BCBSM must make the arrangements for the hospice care—call BCBSM customer service at the number on the inside front cover.
- **For human organ transplants**, you must obtain authorization from the BCBSM Human Organ Transplant Program at 1 (800) 242-3504. Not all transplants are covered. (Refer to page 38 for more information.)

PRONOUNS USED IN THIS BOOK

To avoid awkward wording in this book, masculine personal pronouns (he, him, his) include the feminine (she, her, hers) wherever they apply. However, feminine personal pronouns are used when referring to spouses. If a spouse is a male, the feminine reference will include the masculine wherever it applies.

Where the term "you" or "your" is used, it means an eligible employee or, where applicable, a retiree eligible for E&D Retiree Benefits.

BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM)

BCBSM PPO PROVIDERS

In Michigan BCBSM has agreements with all acute care hospitals and a majority of the doctors. These are called "PPO providers." PPO providers include hospitals and other BCBSM-approved facilities and doctors and other licensed professional providers. These PPO providers have accepted a schedule of negotiated discounted charges, "BCBSM approved amounts," as the amounts they will accept as payment in full for certain services. Because of the discounts received from these providers, your out-of-pocket copayment share of the expenses will be lower.

BCBSM has printed a PPO provider directory which lists the names and addresses of doctors who participate with BCBSM, either individually or within a group practice. You are entitled to a copy of the PPO provider directory, free of charge, upon request from BCBSM. If you need help locating a participating doctor, call the BCBSM customer service office, visit the BCBSM website at www.bcbsm.com, or call the Plan Office.

The Plan and the Trustees do not express opinions regarding the quality of care or services rendered by hospitals and physicians or other health care providers and facilities associated with the BCBSM PPO networks. Neither the Plan nor the Trustees have a financial interest in or direct control of any of the health care providers or facilities associated with the BCBSM PPO networks.

The ultimate decisions regarding your medical care and providers must be made by you in consultation with your doctor.

BCBSM PRESCRIPTION DRUG PROGRAM

BCBSM also administers the Plan's prescription drug program.

All new participants will receive an information packet directly from the Plan Office. This packet will include information on BCBSM's programs and rules for preauthorizations and step therapy.

Direct your questions about the Drug Card Program to BCBSM.

Medco provides mail-order pharmacy services for Plan participants through an arrangement with BCBSM. You should direct your questions about the mail-service directly to Medco at 1 (800) 903-8346.

Direct all questions about prior authorizations to BCBSM.

BCBSM REVIEW FOR SUBSTANCE ABUSE AND MENTAL/NERVOUS DISORDERS

Review and Certification - The BCBSM hospitals in Michigan will provide review and certification services for all hospital treatment of substance abuse (alcoholism, drug addiction, etc.) and mental/nervous disorders provided in or through their hospitals. There will be an automatic internal review of the proposed treatment when a person is admitted to a Michigan hospital for these types of treatment. Certification of the length of stay and appropriateness of the treatment plan will be provided, based on BCBSM guidelines for the type of condition being treated.

Important *- No benefits will be paid for hospital treatment that is not certified by BCBSM. Your doctor can call the BCBSM Mental Health Precertification Unit at 1 (800) 762-2382 to see if a proposed admission will meet BCBSM's severity of illness and intensity of service criteria for certification.*

However, certification of treatment does not necessarily mean that benefits will be paid for the entire period that is certified. For instance, charges for the certified period may be more than the remaining number of days or visits allowed by the Plan for that type of treatment. Check the Schedule of Benefits so that you will know what these limitations are. Remember, benefits are payable only up to but not to exceed the maximum benefits and other limitations shown on the Schedule of Benefits.

Treatment in Non-Michigan Hospitals - If you or a dependent are to be admitted to a non-Michigan hospital for treatment of substance abuse or a mental/nervous disorder, you or the hospital should call BCBSM at 1 (800) 762-2382 before the admission for review and certification of the treatment. By calling in advance, you can find out whether the treatment satisfies the Plan's coverage requirements. (Only the Plan Office can con-

firm whether or not you or your dependent are actually eligible to receive benefits.)

OTHER BCBSM PRECERTIFICATION REQUIREMENTS

BCBSM must also review and precertify:

- Home health (nursing) care (see page 35),
- Convalescent (skilled nursing) facility care (page 36).
- Transplants (page 38),
- Hospice care (page 38), and

CLAIM PAYMENTS

As explained in the "Claim Procedures" section of this booklet that starts on page 51, BCBSM handles most of the medical claim processing for the Plan. When you use PPO providers, you don't have to file claims. These providers will automatically send their bills to BCBSM.

SCHEDULE OF BENEFITS

The benefits described on the Schedule of Benefits apply only to covered expenses, and only to persons who are eligible for the benefits. All benefits are subject to the limitations and exclusions explained in this booklet.

WEEKLY DISABILITY BENEFITS (FOR EMPLOYEES ONLY)

Benefit payable per period of disability:

Amount of weekly benefit - 60% of 40-hour-per-week wage up to a maximum of	$250
Maximum benefit period	52 weeks

Benefits start on the 1st day if due to injury and on the 8th day if due to sickness. If sickness lasts for 8 days or more, benefits are paid retroactively from the 1st day you are seen and certified by your doctor.

Cable pullers or residential and motor shop trainees - Weekly Disability Benefits are payable at 60% of 40 hours to a maximum of $150 per week and a maximum of 13 weeks per period of disability.

BENEFITS FOR EMPLOYEES AND THEIR DEPENDENTS, AND FOR RETIREES AND DEPENDENTS ELIGIBLE FOR EARLY AND DISABILITY RETIREE BENEFITS

Comprehensive Major Medical Expense Benefit (Comprehensive Benefit)

Wherever a "payment percentage" is shown on the following schedule, it means that BCBSM will pay that percentage of the approved amounts a person incurs during a calendar year after deductible satisfaction.

Calendar year deductibles:

Individual deductible	$500
Family deductible (may be satisfied by 2 or more family members)	$1,000

Out-of-pocket limits per calendar year:

Individual out-of-pocket limit	$4,000
Family out-of-pocket limit (may be met by 2 or more family members)	$6,000

(Out-of-pocket payments for substance abuse or mental/nervous disorders do not apply to out-of-pocket limits.)

Lifetime maximum benefit	$5,000,000

Copayment percentage for most approved amounts after satisfaction of the person's or the family's deductible (see the "Special Benefits and Limitations" section of this Schedule for certain exceptions to these percentages):

Charges by ***BCBSM*** PPO providers	70%
Charges by ***out-of-network*** providers*	60% of BCBSM approved amount
After individual (or family) out-of-pocket limit is met	100% of BCBSM approved amount
(No 100% payment for substance abuse or mental/nervous disorders.)	

Special Benefits and Limitations

Routine physical examinations

Payment percentage for one routine physical examination per calendar year	100% of BCBSM approved amount

Second surgical opinions

Payment percentage (BCBSM precertification required; deductible does not apply)	100%

Home Health (Nursing) Care (BCBSM precertification required)

Payment percentage	70%

Hospice care (BCBSM precertification required)

Payment percentage (deductible does not apply)	100%

Convalescent (skilled nursing) facility care (BCBSM precertification required)

Payment percentage	70%

Treatment of substance abuse and mental/nervous disorders (BCBSM precertification required for inpatient treatment):

Maximum allowable days for all inpatient treatment during a calendar year	15 days
Outpatient/office visits - Calendar year maximums:	
Maximum allowable visits during a calendar year for mental/nervous disorders	50 visits
Maximum benefit payable for substance abuse	$5,000
Payment percentage payable (after calendar year deductible)	70%
(No 100% payment even if out-of-pocket limit has been met.)	

Human organ transplants:

Payment percentage for covered skin, cornea, kidney and bone marrow transplants (BCBSM preauthorization required)	70%

* *The BCBSM payment percentage will be paid for out-of-network covered expenses incurred because of a condition that meets the Plan's definition of an emergency situation (page 57). If an out-of-network provider charges more than the BCBSM approved amount you will have to pay the amount in excess of the approved amount.*

Transplants (continued):

Heart, heart-lung, liver, lobar lung, lung, pancreas, pancreas-kidney, small bowel, and small bowel-liver only, if the transplant is performed in a BCBSM designated facility—BCBSM pre-authorization required:

Payment percentage (deductible does not apply)	100%
Lifetime maximum benefit payable per transplant	$1,000,000

(Benefits that apply to this maximum do not apply to the patient's Comprehensive Benefit lifetime maximum benefit.)

Only charges incurred for the human organ transplants specifically listed will be considered for payment. No benefits will be paid for unlisted transplants or for any listed transplant which is not reviewed and preapproved by BCBSM or not received in a BCBSM hospital or BCBSM-approved facility. Certain benefits are also provided for travel and meal expenses. (Refer to page 38 for more specific information about human organ transplants.)

Prescription Drug Program

If a person orders a brand name drug when a generic equivalent is available, the person must pay the difference in cost between the brand name drug and the generic drug in addition to the copay for generic drugs.

This Prescription Drug Program is also provided to participants who are covered under the BCBSM Supplement to Medicare program.

	Your copay
Drug Card Program - up to a 34-day supply (copay paid to BCBSM participating pharmacy):	
Generic drug	$20
Preferred/Formulary brand name drug	$35
Non-preferred brand name drug	$50
Mail Order Program - up to a 90-day supply (copay paid to Medco mail-order pharmacy):	
Generic drug	$40
Preferred/Formulary brand name drug	$70
Non-preferred brand name drug	$100
Nonparticipating Pharmacies - up to a 34-day supply (copays deducted by the Plan Office):	
Generic drug	$25
Preferred/Formulary brand name drug	$40
Non-preferred brand name drug	$55

Discount Vision Plan (VSP Access plan)

You can take advantage of a discount program through Vision Service Plan (VSP)—called the VSP Access Plan. Direct all your questions to VSP at 1 (800) 877-7195 (M-F, 9:00 a.m. to 10:00 p.m.).

ELIGIBILITY

There are special early eligibility rules for newly organized employees, non-bargaining unit employees, apprentices, cable pullers, and residential or motor shop trainees. See pages 20-21 for more information.

DEFINITIONS APPLICABLE TO ELIGIBILITY

Bargaining Unit Employee - A person who is an employee of an employer for whom the employer is required to make contributions to the Plan under a collective bargaining agreement.

Covered Employment - Work that you perform for an employer for which the employer is required to make contributions to the Plan for you.

Credited Hour

1. Any reported hour for which an employer makes a contribution to the Plan for you.

   Exception - If an employer who is required under a collective bargaining agreement to make contributions to the Plan hires you outside of the Local Union hiring process provided for in the collective bargaining agreement, the hours you work will not be considered credited hours for the purpose of obtaining or continuing your eligibility even though the employer may be required to make contributions for the hours you work.
2. Any hour for which you make a regular self-payment to the Plan to continue your Plan coverage;
3. For "Eligibility During Disability," any hour of work credited to you by the Plan for continuing your coverage but for which neither you nor your employer has made a contribution. No partial days will be credited.

Non-Bargaining Unit Employee

1. An employee of the participating employer who is not a member of a bargaining unit but whose employer has a valid participation agreement with the Trustees requiring the employer to make contributions to the Plan on behalf of the employee. One specification of the participation agreement is that this Health Plan be the only coverage provided by the employer; and
2. An employee of a participating Union who is not subject to a collective bargaining agreement, provided the Union has a valid participation agreement with the Trustees requiring the Union to make contributions to the Plan on behalf of the employee; and
3. A salaried apprenticeship instructor or coordinator of a Joint Apprenticeship Training Committee (JATC) training program that has a valid participation agreement with the Trustees requiring contributions on such person's behalf.

For the purposes of receiving benefits under this Plan, a non-bargaining unit employee will be considered a regular employee the same as a bargaining unit employee. He and his dependents will be entitled to Plan benefits and be subject to all Plan provisions governing benefits the same as any other employee and his dependents. However, a preexisting condition exclusion will apply in some cases, and some of the eligibility rules are different.

WORK MONTHS AND COVERAGE MONTHS

The Plan has a month-to-month eligibility system with a basic requirement of 130 hours per month for bargaining unit employees. There is an administrative lag month between each work month and its corresponding coverage month.

130 Hours in This Work Month	*Earns Eligibility for this Coverage Month*
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

INITIAL ELIGIBILITY

Bargaining Unit Employees

You and your dependents will become initially eligible for Plan coverage on the first day of the coverage month corresponding to the work month in which you first accumulate at least 130 credited hours. The same rule applies if you are reinstating your coverage after losing your eligibility. (You can't use disability hours or make self-payments to gain initial eligibility or to re-establish eligibility.)

Example - If you start work in April and have 130 credited hours from working that month, you will become eligible for coverage on June 1 and will be covered through June 30. (June 1 is your "initial eligibility date.")

Non-Bargaining Unit Employees

The work months and coverage months described on page 11 apply to you also. However, your employer is required to make monthly contributions on your behalf for 160 hours times the current base contribution rate. Therefore, unless you are covered under the special early eligibility rules for new non-bargaining unit employees (page 20), you and your dependents will become initially eligible for Plan coverage on the first day of the coverage month corresponding to the work month for which your employer makes the required monthly contribution. You cannot use disability hours or make self-payments to gain initial eligibility or to re-establish eligibility.

If you are an owner-operator (working contractor), you are considered to be a non-bargaining unit employee, and contributions must be made for you on the 160-hours-per-month basis.

Under the Health Plan's rules an employer that participates for its non-bargaining unit personnel must pay contributions on behalf of all non-bargaining unit employees except where the non-bargaining unit employee is covered as a dependent under other coverage or where there is an addendum to a collective bargaining agreement (which must be on file with the Plan Office) that does not require Health Plan contributions for a specific job classification. If you are an individual who is excepted from participation by such an addendum, you may enroll in the Health Plan only during the one-month enrollment period during June of each year which would provide coverage beginning as of August 1.

Late Enrollment Due to Other Coverage - If, on the earliest date you could be eligible under the Plan as a non-bargaining unit employee you are covered as a dependent under another employer-provided group health plan or health insurance, you may waive coverage under this Plan at that time. However, if you want to participate in this Plan after your other coverage ends due to loss of eligibility for reasons such as death, divorce, termination of employment, termination of the employer's contribution toward the coverage or exhaustion of coverage under COBRA, you must request enrollment and begin your Plan participation within 30 days of the date your other coverage ends. To apply for late enrollment under this rule, you must contact the Plan Office and submit proof of the other coverage's effective and termination dates to the Plan Office.

Preexisting Condition Exclusion - The 6-month preexisting condition exclusion described on page 50 applies to all non-bargaining unit employees and their dependents (except for employees of participating Unions who do not reject Plan coverage when they first begin their employment).

Reciprocity

The Michigan Electrical Employees' Health Plan is signatory to the International Brotherhood of Electrical Workers Reciprocal Agreement ("Reciprocal Agreement") along with other IBEW welfare funds. You may at times be employed by employers under contract to contribute to a different IBEW welfare fund that is also a party to the Reciprocal Agreement. In these cases, you may elect to have the other welfare fund transfer the contributions it receives on your behalf to this Plan. This Plan will apply transferred contributions toward your eligibility requirements under this Plan and you will be credited under this Plan with the same number of credited hours as you earned under the other IBEW welfare fund.

The IBEW uses the Electronic Reciprocal Transfer System (ERTS) to handle reciprocity transfers. If you want this Plan to be your home fund when you travel outside the jurisdiction of the Plan, you should register with ERTS. You can register at any IBEW Local Union office.

Your eligibility for the transfer of contributions to and from this Plan is limited to the extent required by the Reciprocal Agreement.

When Coverage Starts (Effective Date of Benefits)

All Employees - Your benefits will normally start on the date you become initially eligible (your "initial eligibility date").

Dependents - If you have dependents on your initial eligibility date, their benefits will normally start on that same date. If you don't have any dependents on that date but later acquire one or more dependents while you are eligible, their coverage will start on the date they become your dependents.

CONTINUING ELIGIBILITY

Basic 130-Hour Rule

Bargaining Unit Employees - Once you become eligible, you and your dependents will continue to be covered during each successive coverage month if you have at least 130 credited hours in the corresponding work month. For example, you will be eligible in October if you have 130 credited hours in August.

Non-Bargaining Unit Employees - You and your dependents will be eligible during each successive coverage month when your employer makes a contribution to the Plan on your behalf for the corresponding work month. Monthly contributions must be for 160 hours multiplied by 100% of the current base employer contribution rate, regardless of the actual number of work hours reported. For example, 160 hours contributed for the August work month will make you and your dependents eligible for coverage in October.

Cable Pullers and Residential and Motor Shop Trainees - Eligibility as a cable puller or trainee can continue as long as sufficient employer contributions are made, up to a maximum of 4 years from the date you first become covered under the Plan.

Rollback Rule

Bargaining Unit Employees - If you don't meet the basic 130-hour rule, your eligibility can also be continued if you have an average of 130 hours going back over a period of up to 12 months. The rollback rule works like this:

- If you don't have 130 hours in the work month, the hours from the month before that are added to the hours you do have. If the 2-month total is 260, then your eligibility will be continued.
- If your 2-month total is less than 260, then your hours for the month before those 2 months are added to the previous total. If the 3-month total is 390, then your eligibility will be continued.
- The rollback process continues in this way. In each step the next prior month's hours are added, and the total is compared to the next highest multiple of 130.

For example - You will be eligible in January 2007 if you have any of the following:

130 hours in	November 2006
260 hours in	October '06 - November '06
390 hours in	September '06 - November'06
520 hours in	August '06 - November '06
650 hours in	July '06 - November '06
780 hours in	June '06 - November '06
910 hours in	May '06 - November '06
1,040 hours in	April '06 - November '06
1,170 hours in	March '06 - November '06
1,300 hours in	February '06 - November '06
1,430 hours in	January '06 - November '06
1,560 hours in	December '05 - November '06

Any credited hours you have in your work record from COBRA self-payments or credited disability hours do NOT count under the rollback rule.

Non-Bargaining Unit Employees - Your coverage will NOT be extended using the rollback rule (or the regular self-payment rules described below) UNLESS:

1. You were covered under the Plan for the prior 36 consecutive months or more; or
2. You are a former bargaining unit employee ("alumnus").

Self-Payments

If your coverage under the Plan is going to terminate, you can make self-payments to continue coverage. You may have a choice of two types of self-payments:

- Regular self-payments; or
- COBRA self-payments.

These self-payment methods are explained in the next two sections.

Regular Self-Payments (Bargaining Unit Employees Only)

If your credited hours are not sufficient to meet either the 130-hour rule or the rollback rule, you can self-pay to cover the gap. All self-payments must be for the

hours you are short of 130 in the applicable work month, times 100% of the current base contribution rate. The rollback rule is not considered when calculating the amount due. The contribution rate used to determine your self-payment is the base hourly rate not including the Special Fund.

Rules Governing Regular Self-Payments - The following rules apply to making regular self-payments:

1. Each payment is for one month of continued coverage.
2. All self-payments will be at the same rate: 100% x short hours x base contribution rate. Your "short hours" are the exact number of hours needed to satisfy the 130-hour rule.
3. Self-payment amounts must be in whole dollars, so if the calculation results in a fraction, your payment will be rounded up to the next whole dollar.
4. Your check or money order for the correct amount (made payable to the Michigan Electrical Employees' Health Plan), along with the self-payment billing form provided by the Plan Office, must be received by the Plan Office *no later than the 15th day of the month in which you receive the statement from the Plan Office.* You and your dependents will not be covered until the payment has been received by the Plan Office. However, once your timely self-payment has been received, your coverage will be retroactively reinstated as of the first day of the coverage month.
5. Hours for which you make a regular self-payment will be counted as regular credited hours for the purpose of the 130-hour rule and the rollback rule.
6. *Regular self-payments can be made for a maximum of 6 consecutive months. Extensions will not be granted.* If you are still not working after your self-pay period ends, you can elect COBRA coverage for an additional 18 months. Months for which you made a regular self-payment will not count toward the 18-month COBRA maximum.
7. You can make regular self-payments only if you are *available for work* within the jurisdiction of the Local Unions participating in this Health Plan except in the case in which you are working under a reciprocity agreement.

> ***Note*** - The Plan Office sends out statements only for your convenience. It is YOUR RESPONSIBILITY to keep track of your eligibility and the hours you work and to contact the Plan Office if you don't have enough hours. The Plan Office is not responsible if you don't get a statement and fail to make a regular self-payment in time to continue your coverage. If you fail to make a regular self-payment by the 15th of the month in which you receive the statement, you may still be entitled to make a COBRA self-payment for COBRA coverage according to the rules in the next section.
>
> If you have less than 130 reported hours in a work month and haven't received a statement from the Plan Office, contact the Plan Office immediately if you want to make a regular self-payment.
>
> You don't have to make the regular self-payments unless you want to. The statements the Plan Office sends to you are for your information so that you can make the regular self-payments (or COBRA self-payments) if you want to continue your Plan coverage.

8. The benefits provided by regular self-payments are continued medical and prescription drug benefits for you and your dependents and continued coverage for you under the Weekly Disability Benefit.
9. You must already be eligible for coverage at the time you make the regular self-payment; regular self-payments cannot be made to acquire initial eligibility or to re-establish eligibility. *Also, you cannot make regular self-payments after you retire and start receiving a pension.*
10. If you are unable to work because you are disabled, you can't make regular self-payments for the time you were disabled. Contact the Plan Office or your Local Union as soon as you are disabled so that you will be credited with disability hours. See page 22 for more information about coverage during your disability.
11. You can authorize the Plan Office to automatically deduct any needed regular self-payments from your Special Fund account. You will need to complete and submit an authorization form if you want the Plan Office to do this. Once your authorization is on file, the funds will automatically be transferred whenever your eligibility would otherwise terminate due to insufficient hours. Transfers will only be made if you have sufficient funds in your Special

Fund account. No partial payments will be made from your account.

COBRA Coverage

Federal law—the Consolidated Omnibus Budget Reconciliation Act (COBRA)—gives you and your dependents the right to be offered an opportunity to make self-payments for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "Continuation Coverage" or "COBRA coverage."

Qualifying Events/Maximum Coverage Periods

18-Month Maximum Coverage Period - You and/or your covered dependents are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 18 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"):

- A reduction in your hours
- Termination of your employment (other than due to gross misconduct)

11-Month Extension Rule - If you or a covered dependent were disabled (as determined by Social Security) any time within the first 60 days of an 18-month COBRA period, the maximum coverage period may be extended to up to a maximum of 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. The COBRA self-payment for the extra 11 months of coverage for the family may be higher. (This 11-month extension rule does not apply to dependents during a 36-month maximum coverage period explained below.)

36-Month Maximum Coverage Period - Your dependents (spouse or children) are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 36 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"):

- Your divorce or legal separation from your spouse
- A dependent child's loss of dependent status
- Your death

Multiple Qualifying Events - If your dependents are covered under an 18-month COBRA period due to termination of your employment or a reduction in your hours and you die, you are divorced or legally separated, you become entitled to Medicare or a child loses dependent status during the 18-month COBRA coverage period, your spouse and children (or the child) are entitled to COBRA coverage for up to a maximum of 36 months reduced by the number of months of COBRA coverage already received under the 18-month continuation.

Only a person (spouse or child) who was your dependent on the day before the occurrence of the first qualifying event (termination of your employment or a reduction in your hours), or a child born to or placed with a covered employee during a period of COBRA coverage is entitled to make an election for this extended coverage when a second qualifying event occurs.

Notification Responsibilities

- If you get divorced or legally separated, or if your child loses dependent status, you, your spouse or child must notify the Plan Office in writing and request a COBRA election notice. The Plan Office must be notified within 60 days of the date of the qualifying event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later. The notice must include sufficient information for the Plan to identify you and your affected dependent(s), and the date and type of the qualifying event.
- For purposes of extending an 18-month maximum coverage period to 29 months, the Plan Office must be notified of the person's determination of eligibility for Social Security disability benefits within 60 days of the Social Security notice of such determination and before the end of the initial 18-month period. The Plan Office must also be notified within 30 days of the date Social Security determines that the person is no longer disabled.
- If a dependent is covered under an 18- or 29-month coverage period, your spouse, or the child, as applicable, must provide written notification to the Plan Office if you get divorced or legally separated or if a child loses dependent status. The Plan Office must be notified within 60 days of the event. If the affected dependent does not notify the Plan Office within 60 days of the second qualifying event, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.
- It is your employer's responsibility to notify the Plan Office of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notification of your election rights as soon as possible, you or the affected dependent

should notify the Plan Office and request a COBRA election notice any time any type of qualifying event occurs.

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

Benefits Provided Under COBRA Coverage - The benefits provided under COBRA coverage will be the same medical, prescription drug and Special Fund benefits that you and/or your dependents were eligible for on the day before the qualifying event. Weekly Disability Benefits are not provided to you under COBRA coverage.

Additional COBRA Coverage Rules

1. Each member of your family who would lose coverage due to a qualifying event is entitled to make a separate election of COBRA coverage. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents. You don't have to show proof that you and/or your dependents are insurable in order to be entitled to COBRA coverage.
2. If coverage is going to terminate due to your termination of employment or reduction in hours and you don't elect COBRA coverage for your dependents when they are entitled to the coverage, your dependent spouse has the right to elect COBRA coverage for up to 18 months for herself and any children within the time period that you could have elected COBRA coverage.

Electing COBRA Coverage

1. Within 30 days after being notified of a qualifying event, the Plan Office will send the affected person(s) an election form and notice about the person's COBRA rights, or, if applicable, a notice of the unavailability of COBRA coverage.
2. The letters and forms you will receive will tell you how much the monthly payments are and their due dates, when you have to return the election form, when the coverage will terminate, etc.
3. The person electing COBRA coverage has 60 days after he is sent the COBRA materials or 60 days after his coverage would terminate, whichever is later, to return the completed election form. An election of COBRA coverage is considered to be made on the date the election form is mailed (postmarked) or personally delivered to the Plan Office. If the election form is not returned to the Plan Office within the allowable time period, you and/or your dependents will not be entitled to elect COBRA coverage after the due date.

Making COBRA Coverage Self-Payments

1. The amount of the monthly COBRA self-payment is determined by the Trustees based on federal regulations and is stated on the election form. The amount is subject to change. If the amount is changed while you are making self-payments, you must pay the new amount starting with the effective date of the new rate.
2. A person has 45 days after the date of the election to make the initial (first) COBRA self-payment for coverage provided between the date coverage would have terminated and the date of the payment. (If a person waits 45 days to make the initial payment, any regular monthly payments which also fall due during that period must be paid at that time.)
3. The due date for each following monthly COBRA self-payment is the first day of the month for which coverage is desired. A monthly self-payment will be considered on time if it is received within 30 days of the due date.

Termination of COBRA Coverage - COBRA coverage for a covered person will end sooner than the end of the applicable maximum coverage period when the first of the following events occurs:

1. A correct and on-time payment is not made to the Plan with respect to coverage for the covered person.
2. The person *becomes* entitled to Medicare benefits after the COBRA coverage election date.
3. The Plan no longer provides group health coverage to any employees.
4. The person has been receiving extended COBRA coverage for up to an additional 11 months due to his or another family member's disability, and Social Security determines that he or the other family member is no longer disabled.
5. The person *becomes* covered under another group health plan as an employee or otherwise after the COBRA coverage election date. *Exception* - This termination rule will not apply if the person has a

preexisting medical condition that would cause benefits to be excluded or limited under the other plan.

Important Note About Employer Withdrawal - If you or a dependent are making COBRA self-payments and your contributing employer withdraws from participation in the Michigan Electrical Employees' Health Plan, some important rules apply to your continued coverage. Refer to "Termination Upon Employer Withdrawal" on page 18.

Eligibility During Disability

The Plan has special rules to help you maintain your eligibility if you become totally disabled. See "If you Become Disabled" starting on page 22 for more information.

Payroll Deductions for Deficit Contributions

Your employer's collective bargaining agreement includes a "Maintenance of Benefits" provision. This means that if the cost of the Plan increases over the total amount that the employers are contributing to the Plan for their employees, the employer contribution rate will be increased to an amount that will "maintain" Plan benefits at the current level.

If the Plan cost goes up and the contribution rate is increased, your employer may not be obligated to pay the new rate until after a specific date stated in the collective bargaining agreement. If this happens, you will have to pay the "deficit amount"—the difference between what your employer pays per hour and the amount of the new hourly contribution rate. Your employer will deduct this "deficit amount" from your paycheck and pay it to the Plan Office along with his regular contribution for you.

If your employer fails to send the full amount of the contribution to the Plan Office, you might lose your coverage for the month for which payment should have been made, or your level of coverage could be reduced.

Medicare-Eligible Active Employees

If you become age 65 and eligible for Medicare while you are working as an active employee, the Plan will continue to pay Plan benefits for you subject to the coordination of benefits rules starting on page 63.

Military Service

"Military service" means service in the uniformed services of the United States as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

If you leave covered employment and enter military service for 31 days or more while you are eligible, coverage under the Plan for you and your dependents (if covered) will continue through the 30th day of your leave and will terminate on the 31st day of your leave. You can elect to continue coverage for yourself and your dependents by making self-payments to the Plan, provided you and your dependents are eligible for Plan coverage when your absence for military service begins.

The maximum coverage period will be 24 months or until the date you are required to return or make yourself available for reemployment under USERRA, whichever period is shorter. The Plan treats your election under USERRA the same as a COBRA election and COBRA and USERRA continuation coverage periods will run at the same time (concurrently). The procedures and periods used to elect to make self-payments for this continuation coverage are generally the same as those for COBRA coverage, provided the COBRA rules do not conflict with USERRA. If you do not elect USERRA coverage in a timely manner and make all self-payments within the applicable timeframe, you lose the right to continue coverage under this provision and that right will not be reinstated. However, if there are differences between the USERRA rules and the COBRA rules, you and your dependents will receive the benefit of the more generous rules.

If you have any accumulated credited hours when your leave for military service begins, you have the following options to pay for your continued coverage under the Plan:

1. You can use the accumulated credited hours to continue coverage after your absence to enter military service (provided you have enough hours to provide any continued coverage). After your hours have been exhausted, you may make self-payments until the end of the maximum coverage period that began with the date of your absence to perform military service.
2. You can freeze your accumulated credited hours and make self-payments to continue your Plan coverage. After your discharge from military service, your credited hours will be reinstated immediately

provided you comply with the reemployment requirements of USERRA. If you do not comply with the USERRA reemployment requirements, your accumulated credited hours are forfeited.

You must notify the Plan of an absence due to military service in advance to be eligible to continue coverage under this provision. If you do not provide advance notice of your military service, your eligibility will terminate on the 31st day of your military leave (unless you can demonstrate your inability to provide notice in a timely manner that is satisfactory to the Trustees) and you will lose the right to continue coverage under this provision. Your right to continue coverage under this provision will not be reinstated unless the Trustees determine, in their sole discretion, that you were unable to provide notice in a timely manner.

If your covered employment is interrupted by military service that is less than 31 days, you will receive 40 credited hours for each week during which your military service is performed.

You must provide a copy of your military orders to the Plan Office in order to take advantage of any of the provisions described in this section.

The military's rules for coverage may vary from time to time and in different circumstances. In the event of your absence due to military service, contact the Plan Office to discuss the best option for you.

Additional information about reemployment rights of persons returning to work from the uniformed services of the United States is available from the Veterans Employment and Training Administration of the United States (VETS).

TERMINATION UPON EMPLOYER WITHDRAWAL

A withdrawal occurs when an employer's collective bargaining agreement ceases to require contributions to the Plan for active employees or when the employer ceases to be required to make contributions to the Plan. A withdrawal can also occur when a local union negotiates health benefit coverage for a substantial number of its members under a plan other than this Plan.

When a withdrawal occurs, persons having Plan coverage because of current or past employment with the employer that has withdrawn will cease to be eligible for coverage under this Plan as of the date the employer withdraws from the Plan. This includes active employees, retired employees, employees (and dependents) making self-payments, individuals on COBRA coverage, individuals maintaining coverage due to reciprocity, non-bargaining unit employees of the affected employers, dependents, and Supplement to Medicare participants. Termination of eligibility also cancels all of an employee's credited hours. Therefore, no extended eligibility otherwise available under the Plan because of credited hours will be available.

If the employer maintains a group health plan for employees after withdrawing from the Plan, the employer shall provide coverage under that group health plan for its employees, former employees and their dependents who are covered under this Plan or who are covered under this Plan's COBRA coverage. That group health plan must not exclude or limit treatment of preexisting conditions. The employer will be considered the Plan Sponsor and this Plan will have no responsibility for providing benefits for claims incurred after the date the employer withdraws from the Plan.

Should the Plan be liable for benefits following the employer's withdrawal, the Plan shall provide benefits only to the extent the employer contributes to the Plan in an amount necessary to subsidize the coverage for these persons. The subsidy cost will be determined according to rules established by the Trustees.

If your employer withdraws from this Plan as a contributing employer, contact the Plan Office immediately to see what effect, if any, the withdrawal will have on your and/or your dependents' coverage under this Plan.

TERMINATION OF ELIGIBILITY

Termination of Employee Coverage - You will cease to be eligible for Plan coverage on the first to occur of the following dates unless you are entitled to make an election of COBRA coverage, and a correct and timely election and COBRA self-payment is made on your behalf, or unless you make a regular self-payment:

1. The date of your death.
2. The date you enter the armed forces of any country (unless coverage is continued under the "Military Service" rules starting on page 17).
3. The date the Trustees discontinue this Plan of Benefits.
4. The end of the last day of the coverage month corresponding to the last work month for which you met the credited hours requirement (under either the

130-hour or rollback rules, or for a non-bargaining unit employee under the 160-hour rule).

5. If you are making regular self-payments and fail to make a correct and on-time payment, at the end of the last day of the last month for which you had previously earned or paid for coverage.
6. If you are making COBRA self-payments, at the end of the last day of the last month for which you made an on-time self-payment or on the date of occurrence of any event stated in "Termination of COBRA Coverage" on page 16, whichever occurs first.
7. With respect to an employee who is covered due to his current or past employment with a withdrawing employer or group, the date on which the withdrawal occurs.

Termination of Dependent Coverage - A dependent of yours will cease to be eligible for Plan coverage on the first to occur of the following dates unless the dependent is entitled to COBRA coverage and an on-time COBRA self-payment is made by or on behalf of the dependent (dependents cannot make regular self-payments):

1. The date the Trustees discontinue this Plan of Benefits.
2. The date the Trustees terminate coverage for dependents under this Plan of Benefits.
3. The date you cease to be eligible for Plan coverage for reasons other than your death.
4. For your spouse, on the date of your divorce or legal separation under a decree of separate maintenance.
5. For a dependent child, the date the child fails to meet the Plan's definition of a dependent.
6. If COBRA self-payments are being made by or on behalf of the dependent, at the end of the last day of the last month for which an on-time self-payment was made or on the date of occurrence of any event stated in "Termination of COBRA Coverage" on page 16, whichever occurs first.
7. In the event of your death, at the end of the last day of the last month for which you had earned or paid for eligibility before your death, unless a self-payment for COBRA coverage or the Widow Program is made by or on behalf of the dependent.
8. If a surviving dependent's coverage is being continued through self-payments for the Widow Program (starting on page 31):
   a. If a correct and on-time payment is not made, at the end of the last day of the last month for which a correct and on-time self-payment was made;
   b. The date the dependent becomes eligible for Medicare; or
   c. For a surviving spouse and her dependent children, if any, the date on which she remarries.

EARLY ELIGIBILITY PROGRAM

NEWLY ORGANIZED EMPLOYEES

If you are an individual employee who has been newly organized (or an employee of a newly organized employer), you may be entitled to make self-payments for early eligibility while you work to meet the regular initial eligibility rules.

Rules Governing Early Eligibility

1. You cannot self-pay for coverage for the month in which you start work. For example, if you first begin covered employment in August, you can self-pay for September coverage.
2. Self-payments for early eligibility must be at the rate of 130 hours per month times the current base contribution rate, and you can make up to 2 consecutive self-payments for early eligibility. After that you must establish eligibility through work hours.
3. The early coverage provided for you and any covered dependents will be all of the Plan's normal benefits. Coverage is subject to the preexisting condition exclusion (see page 50).
4. The opportunity of obtaining early eligibility for coverage for you and your dependents will be available to you only once during your lifetime, whether under this provision or any of the Plan's other special eligibility provisions.
5. Your continuing eligibility will be governed by the normal rules for bargaining unit employees (the 130-hour rule and the rollback rule, plus the regular self-payment rule).
6. If you do not become eligible under the Plan's regular eligibility rules at the end of the allowable period of your coverage under these rules, you may be entitled to elect to make COBRA self-payments for continued Plan coverage according to the rules governing COBRA coverage.
7. If you are covered due to your current or past employment with a withdrawing employer or group, your coverage will terminate on the date the withdrawal occurs.

NEW NON-BARGAINING UNIT EMPLOYEES

If you are a new non-bargaining unit employee, you can make up to 2 monthly self-payments for early eligibility for yourself and your dependents. The rules governing your early eligibility are the same as the rules for newly organized employees, except that your payment must be at the rate of 160 hours per month times the current base contribution rate.

After that, the rules for all other non-bargaining unit employees will apply.

APPRENTICES

If you are a new apprentice entering a training program arranged by the JATC, you may be entitled to make self-payments for early eligibility. The rules governing your early eligibility are the same as the rules for newly organized employees.

CABLE PULLERS AND RESIDENTIAL & MOTOR SHOP TRAINEES

You may be entitled to self-pay for early eligibility if you are a new cable puller or a residential or motor shop industry trainee, and if your employer's collective bargaining agreement has a provision for such a classification and the employer makes the required contributions to the Plan.

The rules governing your early eligibility are the same as the rules for newly organized employees.

The following rules will also apply:

1. Any employee who becomes a cable puller more than 6 months after beginning covered employment in the electrical industry cannot become eligible under the early eligibility rules. Similarly, any employee who enters a training program more than 6 months after beginning covered employment in the electrical industry, even if the program is an approved residential or motor shop training program, will not be considered a trainee under the terms of the Plan and cannot self-pay for early eligibility.

2. If you cease to be a cable puller or if you cease to participate in the approved training program, or if you do not become eligible under the Plan's regular eligibility rules by the end of your allowable early eligibility period, you may be entitled to elect to make COBRA self-payments for continued Plan coverage according to the rules governing COBRA coverage.
3. Your coverage under these eligibility rules will terminate if you cease to be a cable puller or drop out of the training program.

Note: Eligibility as a cable puller or trainee can continue as long as sufficient employer contributions are made, up to a maximum of 4 years from the date you first become covered under the Plan.

IF YOU BECOME DISABLED

ELIGIBILITY DURING DISABILITY

Short-Term Disability

If you become totally disabled either on the job or off the job, you will be credited with *disability hours* during the period of your total disability according to the following rules:

1. You must provide the Plan Office with acceptable medical proof of total disability. If you fail to supply proof of disability within 6 months of the date you become disabled, your application for disability hours will be denied.
2. You will be credited with 8 hours for each full day of disability that falls on a normal work day of the week except Saturdays and Sundays, starting with your first full day of disability. No hours are credited for partial or half days.
3. The disability hours will be used as regular credited hours in determining your eligibility under the 130-hour rule, but they will NOT be counted under the rollback rule.
4. You can be credited with up to a maximum of 160 disability hours during a month, and you can receive disability hours for up to 24 months for the same or related disability.
5. If, while receiving disability hours, you take normal or early retirement (other than due to disability) before you have received the 24 months of disability hours, you will not be credited with any further disability hours.
6. If you become disabled after satisfying the initial eligibility requirements but before your initial eligibility date, you will be credited with disability hours beginning with your initial eligibility date.
7. You cannot use disability hours to gain initial eligibility or to re-establish eligibility if your eligibility terminates.

If you are receiving Workers' Compensation benefits due to a work-related injury but are no longer under a doctor's care, contact the Plan Office to find out how to qualify for Eligibility During Disability.

Long-Term Disability

If you are totally disabled and have received 24 months of coverage under the short-term disability rules but do not qualify for Early and Disability Retiree Benefits or Social Security disability benefits, you can make self-payments to continue your coverage as follows:

1. Your monthly self-payments will be 160 times 100% of the current employer contribution rate. This will provide medical and prescription drug coverage for you and your dependents (no Weekly Disability Benefits).
2. Your monthly self-payments are due on or before the first day of the month for which you are paying. If you fail to maintain continuous and uninterrupted coverage by making on-time payments, you will not be allowed to make any further self-payments.
3. You can make these self-payments until you are no longer totally disabled or until you qualify for Early and Disability Retiree Benefits or Medicare. *Proof of your disability must be submitted with each monthly self-payment.*
4. If you return to active work and become totally disabled while eligible due to the same or related disability, you will not qualify for 24 months of disability hours, but you may start self-paying again under these rules at the 100% rate.
5. If you die while making self-payments under this provision, your spouse can make self-payments according to the same rules that apply to other widows (see page 31).

WEEKLY DISABILITY BENEFIT

Only active eligible employees are eligible for Weekly Disability Benefits. Retirees and dependents are not eligible to receive this benefit.

Eligibility for Weekly Disability Benefits - In order to be eligible for Weekly Disability Benefits, you must be eligible from working or from making regular self-payments up to the date your disability starts (your eligibility cannot have been earned from using disability

hours). Also, you must make, or continue to make, any self-payments which are billed by the Plan Office. If, after you start receiving weekly benefits, the Plan Office determines that you were not actually eligible from working or making regular self-payments when your disability started, you will be required to repay the Plan the amount of the weekly benefits the Plan has already paid to you.

Definition of Total Disability - The definition of total disability, as applied to this benefit, means your complete inability to perform any and every duty of your occupation or employment as a result of non-occupational accidental bodily injury or sickness.

Your disability must be certified by a doctor. If the doctor who certifies your disability is a chiropractor, you must have the disability certified after 4 weeks by a medical doctor.

When Benefits Start - Regardless of the following rules, a disability will not be considered to have started until the day you are examined by a doctor and the doctor certified your disability.

- Benefits will start on the first day of disability due to an accidental injury, provided the disability begins within one week from the date of the accident.
- Benefits will start on the eighth day of disability due to sickness. However, if your sickness lasts for 8 days or more, you will receive a retroactive disability benefit payment for the first 7 days of the sickness. (Disabilities due to pregnancy, pregnancy-related conditions and maternity are paid as disabilities due to sickness.)
- If you become disabled after working enough hours to satisfy the initial eligibility rules but before actually becoming eligible, your Weekly Disability Benefits will begin on the first day (for injury) or eighth day (for sickness) after you become eligible.
- In no event will weekly benefits start before your initial eligibility date. Also, if you are receiving unemployment benefits, your weekly benefits will not start until your unemployment benefits are discontinued.

Amount of Benefit - The amount of your weekly benefit is the lesser of $250 or 60% of your 40-hour-per-week wage. Benefits are based on a 5-day work week (excluding Saturdays and Sundays). If benefits are due you for a part of a week, you will receive one-fifth of the weekly benefit for each day of disability.

The wage rate used to determine your benefit will be the rate you are receiving at the time you become disabled. (This does not apply to residential trainees, motor shop trainees or cable pullers. The weekly benefit for these employees is $150 per week for a maximum of 13 weeks.)

Length of Benefit Period - If you become totally disabled and unable to work as a result of *non-occupational* accidental injury or sickness while you are eligible for this benefit, weekly benefits are payable for up to 52 continuous weeks during one period of disability.

However, if you receive weekly benefits for more than 26 weeks and if you qualify for Social Security disability benefits, you will be required to reimburse the Plan for any disability payments you received from the Plan after the first 26 weeks for which you also received a Social Security disability payment.

Concurrent Periods of Disability - More than one disability occurring or existing at the same time will be considered one continuous period of disability. Benefits payable will be limited to a maximum of 52 weeks.

Sporadic Periods of Disability - Sporadic periods of disability (disabilities happening from time to time) resulting from the same or related causes will be considered one continuous period of disability even if you return to work between the periods of disability. Benefits payable will be limited to a maximum of 52 weeks.

If a second period of disability is due to an injury or sickness entirely unrelated to the cause of the first disability, then the second disability will begin a new period of disability as long as you are given a medical release from the certifying doctor for the first disability.

Note About Occupational Disabilities - If your disability is occupational, you are NOT eligible to receive Weekly Disability Benefits, but you must notify the Plan Office so that you will be credited with disability hours. However, if you receive Weekly Disability Benefits for a disability and then later receive Workers' Compensation benefits for that same disability, you will be required to reimburse the Plan for the weekly benefits you received from the Plan.

Taxation of Weekly Disability Benefits - You must include your Weekly Disability Benefits in your gross income and pay federal income tax on them. The Plan Office will send you a W-2 form to use for this purpose. If you have a question about including weekly benefits in your gross income or about exclusions in the law, check with a competent tax advisor or counsel.

Your weekly benefits are also subject to Social Security Taxes (FICA). In accordance with federal law, the Plan

will withhold your share of the FICA tax from each weekly benefit payment (up to a maximum of 6 months) and will send it to the government.

Exclusions and Limitations - No Weekly Disability Benefits will be paid:

1. For any disability resulting from occupational accidental injury or sickness or occurring while performing service in the uniformed services of any country;
2. For any disability resulting from sickness or injury for which you are not under the direct and continuous care of a doctor (this means that you are examined by a doctor at least once every 6 to 8 weeks);
3. After the first 26 weeks of benefits, for any period during which you are eligible for Social Security disability payments; or
4. For any disability which exists beyond the date you retire (unless you are on disability retirement), or which starts after you retire.

WHEN YOU RETIRE

QUALIFYING FOR RETIREE BENEFITS

There are 3 ways in which retired employees may qualify to receive benefits under the Plan.

1. **Early and Disability (E&D) Retiree Benefits -** If you are not eligible for Medicare, you may be entitled to make self-payments for E&D Retiree Benefits. You can be eligible for the E&D Retiree Benefits only if you are not eligible for Medicare.
2. **Supplement to Medicare -** If you are eligible for Medicare, you may be entitled to make self-payments for the Supplement to Medicare.
3. **COBRA -** Retirement is a COBRA "qualifying event." If you are eligible for active Plan benefits when you retire, you may make self-payments for up to 18 months for continued coverage for you and your covered family members under the COBRA coverage rules.
   - You can make COBRA self-payments for a period after you retire and then switch to the E&D Retiree Benefits if you satisfy all of the following requirements:
     - ❑ You were eligible for at least 36 months during the 60 months immediately preceding your retirement date as a result of active employment or on account of disability, layoff or unemployment before your COBRA coverage became effective (see rule No. 2 under "Eligibility Requirements for E&D Retiree Benefits" on page 26);
     - ❑ You maintain continuous COBRA coverage, and enroll in the E&D Retiree Benefits program before the end of your 18-month COBRA period; and
     - ❑ Your retiree coverage immediately follows your COBRA coverage with no interruption in coverage (There can be no gap between your COBRA coverage and the start of your E&D Retiree Benefits.).
   - Medicare entitlement is a terminating event under COBRA coverage. A person who is not eligible for Medicare when he elects COBRA but who later becomes eligible for Medicare will lose the right to make any additional COBRA coverage self-payments.
   - If you elect coverage under the Plan's E&D Retiree Benefits or the Supplement to Medicare, you are rejecting your right to elect COBRA and CANNOT elect it in the future. If you do not elect and maintain COBRA coverage for the maximum period, you and your dependents lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions.

BENEFITS FOR RETIREES ARE NOT ACCRUED OR VESTED

The coverage provided by the Plan for retirees, including coverage for their spouses, surviving spouses and dependent children (whether it is early, disability or Supplemental to Medicare) is a ***subsidized coverage.***

If the Trustees determine that the amount of the subsidy by the Plan for the coverage reaches a level so that the subsidy is too large a portion of Plan costs, the Trustees may reduce the coverage, initiate or increase self-payments for the coverage, or eliminate the coverage.

IMPORTANT LIMITATIONS

No Regular Self-Payments After Retirement - Once you start receiving a pension, you are not entitled to make regular self-payments for coverage under the active employee plan. In order to receive benefits under the Plan, you must either make COBRA self-payments or enroll for coverage under the E&D Retiree Benefits or the Supplement to Medicare.

No Credit for Reciprocal Hours Worked After Retirement - If you are retired and covered under any of the retiree benefits provided under the Plan and then return to work in another jurisdiction for which reciprocal hours are sent to the Plan, you will still be considered by the Plan to be retired in all respects. Except for Special Fund contributions, any reciprocal contributions received by the Plan will be applied to the Plan's overall retiree subsidy and will not be applied to your credit, either in the form of a reduced self-payment or credited hours.

Termination Upon Employer Withdrawal - If you are covered under any of the retiree benefits provided under the Plan and your former employer withdraws from participation as a contributing employer to this Plan, the employer's withdrawal may have an effect on your benefit coverage. If you know that your employer has withdrawn from participation in the Plan, contact the Plan Office immediately to find out if your coverage under this Plan will be affected by the employer's withdrawal. (For more information see "Termination Upon Employer Withdrawal" on page 18.)

EARLY AND DISABILITY RETIREE BENEFITS

Eligibility Requirements for E&D Retiree Benefits - You will be eligible for E&D Retiree Benefits if you meet all of the following requirements:

1. You are not currently eligible for Medicare;
2. You were eligible to receive benefits under either the basic 130-rule or the rollback rule as a result of active employment or on account of disability, layoff, or unemployment (but not COBRA coverage) on the day before your retiree coverage begins, and for at least 3 years (36 months) out of the 5 years (60 months) immediately preceding your retirement date. Your retiree coverage must immediately follow, with no interruption in coverage;
3. You provide written proof that you are:
   a. Now retired either under the early retirement provisions of an industry-sponsored pension plan or under the disability provisions of the Social Security program, or you meet other requirements established by the Trustees; OR
   b. A retired non-bargaining unit employee who is at least age 55, and you meet the service requirements and all other requirements for retiree coverage except for qualifying for an industry-sponsored pension plan (your retiree coverage will terminate if you return to work, including clerical or management work, for an employer in the industries covered by the Plan); and
4. You have enrolled and made the proper retiree self-payments to the Plan.

Dependent Eligibility - If you are covered under the E&D Retiree Benefits, your dependents will also be eligible for E&D Retiree Benefits. If your spouse becomes eligible for Medicare before you do, she will become covered under the Supplement to Medicare. If you acquire a new dependent, you should notify the Plan Office within 30 days.

Spouse Plan - If you are eligible for the Supplement to Medicare, your dependents who are not eligible for Medicare will be eligible for E&D Retiree Benefits. Your spouse (and any dependent children) will be considered covered under the "spouse plan," which requires your spouse to file claims for herself and any children under her name and Social Security number instead of under yours. Your spouse's first self-payment under the spouse plan is due before her coverage would otherwise terminate. Additional information about the spouse plan is available from the Plan Office.

Enrollment for E&D Retiree Benefits - If you are under age 65 and plan to retire, or if you are retiring because of disability and are not yet eligible for Medicare, you must contact the Plan Office to enroll and make the required self-payments.

Your enrollment must be made before your coverage under the regular active employee plan terminates. If you fail to do this, you permanently waive your right to enroll. Even if you are covered under another plan when you retire, such as your spouse's plan, you must still enroll while you are eligible for the regular active employee benefits if there is any possibility that you might want the E&D Retiree Benefits later on.

Self-Payments for E&D Retiree Benefits

1. The amount of your monthly self-payment is based on your age in the month for which the payment is made, and is the same whether or not you have a spouse or child. However, if your spouse becomes covered under the Supplement to Medicare before you do, you will need to pay the Supplement to Medicare rate for her, and a reduced single-coverage E&D rate for yourself. Self-payment rates are determined by the Trustees based on the cost of the coverage and can be changed at any time. When you contact the Plan Office to enroll for E&D Retiree Benefits, you will be told how much the monthly payments will be and you will be given the forms for sending in your payments. You will also be sent an acknowledgment each time a payment is received.

   Note: There is a special reduced self-payment rate for participants who retire due to disability. The disability rate applies only to retirees who are disabled at the time they retire, not to participants who obtain a Social Security disability award after they start receiving E&D Retiree Benefits.

2. You can have the payments automatically deducted from your pension check. In order to do this, you must complete an authorization form provided by the Plan Office. You can also make your payments by check or money order. Your payment, along with the correct form, must be received by the Plan Office no later than the 15th day of the month for which you are paying. Make your check or money order payable to the Michigan Electrical Employees' Health Plan. *You will not have eligibility until the payment for that month is received.*
3. You can make up to 6 months of payments in advance.
4. If you fail to make a payment by the date it is due, coverage for you and your dependents will terminate and no further self-payments will be allowed.

E&D Benefits Payable - If you meet the eligibility requirements, you and your dependents will continue to be eligible for the same medical and prescription drug coverage you had under the regular active employee plan. *You will NOT be eligible for Weekly Disability Benefits* (Weekly Disability Benefits and/or disability hours stop on the date you retire).

Credit for Employer Contributions - If you are making self-payments for E&D Retiree Benefits and return to work for a contributing employer, you may be entitled to some reimbursement of your self-payments as follows:

1. These rules apply only to temporary and casual work, but not to work performed under a reciprocity agreement.
2. If you have made a self-payment for E&D Retiree Benefits for a month for which you also have credited hours from an employer contribution, you may be entitled to receive a refund of your self-payment for that month.
3. The refund for any month cannot be greater than the self-payment you made for that month.
4. You can be reimbursed for up to 2 months of self-payments during any period of 12 consecutive months.
5. You must contact the Plan Office within 90 days of your last day of employment to apply for your self-payment refund.

COBRA Coverage for Dependents Under Certain Circumstances - If you are making retiree self-payments and you are divorced or legally separated, your spouse may be entitled to make COBRA self-payments for continued E&D Retiree Benefits under the applicable rules governing COBRA coverage (pages 15-17).

If you are making retiree self-payments and a dependent child loses dependent status, the child may be entitled to make COBRA self-payments for continued E&D Retiree Benefits under the applicable rules governing COBRA coverage.

Termination of Retiree Coverage - You will cease to be eligible for E&D Retiree Benefit coverage on the first to occur of the following dates:

1. The first day of the month during which you become entitled to Medicare.
2. The date the Trustees discontinue E&D Retiree Benefits.
3. The date the Trustees discontinue this Plan of Benefits.
4. The date of your death.
5. If you are a retiree who retired from non-bargaining unit employment, the date you return to work, including clerical or management work, for an employer in the industries covered by the Plan.
6. If you fail to make a correct and on-time self-payment, the end of the last day of the last month for which a correct and on-time self-payment was made.

Termination of Dependent Coverage - A dependent of yours will cease to be eligible for E&D Retiree Benefit coverage on the first to occur of the following dates:

1. The date the Trustees discontinue this Plan of Benefits.
2. The date the Trustees discontinue E&D Retiree Benefits or discontinue dependent coverage under the E&D Retiree Benefits.
3. If a correct and on-time payment fails to be made to the Plan by or on behalf of the dependent to maintain coverage, the end of the last day of the last month for which a correct and on-time payment was made.
4. If you are a retiree who retired from non-bargaining work, the date you cease to be eligible for E&D Retiree Benefits because of your return to work for an employer in the industries covered by the Plan.
5. For a dependent child, the date the child loses dependent status, unless the child is entitled to COBRA coverage, an on-time COBRA self-payment is made by or on behalf of the child.

6. For a dependent spouse, the date of your divorce or legal separation under a decree of separate maintenance, unless the spouse is entitled to COBRA coverage, an on-time COBRA coverage self-payment is made by the spouse.
7. For a dependent spouse if you are paying for E&D Retiree Benefits for your dependents after you become eligible for Medicare, on the first day of the month during which the spouse becomes eligible for Medicare.
8. In the event of your death:
   a. On the first day of the month following the month in which you die unless a self-payment is made for E&D Retiree Benefits under the Widow Program (starting on page 31) or COBRA. (If you do not elect and maintain COBRA coverage for the maximum period, your dependents lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions);
   b. For a dependent spouse who is eligible for Medicare on the date of your death, on the first day of the month following the month in which you die; or
   c. For dependents whose E&D Retiree Benefits are being continued through self-payments under the Widow Program:
      - If a correct and on-time payment is not made by or on behalf of the dependent, the end of the last day of the last month for which a correct and on-time payment was made;
      - For a dependent child, the date the child loses dependent status;
      - For a surviving spouse or child who is not eligible for Medicare on the date of your death, the date on which the spouse or child becomes eligible for Medicare; or
      - For a surviving spouse and her dependent children, if any, the date on which she remarries.

When You Become Eligible for Medicare - When you become eligible for Medicare, you are no longer eligible for E&D Retiree Benefits. (You will, though, be eligible for the Supplement to Medicare.)

You can continue to make self-payments for E&D Retiree Benefits coverage for any of your dependents (spouse and/or dependent children) who are not eligible for Medicare. Your non-Medicare-eligible spouse (and any dependent children) will be considered covered under the E&D Retiree Benefits "spouse plan" (see page 26).

You can stop making the payments for your dependents at any time, and their coverage will terminate at the end of the period for which you have already paid. After that time their coverage cannot be reinstated. If you stop making the payments, your spouse will still be eligible for the Supplement to Medicare when she reaches age 65, enrolls in both Part A and Part B of Medicare, and the proper self-payments are made on her behalf.

Retirees With End Stage Renal Disease (ESRD) - If you are eligible for Medicare due solely to ESRD, you will be covered under the E&D Retiree Benefits program during the 30-month period that group health plans are required to pay primary over Medicare. During this 30-month period, the required self-payment will be the same as the amount required for coverage under the Supplement to Medicare.

When Your Spouse Becomes Eligible for Medicare - When your spouse (or other eligible dependent) becomes eligible for Medicare, her E&D Retiree Benefits coverage will terminate, and she will become eligible for the Supplement to Medicare. She must be enrolled in both Part A and Part B of Medicare. If a dependent who is entitled to Medicare is NOT enrolled in Medicare Part A and Part B, that dependent's coverage will terminate.

Even if both you and your spouse are covered under the Supplement to Medicare, you can continue to make payments to cover your dependent children under the E&D Retiree Benefits.

Be Sure to Enroll in Medicare Before Your 65th Birthday - If you are eligible for E&D Retiree Benefits but will soon be eligible for Medicare, contact your local Social Security office (preferably before you become 65) to find out how to enroll for Medicare Part A and Part B. This also applies to any dependent who will soon be eligible for Medicare.

Except as described above for retirees with ESRD, you can be eligible for the E&D Retiree Benefits only as long as you are not eligible for Medicare. Once you become eligible for Medicare, you are eligible ONLY for the Supplement to Medicare. The same rule applies to your eligible dependents.

SUPPLEMENT TO MEDICARE

Retiree Eligibility - You will be eligible for coverage under the Supplement to Medicare if you meet the following requirements:

1. You *must* be enrolled for both Part A and Part B of Medicare;
2. You must have been eligible to receive benefits under the Plan as an active employee as a result of active employment or on account of disability, layoff, or unemployment (but not COBRA coverage) on the day before your retiree coverage begins, and for at least 3 years (36 months) out of the 5 years (60 months) immediately preceding the date of your retirement; and
3. You must make correct and on-time self-payments for the coverage.

Dependent Eligibility - A dependent (spouse or child) will be eligible for the Supplement to Medicare if the following requirements are met:

1. You (the retiree) must be an eligible retiree covered under the E&D Retiree Benefits or the Supplement to Medicare;
2. The dependent must be eligible for Medicare and must be enrolled in both Part A and Part B of Medicare; and
3. You must make correct and on-time self-payments for the coverage.

Previous E&D Retiree Coverage Not Required - You do not have to participate in the E&D Retiree Benefits program in order to be eligible for the Supplement to Medicare when you become eligible for Medicare. However, you must contact the Plan Office before your 65th birthday if you want to enroll in the Supplement to Medicare.

Benefits Provided - If you meet the eligibility requirements stated above and make any required self-payments, you will be eligible for a BCBSM "Medigap" program that supplements the benefits provided by Part A and Part B of Medicare. This program also includes the same prescription drug benefits provided to active employees. The benefit schedule is provided in a separate document, and you can obtain a copy from the Plan Office.

Medicare Part D Prescription Drug Plans - Medicare prescription drug coverage is available to everyone with Medicare. This coverage is provided through private plans approved by Medicare (often referred to as "Medicare Part D plans"), and you must pay a monthly premium for Part D coverage.

Medicare-eligible retirees (and Medicare-eligible spouses of retirees) have the option of dropping this Plan's prescription drug coverage and switching to a Medicare Part D plan.

- You cannot choose dual coverage.
- Your self-payment amount to this Fund will not change if you elect a Part D plan.
- This Fund will not pay your Part D plan premiums.
- If you elect a Part D plan, you can still make payments for this Plan's Supplement to Medicare. In such case, the Supplement to Medicare will provide you with supplemental hospital and physician benefits—but not prescription drug benefits.
- If you change your mind later, you will have a once-per-lifetime opportunity to can get back into the Plan's prescription drug program. But you must first drop your Part D plan.
- You and your spouse can be covered under different drug plans.
- You must inform the Plan Office if you or your spouse chooses Part D coverage. If you do not provide timely notification, and if the Plan continues to pay your drug expenses, you will have to repay the Plan for the amount it paid. Your double coverage could also cause problems and overpayment situations with your Part D plan.

Please note that as of January 1, 2006 this Plan's prescription drug coverage for retirees has been determined to be creditable coverage, which means it is at least as good or better than the coverage provided under a standard Part D plan. It also means that you can keep this coverage and not have to pay an extra late enrollment penalty if you later decide to enroll in Medicare Part D coverage and your enrollment date is within 63 days of the termination date of this Plan's prescription drug coverage.

Adding a Dependent - If you (the retiree) marry or remarry, you must notify the Plan Office within 30 days of the date of the marriage, so that you can begin making any necessary self-payments on a timely basis. If you do not enroll your new spouse in the Plan's Supplement to Medicare at that time, you cannot later add her to your coverage. If you divorce and later remarry the same spouse, she will only be covered after your remarriage if she was covered before your divorce.

Self-Payments for the Supplement to Medicare

1. Self-payments are required for each person.
2. The amount of the self-payment is determined by the Trustees and may be changed at any time.
3. You can have the payments automatically deducted from your pension check. In order to do this, you must complete an authorization form provided by the Plan Office.
4. You can also choose to make the monthly payments by check or money order.
5. Payment is due on the first day of the month for which coverage is desired.

Termination of Retiree Coverage - You will cease to be eligible for the Supplement to Medicare on the first to occur of the following dates:

1. The date the Trustees discontinue the Supplement to Medicare.
2. The date the Trustees discontinue this Plan of Benefits.
3. The date of your death.
4. If you fail to make a correct self-payment by the first day of the first month for which the payment is billed, the end of the last day of the last month for which a correct and on-time self-payment was made.

Termination of Dependent Coverage - A dependent of yours will cease to be eligible for the Supplement to Medicare on the first to occur of the following dates:

1. The date the Trustees discontinue this Plan of Benefits.
2. The date the Trustees discontinue the Supplement to Medicare.
3. The date the Trustees discontinue coverage for dependents under the Supplement to Medicare.
4. If you fail to make a correct self-payment by the first day of the first month for which the payment is billed, the end of the last day of the last month for which a correct and on-time self-payment was made.
5. The date of your divorce or legal separation from your spouse.
6. If a surviving spouse is continuing coverage under the Supplement to Medicare after your death, the date of the spouse's remarriage or death, whichever occurs first.

IN THE EVENT OF YOUR DEATH (Surviving Dependent Coverage)

ACTIVE EMPLOYEES

If you die while you are covered under the Plan as an active employee, your surviving dependents may be entitled to continue Plan coverage by making self-payments for COBRA coverage or for the Widow Program.

COBRA Coverage

Your surviving spouse (or dependent children) may be entitled to make self-payments for COBRA coverage (see pages 15-17 for the governing rules).

Widow Program

(For Surviving Spouses and/or Dependent Children)

After your death, the Plan Office will apply any eligibility you earned or paid for before your death to your surviving dependents' eligibility. Then, if your surviving dependents decline COBRA and want to make self-payments for continued coverage under the Widow Program, the rules stated below will apply. The payments may be made by your surviving spouse, or by or on behalf of a surviving dependent child (or children) if you have no surviving spouse.

The Widow Program Self-Payment Rules

1. Your spouse must make the first payment on or before the date that coverage would otherwise terminate. If an on-time self-payment is not made, she may not make any future self-payments.
2. The amount of required payment each month is determined by the Trustees and can be changed at any time.
3. Your spouse must contact the Plan Office to apply to make the self-payments. After the first payment is made, the Plan Office will send her a self-payment statement acknowledging that payment. Your spouse can use a copy of that form to send in the next payment.
4. All monthly self-payments after the first payment are due no later than the 15th day of the month for which the payment is being made. If your spouse fails to make an on-time self-payment, coverage will terminate at the end of the month for which a payment had already been made, and no further self-payments may be made.
5. Your spouse can continue to make self-payments for the Widow Program until coverage terminates according to the termination rules stated in No. 8 on page 19.

E&D RETIREES

If you die while you are eligible for E&D Retiree Benefits, your surviving dependents may be entitled to continue coverage for E&D Retiree Benefits by making self-payments for COBRA coverage according to the COBRA coverage rules (pages 15-17).

If your surviving dependents decline COBRA coverage they can make self-payments for continued E&D Retiree Benefits under the Widow Program. The payments may be made by your surviving spouse or by or on behalf of a surviving dependent child (or children) according to the same rules if there is no surviving spouse.

The same self-payment rules that apply to survivors of active employees will apply, except that:

1. Your spouse must make the first self-payment on or before the first day of the month following the month during which your death occurs—for example, by May 1 if you die on April 20. If an on-time payment is not made, coverage will terminate and she may not make any future self-payments.
2. Your dependent spouse can make self-payments until she becomes eligible for Medicare or remarries. If your surviving child is making the self-payments, the payments can be made until the child no longer meets the definition of a dependent (for example, because of age) or becomes eligible for Medicare.

RETIREES COVERED UNDER THE SUPPLEMENT TO MEDICARE

If you die while both you and your spouse are covered under the Supplement to Medicare, or if you are covered under the E&D Retiree Benefits but your spouse is

covered under the Supplement to Medicare, your spouse will continue to be eligible for the Supplement until she dies or until she remarries, whichever occurs first, provided she continues to make the required self-payments.

If you die while only you are covered under the Supplement and you have been making payments for the E&D Retiree Benefits under the "spouse plan" for your dependents, your spouse can continue E&D Retiree Benefits under the Widow Program for herself and any dependent children. She can make the payments until she becomes 65 and eligible for Medicare or until she remarries, whichever occurs first. If your spouse dies after your death, your dependent child's coverage under the Supplement to Medicare will cease.

If your spouse does not want to continue coverage for the Widow Program E&D Retiree Benefits, she can stop making the payments and the Widow Program E&D Retiree Benefits will terminate at the end of the period for which payments had already been made. However, even if she stops making the payments, she will still be eligible (unless she has remarried) to enroll in the Supplement to Medicare when she becomes age 65 and eligible for Medicare, provided she is enrolled in both Part A and B of Medicare and makes the required monthly self-payments.

When your spouse becomes eligible for Medicare, she should contact the Plan Office for information about enrolling.

COMPREHENSIVE MEDICAL BENEFITS

This section does not apply to persons covered under the Supplement to Medicare.

All benefits for hospital, surgical, and other health care expenses incurred by you and your dependents are covered under one benefit—the Comprehensive Major Medical Expense Benefit (usually referred to in this booklet as the "Comprehensive Benefit"). This section describes the benefits available under the Comprehensive Benefit and how the benefits are paid.

HOW MEDICAL BENEFITS ARE PAID

Maximum Benefits and Limitations

Once a covered person has received benefits for a particular type of treatment totaling the lifetime maximum benefit or calendar year maximum benefit for that type of treatment, no further Plan benefits will be paid for him for that type of treatment during the rest of his lifetime, or during the rest of that calendar year, as applicable.

Lifetime Maximum Benefits and Limitations - There are certain lifetime maximum benefits and other lifetime limitations that apply to particular types of treatment. All benefits received by a covered person for covered medical expenses incurred for a particular type of treatment that is subject to a lifetime maximum benefit or limitation will apply to the lifetime maximum benefit or limitation for that type of treatment as well as to the person's Comprehensive Benefit lifetime maximum benefit. This rule applies wherever a lifetime maximum benefit is shown on the Schedule of Benefits, whether or not there is an interruption in the person's Plan coverage or whether the person's Plan status changes—for example, from dependent to employee status or vice versa, or from employee to retiree status.

Calendar Year Maximum Benefits and Limitations - There are certain calendar year maximum benefits and limitations that apply to particular types of treatment. All benefits received by a covered person for covered medical expenses incurred during a calendar year for a particular type of treatment that is subject to a calendar year maximum benefit or limitation will apply to the calendar year maximum benefit or limitation for that type of treatment as well as to the person's Comprehensive Benefit lifetime maximum benefit. This rules applies wherever a calendar year maximum benefit is shown on the Schedule of Benefits, whether or not there is an interruption in the person's Plan coverage during the year or whether the person's Plan status changes during the year—for example, from dependent to employee status or vice versa, or from employee to retiree status.

Calendar Year Deductibles

(For the purposes of this explanation, the term "year" means a calendar year.)

Individual Deductible - Once a family member has incurred and properly submitted a claim for $500 of covered medical expenses during a year, he has "satisfied" his individual deductible. No payment is made for expenses used to satisfy deductibles—you must pay them out of your own pocket.

Family Deductible - After two or more persons in your family have incurred a total of $1,000 in covered medical expenses applied to calendar year deductibles during a year, the family deductible has been "satisfied." No further covered medical expenses incurred by members of your family will be applied to deductibles during the rest of that year.

Calendar Year Deductible Rules - All deductibles are based on an accumulation period of a calendar year, and only covered medical expenses can be used to satisfy deductibles. If a person is suffering from a condition for which covered medical expenses are incurred in two or more calendar years, the deductible must be satisfied each year.

Each family member must satisfy the individual deductible each year except as follows:

- Once the family deductible is satisfied during a year, no further individual deductibles must be satisfied by any other family members during that year.
- Any covered medical expenses incurred by a person during October, November or December of a calendar year that are applied to his individual deductible for that year will also be applied in the same amount to his individual deductible for the next year. Any

such carried-over amounts of individual deductibles will not apply to the family deductible for the next year.

You, the employee or retiree, are responsible for paying the covered medical expenses used toward satisfaction of deductibles for all members of your family.

Copayment Percentages; Out-of-Pocket Limits

Once a person has satisfied his individual calendar year deductible during a year (or after the family deductible has been satisfied), the Plan will start paying 70% of that person's additional covered medical expenses (60% for out-of-network charges). The person's copayment share of those covered medical expenses is 30% (40% for out-of-network charges). When $4,000 in out-of-pocket payments have been made by him or on his behalf during that year as his 30% or 40% copayment share of the expenses, the Plan will pay 100% of the covered medical expenses he incurs during the rest of that year (some exceptions apply—see "Amounts Not Counted Toward Out-of-Pocket Limits" below).

Once a family has satisfied the family calendar year deductible during a year, the Plan will start paying 70% of the additional covered medical expenses incurred by all family members (60% for out-of-network charges). When $6,000 in out-of-pocket payments have been made on behalf of all family members as their 30% or 40% copayment share of covered medical expenses they incur during a year, the Plan will pay 100% of the covered medical expenses incurred by all family members during the rest of that year (some exceptions apply).

Both PPO and non-PPO expenses apply to out-of-pocket limits.

Out-of-Network Emergency Treatment - The BCBSM copayment percentage will be paid for out-of-network covered expenses incurred by a covered person because of a condition that meets the Plan's definition of an emergency situation (page 57).

Amounts Not Counted Toward Out-of-Pocket Limits

Any out-of-pocket payments you make for the following do not count toward meeting any individual or family out-of-pocket limits:

- Covered medical expenses used toward satisfaction of calendar year deductibles.
- Charges by out-of-network providers that are in excess of the BCBSM approved amounts.
- Expenses not considered covered medical expenses.
- Treatment for substance abuse and mental/nervous disorders.
- Expenses incurred after any applicable maximum benefit or other limitation has been reached for a particular type of treatment.

Amounts accumulated during a year toward meeting an out-of-pocket limit don't carry over to the next year.

COVERED MEDICAL EXPENSES

Covered medical expenses are the ***reasonable and customary*** charges a covered person actually incurs for the following list of ***medically necessary*** services, supplies, and types of treatment which are acceptable to be considered for payment. Payment will not be made for charges in excess of ***BCBSM approved amounts***, or in excess of any maximum benefits or limitations shown on the Schedule of Benefits.

Covered medical expenses include charges incurred for the following:

1. **Hospital Services and Supplies:**
   a. Hospital room and board and general nursing care for each day of confinement for which the hospital charges its daily rate, including intensive care and coronary care units.
   b. Hospital nursery care of a healthy newborn infant, provided the infant meets the definition of an eligible dependent (charges for delivery of the infant are considered the mother's expenses and are not covered if the mother does not meet the definition of an eligible dependent).

      Note about length of maternity hospitalizations - A covered person and her newborn infant are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarean section. Further, the Plan or BCBSM cannot require the provider (hospital or doctor) to obtain authorization for prescribing a length of stay not in excess of these periods. (The attending provider may

however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Cesarean section.) Benefits will be provided for the covered medical expenses incurred during the prescribed time periods, subject to all applicable Plan benefit provisions, maximums and limitations.

c. Other medically necessary hospital services and supplies, including but not limited to medicines and drugs prescribed and administered while in or at the hospital, administration, cost of equipment, supplies and services of an anesthesiologist for the administration of anesthesia, operating, delivery and recovery rooms, and services and supplies rendered for treatment of accidental injuries and conditions that meet the definition of a medical emergency (page 58).

d. Outpatient preadmission testing before a hospital admission for surgery in a hospital outpatient department or a BCBSM-approved free-standing facility, provided that the tests are: (1) ordered by the doctor who will perform the surgery; (2) performed in connection with the condition for which the surgery is to be performed; (3) performed within 7 days of the hospital admission; and (4) are medically valid at the time of the admission.

2. **Doctors' Services and Supplies,** provided in or out of a hospital, including surgery as well as medical care and treatment.

   Limitation: With respect to chiropractic services, only the following are covered: examinations, x-ray examinations, spinal manipulations, traction and hot/cold packs.

3. **Voluntary Second Surgical Opinions -** When a doctor recommends either inpatient or outpatient surgery, you can get a second opinion on the advisability of having the surgery at no cost to you for the consulting doctor's services and necessary x-rays and lab work.

   - The BCBSM Referral Center (see the inside front cover) must be called when you want to arrange a second surgical opinion. A referral analyst will provide you with names of doctors in your area and will schedule an appointment with the consulting doctor you choose.
   - The consulting doctor's recommendation will not affect the approved amount for the surgery. Whether or not the recommendation favors surgery, you make the final decision about having the surgery.

4. **Treatment of Injury to Teeth -** Services and supplies provided for treatment of an accidental injury to sound natural teeth provided within 6 months of the accident.

5. **Private Duty and Home Health Care**

   a. Private duty nursing care provided by an R.N. to an eligible family member who is confined as a hospital inpatient, but only if the attending doctor certifies in writing that the nursing care is medically necessary;

   b. Private duty nursing care provided by an R.N. to an eligible family member in his home, if the attending doctor certifies the care is medically necessary and if the arrangements are authorized by BCBSM before the care starts; and

   c. Medically necessary home health (nursing) care that is provided as an alternative to hospitalization. The home health care must be arranged by BCBSM and provided by a BCBSM-approved home health agency (page 58). Only BCBSM approved amounts for the following services and supplies will be considered for payment:

      1) Part-time or intermittent nursing care (for skilled nursing visits only) provided by or under the supervision of a registered professional nurse;

      2) Part-time or intermittent home health aide services, but only if those services are preauthorized by BCBSM according to the following criteria: (a) the services are medically necessary; (b) the services could qualify for coverage if performed in a hospital and without regard for the benefits provided under this home nursing care coverage; and (c) the services would have been performed in a hospital if they had not been provided under this home nursing care coverage;

      3) Medical services of interns and residents in training under an approved teaching program of a hospital the home health agency is affiliated with;

      4) Medical supplies (other than drugs and biologicals) and the use of medical appliances; and

5) Any of the above items and services which involve the use of equipment on an outpatient basis at a hospital or skilled nursing facility under arrangements made by the home health agency (excluding transportation).

The only type of service that is covered is a service that would be covered if it were performed while the patient was hospitalized.

6. **Transportation** as follows:
   a. *Emergency local transportation* - Professional local emergency transportation to a hospital, provided the condition requiring the transportation meets the definition of a medical emergency (page 58) and the transportation is followed by a covered hospital admission or by covered emergency room treatment as a result of the condition.
   b. *Transferring* - If a doctor certifies that a person's disability requires specialized treatment that is not available in the hospital to which he has been admitted, a transfer is covered from that hospital to the nearest hospital qualified to provide the special treatment. Only one transfer is covered for any one sickness and for all injuries resulting from any one accident. (The transferring transportation must be by regularly scheduled airline or railroad or by air ambulance and only includes transportation within the continental limits of the U.S. or Canada or within the geographical boundaries of Puerto Rico or Hawaii.)

7. **Diagnostic Radiology and Other Tests -** Diagnostic tests, including x-rays, ultrasound, EKGs, EMGs, EEGs, CAT and MRI scans, nerve conduction studies, and laboratory tests and services of radiologists and pathologists for interpreting the tests.

8. **Therapeutic Chemotherapy and Radiology -** Chemotherapy and radiological treatment by x-ray, radon, radium, radioactive isotope or cobalt for treatment of cancer (malignancies).

9. **Routine Physical Examinations -** Each eligible family member is entitled to benefits for one routine physical examination each calendar year. A routine physical exam is an examination a doctor performs to see if a person has any health problems when there are no symptoms of any problems. You do not have to have a physical examination form filled in by the doctor, and there are no specific tests that have to be performed as part of the exam. However, in addition to any other tests which the doctor feels should be performed as part of the exam, the following are tests which are suggested as part of a routine exam:

Medical & family history	Stool analysis
Complete blood count	SMAC blood test
Blood pressure screening	Urinalysis
Thyroid tests (T3 and T4)	Pap smear (females)
PSA and digital exam (males)	Mammogram

If a person goes to a doctor for an examination when he has symptoms of a health problem, that exam is not considered "routine." The expenses incurred for such an exam will be considered for payment under the regular payment rules of the Comprehensive Benefit, subject to deductibles, copayments, etc. If you use an out-of-network provider you may be required to pay the difference between the doctor's fees and the BCBSM approved amount.

10. **Physiotherapy/Speech Therapy -** Services provided in or out of a hospital by a Registered Physical Therapist or by a Registered Speech Therapist, provided the therapy is recommended by the attending doctor and the patient shows signs of improvement.

11. **Post-Cataract Lenses -** The first pair of contact lenses or eyeglasses required after cataract surgery.

12. **Skilled Nursing Facility Confinements -** Confinement and treatment in an approved skilled nursing facility, provided the confinement meets all of the following requirements:
    a. The program of skilled nursing facility care must be approved by BCBSM, the care must be provided by a BCBSM-approved skilled nursing facility (page 59), and BCBSM must make the arrangements for the care.
    b. The confinement must be certified by the attending doctor as essential for the patient's recuperation from injury or sickness. The doctor must personally examine the patient at least once each 30 days and, if the confinement is to be continued, must certify that continuation of the confinement is necessary for the treatment of the injury or sickness that required the confinement. Also, the patient must show signs of

improvement to the point of being able to maintain an independent existence.

c. The confinement must be preceded by at least 3 consecutive days of inpatient hospitalization which qualify for Plan benefits.

d. The confinement must be due to the injury or sickness which required the previous hospitalization and must start within 14 days after termination of the hospitalization or within 14 days after termination of a skilled nursing facility confinement which qualifies for benefits under the Plan.

13. **Treatment for Substance Abuse and Mental/ Nervous Disorders -** Subject to the maximum benefits shown on the Schedule of Benefits, services and supplies, including group therapy sessions, provided for treatment of all such conditions are covered, provided that BCBSM approves and certifies any treatment provided in, by or through a hospital. Benefits will be payable for treatment of a mental/nervous disorder only if the final diagnosis of the condition treated meets the definition of a mental or nervous disorder (page 59).

    Your doctor should call the BCBSM Mental Health Precertification Unit at 1 (800) 762-2382 before arranging any treatment for substance abuse or mental/nervous disorders.

14. **Midwives -** Services and supplies provided by a midwife for prenatal care, delivery, and postnatal care, subject to the following rules, requirements and exclusions:

    a. The midwife must be specialty-certified by the appropriate state agency;

    b. The actual birth must occur in an accredited hospital (charges made for home birth are not covered expenses unless the home birth is performed on an emergency basis);

    c. The midwife must be affiliated with a qualified obstetrician/gynecologist who is available to step in at any time during the prenatal/birth/ postpartum process; and

    d. If the sum of the charges made for the midwife's services and any necessary doctors' services exceeds the amount of charges that would have been incurred if the entire maternity process had been handled by a doctor, the allowable covered medical expenses will be limited to the covered medical expenses that would have been incurred if the entire maternity process had been handled by a doctor.

15. **Physicians' Assistants; Nurse Practitioners -** Services rendered by physicians' assistants and nurse practitioners, provided the services are rendered within the scope of the individuals' licenses and are performed under the supervision of a physician.

16. **Breast Reconstruction and Prosthetics -** This Plan will provide coverage for the following medical and surgical services provided to a covered person in connection with a mastectomy:

    a. Reconstruction of the breast on which the mastectomy has been performed;

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

    c. Prostheses and treatment of all physical complications relating to all stages of the mastectomy, including lymphedemas. (The Plan covers up to 2 breast prostheses and 4 surgical bras each calendar year after surgery for breast cancer.)

17. **Other Services and Supplies** (if not covered above):

    a. *Drugs and medicines* which are available only with a doctor's written prescription, are identified by a prescription number, and are dispensed by a licensed pharmacist.

    b. *Diabetic supplies* (insulin and needles), ostomy supplies (pouches and adhesive), and tracheotomy care kits.

    c. *Blood components,* and administration of blood components and whole blood.

    d. *Prostheses* (such as artificial arms, legs, and eyes) to replace physical organs or parts of organs. Only the initial charge for a prosthesis is a covered medical expense.

    e. *The first pair of orthotics* prescribed by a doctor and furnished by a BCBSM-accredited facility.

    f. *Surgically-implanted devices* (such as pacemakers) or surgical supplies required to aid any impaired physical organ or part of an organ in its natural body function. (A penile implant will be covered only if the impotence/disorder results from an organic cause. Coverage is limited to one implant per lifetime.)

g. *Oxygen* and rental of equipment for the administration of oxygen; rental of a wheelchair or hospital-type bed; and rental of certain durable medical equipment that is necessary for treatment.

h. *Casts, splints, braces,* crutches and trusses which are purchased only with a doctor's written prescription.

i. *Children's orthopedic shoes,* but only if they are purchased with a doctor's written prescription.

(See the "Plan Conditions, Limitations and Exclusions" starting on page 47 to find out what types of services, supplies and treatment are not covered.)

Covered Expenses for Transplants

Human Organ Transplants - Covered medical expenses include services and supplies provided for human organ transplants in accordance with the provisions set forth below. All transplants must be reviewed and preapproved by BCBSM.

Organ and tissue transplants of skin, cornea and kidney - Benefits are payable for these transplants for covered persons only if the transplant is performed in a BCBSM hospital or BCBSM-approved facility. Benefits are payable as shown on the Schedule of Benefits.

Bone marrow transplants - These include "allogeneic" transplants (when another person's bone marrow is transplanted into the patient to treat certain specific conditions) and "autologous" transplants (when the patient's own bone marrow and/or peripheral blood stem cells are used in connection with certain specific conditions).

These transplants are subject to a set of very specific technical guidelines that determine whether benefits will be paid for a transplant. Contact BCBSM for a set of the guidelines to give to the attending doctor. The doctor must have preauthorization from BCBSM to perform the transplant or no benefits will be paid for the transplant.

Specified organ transplants of the heart, heart-lung, liver, lobar lung, lung, pancreas, pancreas-kidney, small bowel, or small bowel-liver:

1. The attending doctor must request authorization from BCBSM before surgery, and the surgery must be performed at a BCBSM-approved transplant facility (call the BCBSM Human Organ Transplant Program at 1 (800) 242-3504 to confirm a facility's participation status).
2. Covered services and supplies include transplant-related medical services, such as surgery, office visits, visiting nurses, home health care, cardiac rehabilitation and durable medical equipment; surgical storage and transportation costs for obtaining the organ; anti-rejection drugs; and certain costs incurred for transportation, meals and lodging.

Donor Expenses in Connection With Organ Transplants - Subject to the Plan's rules regarding medical necessity and experimental or investigative services, supplies and treatments, the Plan will cover expenses incurred by an organ donor or potential organ donor in connection with an organ transplant in accordance with the following rules:

1. Covered medical expenses will include charges incurred for services and supplies provided to a donor in connection with the donation of an organ to a person who is covered under this Plan (whether or not the donor is covered under the Plan), provided that all of the requirements for obtaining human organ transplants are met. (Covered medical expenses do not include charges incurred by an organ donor who is donating to a person who is not covered under this Plan.)
2. If BCBSM's guidelines are met, covered medical expenses will include charges incurred for tests performed to determine if a potential donor (whether or not the donor is covered under the Plan) is able to donate an organ to a person who is covered under this Plan. However, such covered medical expenses will be considered for payment only if they are not covered by the potential donor's own health coverage or insurance. BCBSM maintains a written set of guidelines covering the circumstances under which testing expenses will be paid for a potential donor. If a person covered under this Plan needs an organ transplant and potential donors are to be tested for compatibility, BCBSM should be contacted for a written statement of the guidelines.

Covered Expenses for Hospice Care

The Plan covers hospice care in accordance with the following provisions. *All hospice care must be approved and arranged by BCBSM.*

A "hospice" is a public agency or private organization (or a part of either), primarily engaged in providing a coordinated set of services at home or in outpatient or

institutional settings to persons suffering from a terminal medical condition.

Benefits are payable for a special hospice care services for persons with terminal medical conditions. "Terminal" means that a person's medical prognosis (as certified by a doctor) indicates a life expectancy of 6 months or less.

Hospice Care Covered Expenses - Only the following expenses incurred for hospice care of a person's terminal condition will be considered for payment as hospice care benefits:

1. Nursing care by an R.N. or L.P.N. and services of homemakers and home health aides (such services may be furnished on a 24-hour basis during a period of crisis or if the care is necessary to maintain the patient at home).
2. Medical social services under the direction of a doctor; counseling services and/or psychological therapy by a social worker or a psychologist; and chaplaincy.
3. Physical and occupational therapy and speech language pathology.
4. Non-prescription drugs used for palliative care, medical supplies, bandages and equipment, and drugs and biologicals used for pain and symptom control.
5. Skilled nursing facility short-term inpatient care to provide respite care, palliative care, or care in periods of crisis (limited to 5 days per occurrence and 10 days per lifetime). This care must also be arranged by BCBSM.
6. Skilled nursing facility inpatient care for longer terms if the necessary level of care is not available at home. This care must also be arranged by BCBSM.

General Provisions Governing Hospice Care

1. Benefits for hospice care are payable under the Comprehensive Benefit, but the benefits are payable only for the "Hospice Care Covered Expenses" instead of for the regular covered medical expenses of the Comprehensive Benefit.
2. Hospice care includes certain services and supplies which are not considered regular covered medical expenses under the Comprehensive Benefit. Therefore, a terminally ill person (or someone acting on his behalf) must contact BCBSM to elect to use the services provided for hospice care for most of the care of his terminal condition instead of receiving benefits for that care under the regular covered medical expenses of the Comprehensive Benefit. He will receive any and all palliative care and most direct care of his terminal condition under the Hospice Care Program.
3. Charges incurred by a terminally ill person for surgical operations or hospital confinements due to medical complications of the terminal condition or for treatment of an injury or sickness totally unrelated to his terminal condition are not payable as hospice care benefits. Benefits for those expenses will be considered for payment under the regular covered medical expenses of the Comprehensive Benefit, subject to all applicable exclusions and limitations.
4. The terms and conditions of the overall Benefit Plan also apply to these benefits except where stated otherwise. C.O.B. also applies, both to other plans and to Medicare.
5. Hospice benefits are automatically assigned to the hospice. The hospice will send its bill to BCBSM and will be paid directly by BCBSM. Be sure to contact BCBSM for precertification and arrangements for hospice care for a family member.

Hospice Care Exclusions and Limitations - No hospice care benefits are payable for:

1. Bereavement counseling services provided to a terminal person's family after his death.
2. Administrative services; child care and/or housekeeping services; or transportation (except in a medical emergency).
3. Any services or supplies not provided as "core services" by the hospice providing the hospice care.
4. Any services or supplies for which charges would not be made in the absence of these benefits for hospice care.
5. Any services or supplies that are rendered, provided or supplied by family members.
6. Any services or supplies not reasonable and necessary for the palliation or management of the terminal condition.
7. Long-term inpatient care, surgery or hospital confinements due to medical complications of the terminal condition, or any services or supplies provided for treatment of any injury or sickness other than the terminal condition.

EXTENSION OF COMPREHENSIVE BENEFITS

The term "extension of benefits" means that, if a covered person is totally disabled at the time his coverage would otherwise terminate, limited Comprehensive Benefits will be continued for him for a period of time. (See page 59 for the definition of "totally disabled.") The extension of benefits rules apply separately to you and each of your dependents.

Rules Governing an Extension of Benefits

1. To qualify for an extension of benefits, a person must be totally and continuously disabled at the time his eligibility terminates, and the person must remain totally and continuously disabled to qualify for the extension.
2. Benefits will be payable under an extension only for charges incurred for treatment of the injury or sickness which caused the person's total disability.
3. Benefits will be payable for a person under an extension only to the extent that benefits would normally have been payable for him if his eligibility had not terminated. All maximum benefits, limitations, and exclusions will apply.
4. An extension of benefits does not apply to any disability caused by or which is due to substance abuse or mental/nervous disorders.
5. If a person qualifies for an extension of benefits, Comprehensive Benefits will continue for him for up to 12 months after the date his eligibility terminates.
6. An extension of the Comprehensive Benefit will terminate for a person on the first to occur of the following dates:
   a. The end of the 12-month period following the date his Plan coverage would otherwise have terminated;
   b. The date he is no longer totally disabled; or
   c. The date he becomes covered under any other welfare fund or any group plan or any plan sponsored by an employer or Medicare.

PRESCRIPTION DRUG PROGRAM

(For the purpose of this explanation, all prescription drugs and other prescribed medications or supplies are referred to as "drugs.")

Your Prescription Drug Program consists of two parts—the Drug Card Program and the Mail Order Program. Both Programs are administered by Blue Cross Blue Shield of Michigan (BCBSM) in accordance with a contract with the Trustees. BCBSM contracts with Medco for mail-order pharmacy services.

Drugs obtained through the Prescription Drug Program are not subject to the provisions of the Comprehensive Benefit. No deductibles apply, benefits paid for such drugs do not apply to your lifetime maximum benefit, and amounts you pay as your copay do not apply to out-of-pocket limits.

When the Prescription Drug Program May Not Be Used - If your spouse has other health plan insurance or coverage that pays primary benefits for her and/or for your children (see "Coordination of Benefits," pages 61-64), neither the Drug Card Program nor the Mail Order Program may be used to fill prescriptions for your spouse or any such children. In such a case, the pharmacy must be paid in full for prescriptions filled for them, and your spouse must file a claim for benefits with her own plan. If there is any amount of the charge remaining after her plan has paid its benefits, you can submit a copy of the paid receipt and the other plan's EOB (Explanation of Benefits) form to the Plan Office for consideration. Note, however, that you will not be reimbursed for this Plan's copay amounts.

Information Packet - The Plan Office should already have provided you with a packet of materials containing a BCBSM card, a list of participating pharmacies for use under the Drug Card Program, a Formulary list, plus order forms and instructions for use under the Mail Order Program. ***The Formulary is not a list of covered drugs. The fact that a drug appears on the list does not mean that it is covered by the Plan.***

DRUG CARD PROGRAM

Participating Pharmacies - BCBSM has agreements with a number of chain pharmacies to provide prescription drugs to its clients at negotiated discounted prices. There are hundreds of local participating pharmacies. If your pharmacy is not on the list of participating pharmacies provided to you, call the pharmacy to see if they participate. You can also call the BCBSM Customer Service line for locations of additional independent participating pharmacies in your area. The telephone numbers are listed on the inside front cover of this book.

When You Should Use the Drug Card Program - You should use the Drug Card Program for short-term prescriptions that are needed immediately. If a drug is a maintenance or long-term drug, you should use the Mail Order Program.

If a doctor prescribes a drug that must be taken on a long-term basis, ask the doctor for two prescriptions—one for a 34-day supply that you can have filled immediately at a local participating pharmacy under the Drug Card Program and one for up to a 90-day supply (with refills) that you can obtain through the Mail Order Program.

Using the Drug Card Program - When a doctor is going to prescribe a new medication for you or a family member, show the doctor the Formulary list included in your Prescription Drug Program packet of materials. If your doctor prescribes drugs from this list, the amount the Plan will have to pay for your drug costs will be lower, thus saving money for the Plan and for you.

Take the doctor's prescription to a participating pharmacy and show the pharmacist your BCBSM card. You can get up to a 34-day supply of the drug. You pay the amount shown on the Schedule of Benefits directly to the pharmacist. You will also have to pay the pharmacist the difference in the cost of the brand name and generic drug if a generic equivalent is available but the prescription is filled with a brand name drug. ***These copays are your share of your drug costs. Do not submit a claim for these copays to either the Plan Office or BCBSM.***

Using a Nonparticipating Pharmacy - If you have a prescription filled by a pharmacy that does not participate in the Drug Card Program, you can get up to a 34-day supply of the drug. You must pay the pharmacist for the full amount of the charge and then submit the paid receipt to the Plan Office for reimbursement. After deducting your copay amount, plus the difference in the cost of the brand name and generic drug when you decline a generic substitute, the Plan Office will reimburse you the balance of the charge.

The Plan Office—not BCBSM—will process claims for prescription drugs not purchased at a participating pharmacy. Do not submit any charges for prescription drugs to BCBSM.

MAIL ORDER PROGRAM

When the Mail Order Program Should Be Used - You should use the Mail Order Program to get long-term or maintenance drugs that you take on a continual basis for treatment of chronic health conditions, such as high blood pressure, ulcers, diabetes, etc. This program is not designed to provide drugs you take on a short-term basis—you should obtain those drugs at a local participating pharmacy using the Drug Card Program.

Using the Mail Order Program - When you place an order, you send along a check or money order for your copay per prescription. Your copay shares are shown on the Schedule of Benefits. Note that if you fill a prescription for a brand name drug when a generic equivalent is available, you must pay the difference in cost between the brand name drug and the generic drug, in addition to the generic drug copay. Call the Medco mail-order pharmacy to find out the difference in cost.

Copays are your share of your drug costs. Do not submit a claim for these copays to either the Plan Office or BCBSM.

You can order up to a maximum of a 90-day supply of a prescription drug or refill.

Your packet of information about the Prescription Drug Program includes a brochure, an order form and instructions. Read that information for the details about ordering from Medco, having a doctor call in a prescription, and transferring prescriptions.

If you have questions about a drug or need help with ordering, call the Medco mail-order pharmacy at the number listed on the inside front cover of this book.

COVERED DRUGS

The following are drugs and supplies which may be obtained through the Drug Card Program and the Mail Order Program:

1. Any drug which is considered a covered medical expense under the Comprehensive Benefit, provided that it is approved by the Food and Drug Administration.
2. Prescription contraceptives.
3. Retin A for any age (when medically necessary).
4. Insulin and necessary diabetic supplies.
5. Injectables.

PRIOR AUTHORIZATION/STEP THERAPY

The BCBSM program includes programs that promote prescribing of cost-effective prescription drugs. Doctors and patients will work directly with BCBSM if the patient's medication requires prior authorization or alternative medications.

Prior Authorizations
BCBSM will handle all prior authorizations. Do not call or write the Plan Office for prior authorization.

EXCLUDED DRUGS

The following are not covered under either the Drug Card Program or the Mail Order Program:

1. Appetite suppressants.
2. Growth hormones or drugs to induce growth unless medically necessary to treat a physical illness and if the patient would suffer physical harm in the absence of such treatment.
3. Durable or disposable medical supplies.
4. Immunizations.
5. Vitamins.
6. Medications for cosmetic purposes.
7. Medications or drugs used for experimental indications and/or dosage regimens determined to be experimental.
8. Over-the-counter medications that do not require a doctor's authorization by state or federal law, or any prescription medication or drug that is available as an over-the-counter medication.
9. Prescription refills dispensed more than one year after the original dispensing date.
10. Any drug or medication which is excluded from coverage under the Plan, or any drug or medication which is prescribed for or in connection with any type of treatment or any type of condition for which benefits are excluded under the Plan, as stated in the "Plan Conditions, Limitations and Exclusions" starting on page 47.

DISCOUNT VISION PLAN

You can take advantage of a discount program through Vision Service Plan (VSP)—called the VSP Access Plan.

Eligible employees and their dependents can receive the following discounts from VSP network doctors:

- 20% discount on eye exam.
- 20% discount on frame, lenses and len options when a complete pair of prescription glasses is purchased.
- 15% discount on contact lens exam, including evaluation and fitting.
- Discounts on laser vision correction.

The discounts are only available from a VSP network doctor. The eyewear discounts can only be given when the VSP doctor has provided your eye exam within the prior 12 months.

The Plan Office will send each new participant a wallet-size card explaining this program.

Direct all your questions to VSP at 1 (800) 877-7195. Except for providing general information to participants, the Plan Office is not involved with the VSP Access program. BCBSM is also not involved.

SPECIAL FUND

The Special Fund is a benefit program that has significant financial and flexibility advantages. The Special Fund can save you substantial amounts of money by allowing you to cover a wide range of expenses with untaxed income rather than after-tax income.

It is not, however, a savings account from which you can withdraw at will. You are not vested in the balance. Payments can be made only for the expenses shown below.

YOUR SPECIAL FUND ACCOUNT

1. For every hour that you work (after June 1, 1998) employers in this jurisdiction will make a contribution into an account in your name. The amount of the contribution is determined by the collective bargaining agreement under which you are working and may change from time to time.
2. Work that you perform for employers in other jurisdictions may also generate contributions to your account, subject to reciprocity rules.
3. This program has been designed so that the contributions to your account, the interest that could be credited to your account, and the reimbursements paid from it will not be considered taxable income to you. You should understand that tax laws and regulations, as well as interpretations, change from time to time and you should contact your tax advisor concerning the taxation of Special Fund reimbursements.
4. Nontaxable interest may be credited to your account annually, at the discretion of the Board of Trustees.
5. Your account balance can be carried forward from year to year. There is no "use it or lose it" rule, except as follows: An account with a balance less than $100 that has had no hourly contributions or withdrawals for two calendar years (four years for balances of $100 or more) will be closed and the balance transferred back to the Health Plan.
6. You cannot make self-payments into your Special Fund account. If you make self-payments under the Plan's regular eligibility rules, no amount of that payment will be credited to your Special Fund account.

SPECIAL FUND COVERED EXPENSES

You can request reimbursement for the following expenses from your Special Fund account.

1. Deductibles and copayments from the regular benefit plan.
2. Acupuncture.
3. Medical expenses not covered by or in excess of the regular benefit plan.
4. Vision expenses.
5. Dental treatment expenses or dental insurance premiums.
6. Christian Science practitioners.
7. Guide dogs for blind or deaf persons.
8. Healthcare insurance premiums, but not student health insurance in the student's name.
9. Certain travel and lodging expenses while accompanying a patient. The patient's physician must certify that the family member's presence is necessary for the treatment. Contact the Plan Office for details and limits.
10. Qualified special schooling for the mentally impaired or physically disabled. The schooling must be medically necessary and the school must qualify with the IRS as a special school. Contact the Plan Office for requirements.
11. Smoking cessation programs.
12. Hearing aids and examinations.
13. Special telephone and television equipment for hearing impaired persons.
14. Certain transportation and lodging expenses for medical treatment. Contact the Plan Office for requirements.
15. Surgery or laser treatments to correct vision.
16. Weight loss programs, but not food or dietary supplements.

17. Certain over-the-counter drugs as follows:

Allowed	Not Allowed
Allergy medications	Acne treatments
Antacids	Cosmetics
Anti-diarrhea medicine	Dietary supplements
Antibiotic ointments	Fiber supplements
Calamine lotion	Herbs
Cold medicine	Lip balm
Cough drops and throat lozenges	Shampoos and soaps
First aid creams	Suntan lotion
Motion sickness pills	Toiletries
Nicotine medications and nasal sprays	Weight loss drugs
Pain relievers	Vitamins
Sinus medications and nasal sprays	
Sleep aids	
Suppositories and creams for hemorrhoids	
Wart removal medication	

You may only claim OTC products that are not reimbursed from any other source and that are used for yourself and your covered family members.

The list of covered expenses and any of the Special Fund's rules and procedures can be changed at any time by the Board of Trustees.

Self-Payments - You can also use your account to make self-payments for active, retiree, widow, spouse or COBRA coverage, but only if your account balance is sufficient to pay the full amount due. If there is not enough in your account to make a ***full*** self-payment, your reimbursement request will not be honored, and you will have to make the payment by check or money order. If you make a self-payment from your Special Fund account, and then you become entitled to a refund, the refund will be reimbursed to your account.

Non-Covered Expenses - You cannot receive reimbursement for the following:

1. Cosmetic surgery and treatments.
2. Household help.
3. Charges incurred by a person not covered by the Plan.
4. Health club memberships or expenses.
5. Child or dependent care.
6. Burial expenses.
7. Sales tax, or shipping and handling fees.
8. Long-term care insurance premiums.
9. Student health insurance in the student's name.
10. Expenses reimbursed by some other source.
11. Environmental devices such as air conditioners, air purifiers or humidifiers.
12. OTC products and other non-prescription drugs, medicines and vitamins, unless specifically listed as a Special Fund covered expense.
13. Expenses incurred by a person who is not a participant in the Plan, including a family member who does not meet the Plan's definition of dependent or a child who exceeds the age limit.

HOW TO USE YOUR SPECIAL FUND ACCOUNT

Fill out a Special Fund Payment Request form and return it to the Plan Office along with copies of the itemized bills and/or EOBs from BCBSM. The form authorizes the Plan Office to make a payment from your account. You can obtain forms from the Plan Office, your local Union or from the Plan's website.

- You will be reimbursed for the expense if you have a sufficient account balance.
- You may submit a reimbursement request at any time, but the minimum amount requested should be $50. If you accumulate less than $50 of reimburse able expenses in a year, you may request reimbursement at the end of the year. A reimbursement request will be honored only if it is submitted within two years of the date the expense was incurred.
- If you wish to use your account to make a self-payment, please write to the Plan Office and direct them to subtract it from your account.
- If you do not have enough in your account to make the self-payment you have requested, you will be notified by return mail. You will then have to make your payment by check or money order before the regular due date. The due date will not be extended, and ***you cannot make a partial self-payment from the Special Fund Account.***
- Claims for over-the-counter medications must include store receipts on which the name of the product has been imprinted by the cash register as well as the date of purchase and amount. Non-imprinted, or hand-annotated cash register receipts will NOT be accepted. It is your responsibility to purchase these products at stores that properly document the name of the product purchased.

- A reimbursement request will be honored only if it is submitted *within 2 years* of the date the expense was incurred.
- Reimbursement requests can be made by you or your spouse.
- Reimbursements will be made payable only to you, not to any provider.

Please note: The Plan may reduce the amount of your Special Fund account in order to recover any amount you fail to repay the Plan under its subrogation and reimbursement provisions.

PLAN CONDITIONS, LIMITATIONS AND EXCLUSIONS

WHAT THE PLAN DOESN'T COVER

No payment will be made under the Plan for loss sustained as a result of, or for charges incurred for, any of the services, supplies, or types of treatment listed below.

NO PLAN BENEFITS ARE PAYABLE FOR ANY OF THE FOLLOWING:

1. Charges incurred by a **person who is not covered** under the Plan at the time the charges are incurred.
2. Charges incurred by a covered person for a particular type of treatment once the person has received Plan benefits totaling any applicable **maximum benefit** for that type of treatment during any stated period of time.
3. Treatment of **preexisting conditions** during the 6-month period after the person's enrollment date. (This exclusion does not apply to all participants. See page 50 for more information).
4. Services and supplies which are not approved or **recommended by the attending doctor**.
5. Any amount of a charge that is in excess of a **reasonable and customary** charge, or any charge by a non-BCBSM provider that is **in excess of the BCBSM approved amount**.
6. Routine care and other services, treatments and supplies that are **not medically necessary** (as defined on page 58) unless specifically set forth as a covered medical expense.
7. In-hospital **personal convenience items** such as telephones, televisions, cosmetics, guest trays, magazines, or beds or cots for guests or family members or any other item that is not medically necessary for the treatment of the patient.
8. Services or supplies received from any doctor or hospital which does **not meet this Plan's definition of a doctor or hospital**.
9. Services, supplies, treatments, or procedures that are not provided for the treatment or correction of, or in connection with, **a specific non-occupational accidental bodily injury or sickness** unless specifically identified as being covered under the Plan.
10. Treatment of injuries sustained in the course of the **commission of a felony** for which the person is convicted.
11. **Vision or hearing care**, including glasses, lenses, contacts, hearing aids, vision or hearing exams, or charges for fitting vision or hearing appliances.
12. **Vision/orthoptic therapy**.
13. Services or supplies provided for or in connection with any procedure intended to modify the shape or structure of the eye for the purpose of correcting or enhancing vision, such as **Lasik,** radial keratotomy or other similar procedures.
14. Services, supplies, or procedures that are **experimental or investigative** in nature, or any services, supplies, or procedures that are provided in connection with any treatment or procedure that is experimental or investigative (see page 57).
15. Services, supplies or treatments which are **preventive** in nature. This exclusion applies to items such as well-child care, immunizations, flu shots and treatments which a person may receive as a result of being exposed to a particular disease or to prevent the contraction of any disease.
16. Services, treatments or surgical procedures provided in connection with an overweight condition or condition of **obesity**.

    Exception - Bariatric (obesity) surgery will be payable if the person meets all of the following criteria:

    a. The person is 100% over his medically desirable weight.
    b. The obesity is a threat to the person's life due to other complicating health factors, such as diabetes, heart trouble, hypertension, etc.
    c. The person has a history of unsuccessful attempts to reduce weight by more conservative measures.

17. **Travel**, whether or not recommended by a doctor, except as provided in No. 6 on page 36.

18. Any care, treatment, or surgery that is elective, including non-emergency **plastic or cosmetic surgery** on the body (including but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue).

    Exception - This exclusion does not apply to:

    a. Cosmetic surgery and/or treatment for the correction of defects incurred through traumatic injuries sustained as a result of an accident.

    b. The correction of congenital defects.

    c. Vasectomies and other sterilization procedures for employees, retirees, and dependent spouses.

    d. Reconstructive breast surgery following a mastectomy, including reconstructive surgery on the non-affected breast to achieve a symmetrical appearance.

    Preoperative approval for any plastic or cosmetic surgery must be obtained from BCBSM and, if necessary, a third-party examination will be required.

19. **Reversal** or attempted reversal of vasectomies or other sterilization procedures.

20. Surgical sterilization or **contraceptive devices for dependent children.**

21. Services and supplies provided as a result of dental surgery, dental x-rays, or any other **dental treatment**, including any of the following:

    a. Treatment involving any of the teeth or the gums, their surrounding tissue or structure, the alveolar process, the gingival tissue, or for mouth conditions due to periodontal or periapical disease.

    b. Treatment of other associated structures primarily in connection with the treatment or replacement of teeth.

    c. Drugs and medicines or dental prosthetic appliances or the fitting of any such appliances, except that antibiotics used for the treatment of an existing infection or for prophylactic heart conditions will be considered covered medical expenses.

    Exception - If the services or supplies are provided for the repair of injury to sound natural teeth (teeth with no decay, fractures or abscesses) as a result of a non-occupational accidental injury and the treatment is provided while the person is eligible, the charges for the treatment will be considered covered medical expenses.

22. Membership in **athletic clubs**, spas, exercise groups or diet centers, or any medical supplies for athletic use only.

23. **Over-the-counter medicines**, drugs, or medical or non-medical items which can be obtained without a doctor's prescription (such as, but not limited to, bandages, tape, gauze, peroxide, alcohol swabs, cotton balls, etc.).

24. Vitamins or any form of **dietary supplement** (oral or injectable), whether obtained over-the-counter or by prescription.

25. **Growth hormones** or drugs to induce growth unless medically necessary to treat a physical illness and if the patient would suffer physical harm in the absence of such treatment.

26. **Environmental control devices** such as, but not limited to, air conditioners, air humidifiers, air purifiers, etc.

27. Any type of **biofeedback** treatment.

28. The collection, storage or testing of a covered **person's own blood** for future transfusions.

29. Services or supplies provided to an **organ donor** who is donating to a person who is not covered under this Plan.

30. Laboratory tests or x-rays performed for **research**, case findings or surveys.

31. Treatment, therapy or counseling for **infertility**, or artificial insemination or any related procedures, whether experimental or not, including but not limited to in vitro or in vivo fertilization, egg implantation, etc., or hormone therapy or any other direct attempt to induce or facilitate conception.

32. **Sex change** surgery or any treatment leading to, or in connection with, sex change surgery.

33. **Telephone consultations or missed appointments**.

34. **Special education**, regardless of the type or purpose of the education, the recommendation of the attending doctor or the qualifications of the individual providing the education.

Exception - This exclusion does not apply to self-management training for diabetes when prescribed by a doctor.

35. **Education, training, or room and board** while the person is confined in an institution which is primarily a school or other institution for training, a place of rest, or a place for the aged.

36. Physical therapy, speech therapy, or any other type of therapy if either the prognosis or history of the person receiving the treatment or therapy does not indicate that there is a **reasonable chance of improvement**.

37. Confinement, care, treatment, services or supplies provided in a **nursing home**, rest home, convalescent home or similar establishment unless it is a facility which meets this Plan's definition of a skilled nursing facility and the confinement meets all of the requirements for an approved confinement as stated in No. 12 on page 36.

38. **Custodial care** (care that is designed primarily to assist a person in meeting the activities of daily living, regardless of what the care is called.

39. Any inpatient treatment of **mental/nervous disorders** which is not certified by BCBSM.

40. Any inpatient and outpatient treatment of **substance abuse** which is not certified by BCBSM.

41. Non-hospital treatment of substance abuse or mental/nervous disorders **unless the person providing the treatment is a psychiatrist,** a duly qualified state licensed psychologist, or a non-state-licensed psychologist who is providing treatment upon the recommendation of and under the supervision of an M.D. or D.O.

42. Treatment of substance abuse or mental/nervous disorders provided in or by a facility that does not meet the requirements of an **approved treatment facility**.

43. Treatment provided to a **family member or friend** of a covered person who has a substance abuse problem for the purpose of learning to cope with the covered person's alcoholism or drug addiction (such as Alanon, Alateen, etc.).

44. Treatment or consultation with a **marriage counselor**.

45. Treatment or consultation with a **social worker** except as provided to a terminally ill person under the Hospice Care Program.

46. Services or supplies provided in connection with **smoking cessation**, except that prescription nicotine gum or patches shall be covered up to a maximum of one 100-day course of treatment per lifetime.

47. With respect to **midwife** services, no benefits are payable any of the following:
    a. For charges made for home birth unless the home birth is performed on an emergency basis.
    b. For charges that are in excess of the charges that would have been incurred if the entire maternity process had been handled by a doctor, i.e., if the sum of the charges made for a midwife's services and any necessary doctors' services exceeds the amount of charges that would have been incurred if the entire maternity process had been handled by a doctor.

48. Services or supplies provided by a **chiropractor** other than for examinations, x-ray examinations, spinal manipulations, traction and hot/cold packs.

49. Services or supplies provided by a person who is a **relative** in any way to you or to the dependent receiving the care, or who ordinarily lives in your home or in the dependent's home, or who is an employee of the hospital in which you or the dependent may be confined.

50. Treatment of accidental bodily injury, sickness, or disease sustained while the person was performing any act of employment or doing anything pertaining to any **occupation or employment** for remuneration or profit, or for which benefits are payable in whole or in part under any Workers' Compensation Law, Employer's Liability Law, Occupational Diseases Law or similar law.

51. Services or supplies which are furnished, paid for, or otherwise provided for, or any disability that results from any sickness or injury from past or present service of any person in the **armed forces** of a government, except that this exclusion will not apply to an eligible employee who has satisfied the reemployment provisions of the Veterans' Reemployment Rights Act and who returns to employment from service in the U.S. armed forces unless the sickness or injury is otherwise excluded from

coverage under the Plan or is found to be service-connected by the Secretary of Veterans' Affairs.

52. Services, supplies, or treatment provided while a person is confined in a hospital owned or operated by the **U.S. Government** or its agency, except that the Plan, to the extent required by law, will reimburse a VA hospital for care of a non-service related disability if the Plan would normally cover such care if the VA weren't involved.

53. Services, supplies, treatment or hospital confinements for which the person is **not legally required to pay**, or for charges made that would not have been made if this Plan did not exist.

54. Treatment of injury or sickness caused by: war, or any **act of war**, whether or not war is declared; any act of international armed conflict; any conflict involving the armed forces of an international body; or insurrection.

55. The completing of **claim forms** (or any forms required by the Plan for the processing of claims) by a doctor or other provider of medical services or supplies, or charges made for providing medical records.

56. Any services, supplies or charges that you are **not required to pay.**

The above list is not an all-inclusive list of the Plan's limitations and excluded services, supplies, and treatments. It is only representative of the types of situations for which no payment is made. Basically, benefits are payable under this Plan only for the direct treatment of non-occupational accidental injuries and sicknesses.

PREEXISTING CONDITION EXCLUSION

If you are a non-bargaining unit employee (other than an employee of the union who begins participation in the Plan immediately upon employment), an employee who is covered under the early eligibility rules for newly organized employees, apprentices, non-bargaining unit employees, cable pullers and residential and motor shop trainees, *no benefits* will be payable for treatment of a preexisting condition for you or any of your dependents for the *first 6 months* after your enrollment date.

Benefits for a dependent of a person described above (other than a newborn) are also subject a preexisting condition exclusion.

The rules governing benefits for preexisting conditions will not apply to pregnancy. In addition, the preexisting condition exclusion will not apply to a newborn, an adopted child under age 18, or a child under age 18 who is placed with you for adoption, if any such child is covered under the Plan on the 30th day after birth, adoption or placement for adoption.

Creditable Coverage - In compliance with, and subject to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you had coverage under another group health plan before your enrollment date under this Plan, and if there was not a break in coverage of 63 or more consecutive days between your coverage under the prior plan and your enrollment date under this Plan, some of that prior coverage (called "creditable coverage") may be used to reduce the 6-month limitation or exclusion period for preexisting conditions. In determining the validity and amount of creditable coverage, the Plan may rely upon a written Certificate of Coverage or other information which it receives. If necessary, this Plan will help you in obtaining a Certificate of Coverage. Contact the Plan Office if you have questions about the availability of prior plan coverage as creditable coverage for you or a dependent. If you receive an adverse determination of your creditable coverage from the Plan, you can appeal the decision by following the claim filing and appeal procedures beginning on page 51.

Enrollment Date - Your (the employee's) enrollment date is the date your coverage under the Plan starts, or, if earlier, the first day of any waiting period for coverage. For most employees, your waiting period will commence on the first date of your covered employment. If you have dependents on your enrollment date, that date is also your dependents' enrollment date. If you acquire a dependent after your enrollment date, that individual's enrollment date is the date the individual became your dependent. A late enrollee's enrollment date is the same as the first day of coverage.

CLAIM PROCEDURES

CLAIM FILING PROCEDURES

In general:

Medical claims are handled by Blue Cross Blue Shield of Michigan (BCBSM).

The Plan Office processes claims for:

- Special Fund reimbursements,
- Weekly Disability Benefits,
- Prescription drugs when you don't use a participating pharmacy.

Hospital and Doctor Claims

BCBSM PPO Provider Claims - When you use PPO providers, you don't have to file claims. These providers send their bills to BCBSM which deducts any amount of your yearly deductible not yet satisfied, your copayment share of the expenses, and charges for any non-covered services. BCBSM pays the remaining amount of the BCBSM approved amount directly to the provider. The provider then bills you for any amount remaining unpaid, which should only include any expenses used to satisfy your deductible, your copayment share of the expenses, plus any non-covered expenses. If a PPO provider bills you for additional charges, check with the provider to see if a mistake has been made; if necessary, call BCBSM to tell them about it.

If You Use an Out-of-Network Provider:

- Ask if the provider will accept the BCBSM approved amount as payment in full for the services provided and if the provider will submit your charges directly to BCBSM.
- If the provider will accept the BCBSM approved amount and will submit the bill to BCBSM, you don't have to file a claim. BCBSM will pay the claim in the same way it pays bills from PPO providers.
- If the provider won't accept the BCBSM approved amount and won't submit the bill to BCBSM, you will usually be required to pay the provider directly. You must then send the itemized insurance billing to BCBSM for reimbursement along with a claim form which you can get from the Plan Office or from BCBSM. In such a case, the amount BCBSM reimburses you may be less than the amount the provider charged because BCBSM's reimbursement will be based on BCBSM approved amounts. ***You will be responsible for amounts in excess of any BCBSM approved amount.***

Out-of-State Claims - The 3-letter prefix in front of your contract number on your BCBSM I.D. card identifies you as a Blue Card member. If you receive health care from a Blue Plan (Blue Cross Blue Shield) PPO provider while traveling in the United States outside of Michigan, the out-of-state PPO provider will bill the local Blue Plan for any covered services you receive and will be paid directly from the local Blue Plan. The local Blue Plan will then bill BCBSM for what it paid to the provider. You are responsible only for any deductible amounts, copayment amounts, etc., the same as if the charges had been incurred from a PPO provider in Michigan. Using your Blue Card will give both you and the Health Plan the advantage of the discounts arranged by the Blue Plan.

If you receive health care services while traveling out of the state of Michigan from a provider which does not participate with the local BCBSM, ask if the provider will bill BCBSM directly. If the provider will not, you must pay the bill, get an itemized bill, and file a claim with BCBSM.

Out-of-Country Claims - Generally, your coverage applies no matter where you are. However, any foreign hospital you use must be accredited, and any foreign doctor you use must be licensed. BCBSM has agreements to process claims from Blue Card network hospitals in other countries. If the foreign hospital is a network hospital, the claim will be processed the same as an out-of-state hospital claim. Most foreign country providers will require you to pay the bill. When you pay the bill, get an itemized billing—*written in English if possible.* When you send your claim to BCBSM, state whether the charges are in U.S. currency or foreign currency. Also state whether payment should go to you or to the provider. BCBSM will base its payment for the approved amounts for covered services at the rate of exchange in effect on the date you received the services, less any deductibles, copayments, etc., that may apply.)

To File a Claim With BCBSM

1. Get a claim form (Subscriber Application for Payment form) from BCBSM or the Plan Office.
2. Get itemized bills or receipts from the provider which include the following information:
   - Your (employee/retiree) 9-digit contract number from your BCBSM I.D. card. If this is not on the receipt or bill, you must write it on the receipt or bill,
   - Provider's name and address,
   - Patient's name (no nicknames),
   - Correct date of service,
   - Diagnosis (nature of sickness or injury),
   - Description of services and supplies provided with the correct CPT code ("current physicians terminology" identifier) for each procedure, and
   - Charges listed separately for each service or supply.

   If you pay the provider, you must submit the itemized bill. DO NOT send in cash register receipts, cancelled checks or money order stubs. They are not a substitute for an itemized insurance billing.
3. Send in a separate claim form for each eligible family member who incurs expenses. All bills for the same family member can be submitted with one claim form for that person.
4. Review the claim form to be sure it is accurate and complete. Incomplete forms will be returned to you, causing your payment to be delayed.

   Be sure that you sign and date the claim form and that your name and BCBSM contract number are written on all attachments.
5. Before sending in the claim form, you should make copies of the completed claim form and all bills, receipts or other materials you are attaching to the claim form—BCBSM cannot return any of these to you. It is especially important that you have these copies when claims must be sent to another plan for coordination of benefits purposes.
6. Attach all bills and/or itemized receipts to the claim form and mail it to the address on the claim form. If you don't have a claim form, or if you receive additional bills for a family member after sending in a claim form for that person, send the bills and itemized receipts, along with your BCBSM contract number, to:

   Blue Cross Blue Shield of Michigan
   600 Lafayette East, #B321
   Detroit, MI 48226
7. You should send in a claim as soon as you receive the itemized receipt or bill. A claim will be denied if you submit it more than 15 months after the date the service was received.

Explanation of Benefits (EOB) Forms - After processing your claim, BCBSM will send you an Explanation of Benefits (EOB) form. The EOB is not a bill. It is provided to help you understand how your benefits were paid.

The EOB provides the following information: your name, address and BCBSM contract number; patient's name if you are not the patient; date of service; name of the provider; amount billed by the provider; the BCBSM approved amount for the service; and deductible and copayment information.

It is important that you review your EOB forms carefully. Make sure that the payments made were for services actually received. Check whether names and dates shown agree with your records. If you have any questions or note any discrepancies on an EOB, call the Plan Office or BCBSM.

If you need to send a claim to another health care plan for coordination of benefits purposes, you must make copies of the BCBSM EOB.

Online Delivery of Your EOBs - If you prefer, BCBSM will provide your EOBs to you online instead of by mail. You cannot get them both ways. To sign-up for online EOBs, go to www.bcbsm.com and click on "GO," in the "I am a member box." Find "Member Secured Services" in the upper left corner, and click on "login." Follow the prompts from there.

Plan Office Claims

Claims for Weekly Disability Benefits - If you have a claim for Weekly Disability Benefits (pages 22-24), call the Plan Office for the proper forms and procedures.

Special Fund Claims - To request a reimbursement from your Special Fund account, you must fill out a Special Fund Payment Request form and return it to the Plan Office along with copies of the itemized bills or EOBs from BCBSM. You can obtain forms from the Plan Office, your Local Union or the Plan's website. For more information, see "How to Use Your Special Fund Account" on page 45.

Prescription Drug Claims - The only time you should file a claim for a prescription is when you use a nonparticipating pharmacy or when coordination of benefits applies. If you go to a pharmacy that does not participate in the BCBSM network of pharmacies, you must pay the full cost of the prescription and file a claim with the Plan Office. If another health plan pays primary benefits for prescriptions for a family member, you may file a claim with the Plan Office after the other plan has paid its benefits and sends the family member an EOB. Send a copy of the EOB and the pharmacy receipt showing the drug name, the doctor and the cost to the Plan Office. Cash register receipts are not acceptable.

Claim Filing Time Limit - Claims must be received by the Plan Office within 15 months of the date the expense is incurred. The only exception is that you have 24 months to file Special Fund claims.

Claims for Automobile-Related Accidents

BCBSM and the Plan Office will coordinate benefits on a secondary basis with any motor vehicle insurance, including no-fault coverage, and uninsured or underinsured motorist coverage. If you or any of your covered dependents are injured in an auto accident, BCBSM will determine its benefits after the motor vehicle insurance.

CLAIM PROCESSING PROCEDURES

The amount of time the designated claims office (BCBSM or the Plan Office) can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

- A claim is "post-service" if you have already received the treatment or supply for which payment is now being requested. Most claims are post-service claims.
- A "disability claim" is a claim for Weekly Disability Benefits.
- A "pre-service claim" is a request for preauthorization of a type of treatment or supply that requires approval in advance of obtaining medical care.
- An "urgent care claim" is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, health, or ability to regain maximum function, or that could subject you to severe pain that cannot be adequately managed without the proposed treatment.

Your claim will usually be processed by the applicable claims office within the following time limits:

- Post-service claims—within 30 days.
- Disability claims—within 45 days.
- Pre-service claims—within 15 days.
- Urgent care claims—within 72 hours.

You may have an authorized representative (including a health care provider) act on your behalf, although the Trustees will verify that the person has been so authorized. However, in connection with an urgent care claim, the Plan will recognize a health care professional with knowledge of your medical condition as your representative.

In addition, any request to extend a course of urgent care treatment beyond the period of time or number of treatments previously approved (called a "concurrent care" claim) will be decided as soon as possible, taking into account the medical circumstances, and BCBSM will notify you of its decision within 24 hours after receipt of the request, provided that any such request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Otherwise the urgent care claim time periods will apply.

Plan Extension - The time periods above may be extended if the claims office determines that an extension is necessary due to matters beyond its control. You will be notified prior to the expiration of the usual approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

- Pre-service claims—15 days.
- Disability claims—30 days (a second 30-day extension may be needed in special circumstances).
- Post-service claims—15 days.

When Additional Information Is Needed - If additional information is needed from you, your doctor or the medical provider, the necessary information or material will be requested in writing. If the request goes to your medical provider, you will receive a copy of the request. The request for additional information will be sent within the usual claim processing time limits, except that the additional information needed to decide an urgent care claim will be requested within 24 hours. If your pre-service claim is filed improperly, you will be notified within 5 days of filing the deficient claim and advised how to correct it.

It is your responsibility to see that missing information is provided to the claims office that requested it. For urgent care claims, you will be notified within 24 hours if additional information is required to process your claim.

You will have 48 hours to provide the necessary information and the Plan then has 48 hours to make a decision after the earlier of receiving the necessary information or the 48-hour period you had to provide it. For all other claims, you will have 45 days after you receive a notice for additional information to provide the needed information to the claims office. If you provide the requested information, the claims office will issue its decision within 15 days (30 days for disability claims) of the date the necessary information is received. If you do not provide the information requested, the claims office will make its decision based on the information it has within 15 days (30 days for disability claims) of the end of the period you had to provide the information and the claim may be denied.

Claim Denials - If all or a part of your claim is denied, you will be sent a written notice giving you the reasons for the denial. (For an urgent care claim, you may be notified by telephone. This will be followed by written notice of the same information with 3 days of the oral notice.) The notice will include reference to the Plan provisions on which the denial was based. If applicable, it will give a description of any additional material or information necessary for you to perfect the claim, and the reason such information is necessary. The notice will provide a description of the review procedures and the applicable time limits for following the procedures, and explain that the initial decision is final unless it is appealed in accordance with the Plan's claim appeal procedures. It will include a statement of your right to bring a civil action under section 502(a) of ERISA if your claim is denied on appeal. In cases where the Plan relied upon an internal rule, guideline, protocol or similar criterion to make its decision, the notice will state the specific internal rule, guideline, protocol or criterion used and inform you of your right to a copy free of charge upon your request. If the decision was based on medical necessity or if treatment was deemed experimental, the notification will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. For urgent claims, a description of the Plan's expedited review process will be provided.

CLAIM APPEAL PROCEDURES

When the Claim Denial Was Issued by BCBSM

Urgent Care Claims - If you have an urgent care claim you may orally request that BCBSM review the decision by calling BCBSM at 1 (800) 722-4239. You may also submit your request in writing to BCBSM at the address in the next column.

Concurrent Care Claims - If you have a concurrent care claim and BCBSM withdraws authorization for the care or reduces a previously approved period of treatment, you will have the right to appeal their decision. You will be given advance notice of such a termination or reduction and allowed to appeal the determination and receive a determination from BCBSM before the termination or reduction. The rule allowing the treatment to continue pending an appeal does not apply if your benefits terminate because you have lost eligibility under the Plan or if the termination or reduction is the result of a Plan amendment.

All Other Claims - If BCBSM denies all or part of your claim, you can request a review within 180 days of your receipt of the denial notice by sending a letter, along with any additional information that you think will help a favorable decision to be made on your claim, to:

Blue Cross Blue Shield of Michigan
Major Groups Service Center
600 Lafayette East, X420
Detroit, MI 48226

Your letter should list the Plan's BCBSM Group #51848.

BCBSM will conduct a full and fair review of all the material submitted with your claim, the additional information you have provided, and the reasons you believe the claim should be paid. The review will be conducted by someone other than the person who made the initial decision.

If you are not satisfied with the appeal decision made by BCBSM you can request that the Board of Trustees conduct a second review of the claim. The following section describes the procedures for requesting such a review.

For All Other Claim Denials - The following procedures also apply if you want the Trustees to review a claim that has already been reviewed by BCBSM.

If you want the Appeal Committee of the Board of Trustees designated to review your claim after a denial of benefits, you can request a review within 180 days of

your receipt of the denial notice by sending a letter along with any additional information that you think will help a favorable decision to be made on your claim to:

Board of Trustees
Michigan Electrical Employees' Health Plan
6011 W. St. Joseph, Suite 401
Lansing, MI 48917

The Appeal Committee will conduct a full and fair review of all the material submitted with your claim, the action taken by the claims office, the additional information you have provided, and the reasons you believe the claim should be paid.

Claim Appeal Procedures Applicable to All Levels of Appeal - The following provisions apply to reviews conducted by BCBSM or by the Appeal Committee.

- You have the right, upon request and free of charge, to receive copies of all documents, records and other information relevant to your claim for benefits.
- Your claim review will be conducted by an individual who is neither the party who made the initial denial, nor the subordinate of such party. It will not afford deference to the initial determination, and will take into account all comments, documents, records and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.
- With respect to a review of any determination based on a medical judgement, a health care professional with appropriate training and experience in the applicable field of medicine will be consulted. Such health care provider will be "independent," which means the person consulted will be an individual different from, and not subordinate to, any individual who was consulted in connection with the initial decision. Upon request, you will be provided with the identity of the medical expert(s) whose advice was obtained in connection with the claim, regardless of whether the advice was relied on to make the benefit determination.
- If you submit your request for an appeal in a timely manner, and if you provide all the additional information necessary for a review of the original denial, you will be notified of the decision following review within the following time periods:
  - *Urgent care claims* - As soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of your request for review.
  - *Pre-service claims* - No later than 15 days per level of review.
  - *Post-service and disability claims* - No later than 30 days if the review was conducted by BCBSM, and no later than 30 days for Trustee review of an appeal first denied by BCBSM. For all other reviews by the Trustees, no later than 5 calendar days following the date of the Trustees meeting that immediately follows the Plan's receipt of a request for review, unless the request is filed within 30 days preceding the date of such meeting. In such case, a determination may be made by no later than the date of the second meeting. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a determination will be rendered not later than the third meeting of the Trustees. Before the start of the extension, you will be notified in writing of the extension, and that notice will include a description of the special circumstances and the date as of which the determination will be made.
- All written appeal decisions will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; and a statement of the claimant's right to bring an action under section 502(a) of ERISA. If applicable, you will also be informed of the specific internal rule, guideline, protocol or similar criterion relied on to make the decision and your right to a copy, free of charge, upon request. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request.
- You may not file suit in state or federal court under section 502(a) of ERISA or begin other action against the Plan or its Trustees until you have followed these procedures and exhausted your administrative remedies by appealing the denial of your claim. Failure to exhaust these administrative remedies will result in the loss of your right to file suit as described in the section entitled "Your Rights Under ERISA."
- If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, you may go to court to enforce your rights.

DEFINITIONS

Notes

- Most of the definitions included below are Health Plan Definitions, but some *BCBSM definitions have been included and are marked with a (*).* BCBSM's definitions of some of the other Health Plan terms may be different from the Health Plan's definitions. While some of these differences may affect the processing of your claim by BCBSM, the Health Plan's definition will ultimately govern.
- When a word or phrase defined below is used in this book, the definition shown below for that word or phrase will apply unless stated otherwise in another part of this book.

ASSOCIATION - The Michigan Chapter, National Electrical Contractors' Association, Inc., divisions participating in the Plan.

***APPROVED AMOUNT -** The maximum charge that BCBSM will consider when calculating benefits.

***APPROVED FACILITY -** A hospital or clinic that provides medical and other services, such as substance abuse treatment, rehabilitation, skilled nursing care or physical therapy. To be an approved facility, a facility must meet all applicable local and state licensing and certification requirements, must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association, and must be approved as a provider by BCBSM.

***BCBSM -** Blue Cross Blue Shield of Michigan. (The Health Plan has contracted for provider discounts and certain administrative duties with BCBSM.)

CALENDAR YEAR - The 12-month period starting on January 1 of any year and ending on December 31 of that same year. (*****BCBSM defines this as a "benefit period.")

COLLECTIVE BARGAINING AGREEMENT - The negotiated labor agreements between a Union and the Association or an employer requiring contributions to the Plan.

CONTRIBUTIONS - Payments made by a contributing employer to the Plan on behalf of the employer's employees.

COVERED UNDER THE PLAN - A person is eligible to receive Plan benefits applicable to his status as an eligible employee, eligible retiree or eligible dependent.

DEPENDENT - An individual who is:

1. Your spouse, provided you are not divorced or legally separated under a decree of separate maintenance.
2. Your unmarried child under 19 years of age who lives with you in a parent-child relationship, maintains a permanent residence in your home and is dependent on you for support and maintenance. The Plan may waive the living with you and permanent residence requirement if the child is under age 18 and you are required by a domestic relations order or other court order to provide primary health benefits for the child. The waiver will not be extended beyond the date required by the court order or, if earlier, the date the child no longer qualifies as a dependent. This waiver will not be extended until a copy of the complete court order is received by the Plan Office.
3. Your unmarried child age 19 but less than 22, provided he lives with you in a regular parent-child relationship and maintains a permanent residence in your home, is dependent on you for support, and has a gross calendar year income of less than an amount determined by multiplying 2,000 by the current Federal minimum wage.
4. Your unmarried child age 22 but less than 25 who is a registered full-time student in an accredited secondary school, college, university, or institution for nurses' training, residing in the U.S. or Canada, provided the child is dependent on you for support and maintains a permanent residence in your home.
5. Your child who is age 19 but less than 25 who is attending an IBEW JATC (Joint Apprenticeship Training Committee) sponsored school, provided he lives with you in a regular parent-child relationship and maintains a permanent residence in your home,

is dependent on you for support, and has a gross calendar year income of less than an amount determined by multiplying 2,000 by the current Federal minimum wage. If the child is married, his spouse will not be covered under the Plan. The child will no longer be considered a dependent when he becomes an eligible employee under the Plan.

6. Your unmarried disabled child who: is age 22 or over; is dependent on you for support; is incapable of self-support due to mental retardation, mental incapacity, or physical handicap; became disabled while covered as a dependent under this Plan; and remains disabled. If a child meets these conditions, he will be covered under the Plan as long as you remain eligible.

   Note - If you apply for Social Security benefits, you should request Medicare coverage for your disabled child. This Plan's benefits for the child would be coordinated with Medicare until you become covered under the Supplement to Medicare. At that time, the child would also be covered under the Supplement to Medicare, subject to the eligibility rules.

Important Notes:

- For purposes of the Plan's definition of dependent, the term "child" includes:
  - ❑ Your natural child;
  - ❑ Your legally adopted child or a child placed with you for adoption; and
  - ❑ Your stepchild.
- The Plan will also cover your child for whom the Plan is required to provide benefits in accordance with a Qualified Medical Child Support Order (QMCSO). If you would like a copy of the Plan's QMCSO procedures, please contact the Plan Office.
- The Trustees may require you to submit acceptable proof that a child is your dependent before a claim for that child will be processed. Please contact the Plan Office within 30 days of the birth or adoption of your new child.
- If your spouse or child works for a contributing employer and is eligible under this Plan as an employee, the spouse or child will not be considered a dependent except as provided in No. 5 above.

DOCTOR; PHYSICIAN - A legally qualified physician or surgeon who is a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.) or a Doctor of Chiropractic (D.C.). Also considered a doctor with regard to performing certain oral surgical procedures due to accidental injury or trauma is a Doctor of Dental Surgery (D.D.S.) and, for services performed only within the scope of the individual's license, a Doctor of Podiatric Medicine (D.P.M.).

ELIGIBLE EMPLOYEE - An employee who has met the Plan's eligibility requirements and is entitled to receive the benefits provided under the Plan for employees

ELIGIBLE FAMILY MEMBER; COVERED PERSON - You, the eligible employee or eligible retiree, and any person in your family or your household who meets the definition of a dependent, provided all applicable eligibility requirements for dependent coverage have been satisfied for any such dependent.

ELIGIBLE RETIREE - A retired employee who meets the applicable eligibility requirements established by the Trustees for coverage under the Early and Disability Retiree Benefits or the Supplement to Medicare.

EMERGENCY SITUATION - A situation where at the time of the incident it is reasonable to conclude that immediate medical attention is necessary because of a life-threatening condition or a condition which, if not treated at the closest available facility, could result in serious medical consequences, impairment to bodily functions or cause serious permanent dysfunction of a body organ or part.

EMPLOYEE - An employee of a contributing employer who is required under a collective bargaining agreement or participation agreement to make contributions to the Plan for him.

EMPLOYER; CONTRIBUTING EMPLOYER - Any person, firm, association, partnership, corporation or related trust fund which is primarily engaged in the electrical industry and which enters into a collective bargaining agreement or participation agreement providing for contributions to the Plan on behalf of its employees.

EXPERIMENTAL OR INVESTIGATIVE - The use of any of the following is considered to be experimental or investigative:

1. Any treatment, procedure, facility, equipment, drug, device or supply not yet generally accepted among experts as accepted medical practice; or
2. Any treatment, procedure, facility, equipment, drug, device or supply which cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other federal agency, for which such approval had not been granted at the time the treatment, procedure, facility, equipment, drug, device, or supply was rendered, provided or utilized; or

3. Any treatment, procedure, facility, equipment, drug, device or supply which is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses; or if the prevailing opinion among experts regarding the treatment, procedure, facility, equipment, drug, device, or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses.

Determination of whether a treatment, procedure, facility, equipment, drug, device or supply is experimental or investigative shall be determined solely by the Trustees, in their sole discretion and judgment, in consultation with medical consultants of their choosing.

HOME HEALTH AGENCY - A public agency or private organization (or a subdivision) which meets all of the following requirements: it is primarily engaged in providing skilled nursing services and other therapeutic services in the home of its patients; it has established policies governing the services that it provides; it provides for the supervision of its services by a doctor or a registered professional nurse; it maintains clerical records on all of its patients; it is licensed according to the applicable laws of the state in which the patient receiving the treatment lives and of the locality in which it is located or in which it provides services; and it is eligible to participate in Medicare.

Home health (nursing) care provided through a Home Health Agency must be preapproved and arranged by BCBSM. Contact BCBSM for information about precertification and arrangements.

HOSPITAL - An institution which is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patients' expense and which fully meets the requirements of No. 1, No. 2 or No. 3 below:

1. It is a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
2. It is a hospital, a psychiatric hospital, or a tuberculosis hospital, as defined in Medicare, which is eligible to participate in and to receive payments from Medicare; or
3. It is an institution that provides diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment, and care of injured and sick individuals under the supervision of a staff of doctors licensed to practice medicine; is operated continuously with organized facilities for operative surgery on the premises; provides on the premises 24-hour-a-day nursing services by or under the supervision of registered graduate nurses (R.N.s); and is not, other than incidentally, a place for rest, for the aged, for drug addicts or alcoholics or a nursing or convalescent home.

   In addition, to be an approved hospital for BCBSM payment purposes, the facility or institution must meet all applicable local and state licensure and certification requirements, must be accredited as a hospital by state or national medical or hospital authorities or associations, and must be approved as a provider by BCBSM or an affiliate of BCBSM.

MEDICAL EMERGENCY - An injury or the sudden onset of an illness of such a degree that, unless immediate medical attention is received, it could reasonably result in permanently placing the person's health in danger, cause serious medical consequences, cause serious impairment to bodily functions, or cause serious and permanent dysfunction of any bodily organ or part. The symptoms must occur suddenly and unexpectedly and be so severe that immediate medical relief is necessary, regardless of the time. The condition must be one for which immediate medical attention is normally required. A condition is considered to be a medical emergency if oxygen must be administered to the person. Some examples of medical emergencies are coma, heart attack, stroke, frostbite, sunstroke, poisoning, drug reaction, diabetic coma, convulsions and/or seizures and unconsciousness.

MEDICALLY NECESSARY - The use of only those services, treatments or supplies provided by a hospital, doctor, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees, to identify or treat an injury, disease or sickness. The service or supply must be consistent with the symptoms, diagnosis and treatment of the condition; must be appropriate according to acceptable standards of good medical practice; must not be solely for the convenience of the patient, doctor or hospital; must be the most appropriate which can be safely provided to the patient under the circumstances; and must not be experimental or investigative in nature.

MEDICARE - The Health Insurance for the Aged Program under Title XVIII of the Social Security Act and the Social Security Amendments of 1965, as this Program is currently constituted and as it may later be amended.

MENTAL OR NERVOUS DISORDER (MENTAL/NERVOUS DISORDER) - A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, regardless of whether such disease or disorder has causes or origins which are organic, physiological, traumatic, or functional.

***NON-PPO PROVIDERS (OUT-OF-NETWORK PROVIDERS) -** Providers that have not signed agreements with BCBSM to accept the BCBSM payment as payment in full. However, non-PPO professional (non-facility) providers may agree to accept the BCBSM approved amount as payment in full on a per-claim basis.

***OUTPATIENT (AMBULATORY) SURGICAL FACILITY -** A separate outpatient facility that is not part of a hospital, where surgery is performed and care related to the surgery is given. The procedures performed in this facility can be performed safely without overnight inpatient hospital care. BCBSM should be contacted before any outpatient surgery to determine if the facility is BCBSM-approved.

***PPO PROVIDERS -** Providers that are in the BCBSM PPO network. These providers have signed agreements with BCBSM to accept the BCBSM approved amount for covered services as payment in full.

PLAN; BENEFIT PLAN - The self-funded Michigan Electrical Employees' Health Plan described in this book.

PREEXISTING CONDITION - A preexisting condition is a sickness, injury, disease, or other mental or physical condition for which medical advice, diagnosis, care or treatment (including the use of prescription drugs or medicines) was recommended or received by a person during the 6-month period immediately before the person's enrollment date. Genetic information is not considered a "condition" unless the condition related to such information was treated or diagnosed within the 6-month period before the person's enrollment date.

REASONABLE AND CUSTOMARY; REASONABLE AND CUSTOMARY CHARGE - An amount determined by comparing a particular charge with the charges made for similar services and supplies in the locality concerned to individuals of similar age, sex, circumstances and medical condition. The result of this comparison determines the amount that is the maximum allowable charge to be considered a covered expense under this Plan. Data and recommendations from the HIAA (Health Insurance Association of America) weigh heavily in the Plan's determination of reasonable and customary charges and payment policies.

SELF-PAYMENTS - Payments made to the Plan by employees, retirees, and dependents to continue Plan coverage.

SKILLED NURSING (CONVALESCENT) FACILITY - An institution, or a distinct part of an institution, which meets all of the following requirements: (a) it is primarily engaged in providing inpatient skilled nursing care, physical restoration services and related services for patients who are convalescing from injury or sickness and who require medical or nursing care to assist the patients to reach a degree of body functioning to permit self-care in essential daily living activities; (b) it has a transfer agreement with one or more hospitals; (c) it has one or more doctors and one or more registered professional nurses responsible for the care of its inpatients; (d) every patient is under the supervision of a doctor; (e) it maintains clinical records on all patients; (f) it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals; (g) it has a utilization review plan; (h) it is duly licensed by the appropriate governmental authorities; (i) it is eligible to participate under Medicare; and (j) it is not an institution which is primarily for the care and treatment of mental diseases or tuberculosis.

Skilled nursing facility care must be preapproved and arranged by BCBSM. Contact BCBSM for information about precertification and arrangements.

SUMMARY PLAN DESCRIPTION - This book, which is an easy-to-understand summary of the legal-type governing Plan Document. If any information in this summary is unclear or incorrect, the provisions of the Plan Document will govern.

TOTALLY DISABLED; TOTAL DISABILITY - For you, the employee, being totally disabled means that you are completely unable to perform any and every duty associated with your occupation or employment as a result of non-occupational accidental bodily injury or sickness. For the sole purpose of receiving disability hours, the total disability may be due to either an occupational or non-occupational cause.

For a dependent or a retiree, being totally disabled means that the person is completely unable to perform the normal activities of a person of like age and sex as

a result of non-occupational accidental bodily injury or sickness.

TRUSTEES - The Union and Employer Trustees who are responsible for the operation of the Trust Fund through which this Plan of Benefits is provided.

UNION - The Local Unions affiliated with the International Brotherhood of Electrical Workers, AFL-CIO, which are listed on page 75.

GENERAL PLAN PROVISIONS

TRUSTEE AUTHORITY

The Board of Trustees has full authority to increase, reduce or eliminate benefits and to change the eligibility rules and other provisions of the Plan at any time. However, the Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable while they are in effect. The right to change or eliminate any and all aspects of benefits provided for retirees and their dependents is a right specifically reserved to the Trustees. The Trustees have the authority to amend or terminate such benefits and to initiate or increase self-payments for the coverage at any time. Any such change shall be effective even though an employee has already become a retiree.

Notices of any changes or deletions of the information in this book will be provided to each participant within the time required by applicable regulations, but some changes may take effect before you are notified of a change. Before incurring any non-emergency expense, you should contact the Plan Office to confirm your current entitlement to coverage.

This book is intended to give you an accurate summary of the benefits and provisions of your Health Plan. It does not describe Plan changes that occurred after the book was printed. The Plan Document and the Trust Agreement, which you can read at the Plan Office or other specified locations, contain a detailed description of the rules, regulations, benefits, and provisions of your Health Plan. If any discrepancy exists between this booklet and the Plan documents, the provisions of the Plan documents will govern.

Only the full Board of Trustees is authorized to interpret the Benefit Plan described in this book. The Trustees' interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious. No agent, representative, officer, or other person from the union or an employer has the authority to speak for the Trustees or to act contrary to the written terms of the governing Plan documents.

If you have questions about your eligibility or a claim, contact the Plan Office. Matters that are not clear, or which need interpretation, will be referred to the Trustees.

COORDINATION OF BENEFITS (C.O.B.)

Benefits are coordinated when you and your dependents are covered by this Plan as well as by another group health plan (such as your spouse's plan). Coordination allows benefits to be paid by two or more plans, up to but not to exceed 100% of the allowable expenses on the claim.

General C.O.B. Information

1. Benefits are coordinated on all employee (active or retired) and dependent claims. C.O.B. applies to all benefits except Weekly Disability Benefits.
2. You must file a claim for any benefits you are entitled to from any other source. Whether or not you file a claim with these other sources, your Plan payments will be calculated as though you have received any benefits you are entitled to from the other source(s).
3. This Plan will not pay benefits for expenses which would have been covered by the other plan but which are not covered because the person failed to take the action required under the rules of the other plan to qualify for benefits. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures such as hospital preadmission review or certification, second surgical opinions, certification of chemical dependency or mental health treatment, or any other required notification or procedure of the other plan, including failing to file a claim.
4. If the other plan refuses to pay benefits according to this Plan's rules, this Plan may continue to pay benefits as if it were primary in consideration of being subrogated to the affected person's rights against the other plan.

5. Benefits are paid in C.O.B. for "allowable expenses," which are expenses that are eligible to be considered for reimbursement.
6. Benefits are coordinated with group insurance and group subscriber contracts; uninsured and underinsured arrangements of group or group-type coverage; group or group-type coverage through HMOs and other prepayment group practice and individual practice plans; group-type contracts; labor management trusteed plans; union welfare plans (including this Plan if husband and wife are both eligible employees); employer organization plans or employee benefit organization plans; any federal or state or other government plan including Medicare; and motor vehicle insurance or similar protection, including uninsured or underinsured motorist and no-fault coverage. If you or anyone in your family is covered under another plan, you can contact the Plan Office to find out whether that plan fits the definition of a group plan.

Order of Benefit Payments

1. If the other plan doesn't have C.O.B., that plan will pay its benefits first and this plan will pay second.
2. When the other plan does have C.O.B.:
   a. The plan covering a person (for whom a claim is filed) as an employee will pay first and the plan covering that person other than as an employee will pay second; and
   b. The plan covering a dependent (for whom a claim is filed) whose coverage is due to a parent's employment will pay before a plan whose coverage is due to COBRA self-payments.
3. To the extent that this Plan covers injuries received in an automobile accident, such claims will be paid first by any motor vehicle insurance, including uninsured or underinsured motorist and no-fault coverage, before this Plan pays.
4. **On claims for dependent children:**
   a. When the parents are not separated or divorced, the plan covering the parent whose birthday comes first in the year will pay first and the plan covering the parent whose birthday comes later in the year will pay second.
   b. When the parents are separated or divorced, benefits are payable according to any existing court decree. If both parents are equally responsible for the child's health care according to a court decree, the plan covering the parent with custody (if not remarried) pays first and the plan covering the parent without custody pays second. If the parent with custody has remarried, that parent's plan pays first, the stepparent's plan pays second, and the plan covering the parent without custody pays third.
   c. If you and your spouse are both covered as employees under this Plan, benefits for claims for your children will be coordinated as explained above.
5. A plan that covers a person as an employee who is not laid off, retired, or making COBRA self-payments as a former employee will pay its benefits before a plan that covers that person as a laid off, retired, or former employee making COBRA coverage payments. This rule applies identically to a dependent of a person who is covered as both an active employee and as a laid off, retired or former employee making COBRA payments. If the other plan does not have this rule and the plans do not agree on the order of benefits, rule No. 6 will be ignored.
6. If the above rules still do not clearly show which plan should pay first, the plan that has covered the person for the longest period of time will pay first, the plan that has covered the person for the next longest period of time will pay second, and so on.
7. If another plan's rules require benefit payments only in excess of benefits provided by another plan or requires it always to be secondary, the following rules apply in coordinating benefits:
   a. If this Plan's rules require this Plan to be primary according to the rules stated above, it will pay primary benefits.
   b. If this Plan's rules require it to pay secondary benefits, the amount payable will be determined as if this Plan were the secondary plan.
   c. If the other plan does not provide requested information about its benefits, this Plan will assume that its benefits are the same as the other plan and pay benefits accordingly. However, necessary payment adjustments will be made when information from the other plan becomes available.

Nonrecognition of Benefit Limitations (COB With Subplans)

Some plans attempt to avoid responsibility for paying their fair share of benefits when they are primary by invoking a special provision that attempts to shift their fair share of a claim to the secondary plan. The rule explained below is intended to protect this Plan in the event the primary plan has one of these cost-shifting rules.

1. If another plan that is primary in accordance with the order of benefit determination rules contains a provision that modifies, limits or reduces its benefits in a way that shifts additional liability to this Plan, then this Plan shall consider such provision to have no force or effect. In that case, this Plan's benefits will be determined as if the other plan had paid based on its regular coverage rules for a person without other coverage.
2. If another plan's rules exclude a person from eligibility because that person is also covered under this Plan, attempts to shift coverage liability to this Plan, or avoids the customary application of this Plan's coordination of benefits rules, then this Plan will consider such rule to have no force or effect.
3. If No. 1 or 2 above apply, this Plan will coordinate its benefits as if the other plan's cost-shifting rules did not exist and as if the other plan paid its full regular benefits. If the other plan's rules cannot be disregarded for a person covered by this Plan on a secondary basis, the maximum benefit payable for such person under this Plan will be $1,000 per calendar year.

C.O.B. With Medicare

Important Notes - You are responsible for enrolling in Medicare Part A and Part B when you are eligible to do so. If you are eligible to enroll in Medicare, this Plan will assume that you have enrolled in both Part A and Part B of Medicare and will coordinate benefits as if benefits payable by Medicare have been paid. This means that this Plan will only pay benefits equal to the benefits it would have paid if you were enrolled in both Part A and Part B of Medicare. This applies whether you are eligible to enroll in Medicare due to becoming age 65 or due to disability. It also applies to dependents who are eligible to enroll in Medicare.

You will not be added to the Supplement to Medicare Program if you are not enrolled in both Part A and Part B of Medicare. This also applies to your dependents.

This Plan will NOT coordinate with Medicare Part D prescription drug plans for retirees and their Medicare-eligible dependents. Medicare-eligible retirees and their Medicare-eligible dependents must choose between this Plan's prescription drug coverage and a Part D plan. See page 29 for more information.

C.O.B. With Medicare for Employees and Their Dependents

1. *C.O.B. With Medicare for Persons Under Age 65* - If an eligible family member is entitled to Medicare for reasons other than being 65 or older, federal law may require this Plan to pay its benefits first—for example, for a totally disabled person. Also, special rules apply to a person who is an End Stage Renal Disease beneficiary under Medicare. Check with the Plan Office or your local Social Security office for more information about this rule.
2. *C.O.B. With Medicare for Age 65 or Over Employees and Their Spouses* - If you continue to work after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules. This Plan will pay its benefits before Medicare pays its benefits.

   If your dependent spouse is age 65 or older and eligible for Medicare while you are still actively working and eligible (regardless of your age), this Plan will pay its normal benefits for her before Medicare pays—if she is covered under her own plan, her plan will pay first, this Plan will pay second, and Medicare will pay last. (Once you retire, benefits will be paid for your spouse as explained in the section below titled "C.O.B. With Medicare for Retirees and Their Dependents.")

   You (and/or your spouse) can decline coverage under this Plan. If you do, Medicare will be your only health care coverage. If you and/or your spouse prefer Medicare as your health care coverage when you are age 65, contact the Plan Office (or your spouse should notify her own plan). Unless you make such a choice, this Plan will usually continue to pay primary benefits for you (and its normal benefits for your spouse) as long as you stay regularly eligible.

C.O.B. With Medicare for Retirees and Their Dependents

If a retiree or a dependent of a retiree is eligible for the Supplement to Medicare, Medicare will pay benefits first on that person's claims and the Supplement to Medicare will pay certain supplementary benefits (see pages 29-30).

If you or your spouse want information about Medicare enrollment, contact your local Social Security office (at least 30 days before your 65th birthday, if possible).

CIRCUMSTANCES WHICH MAY RESULT IN DENIAL OR LOSS OF BENEFITS

The Trustees or their representatives are authorized to deny payment of a claim, and the reasons for denial may include one or more of the following:

1. The person on whose behalf you filed the claim was not eligible for benefits on the date the expenses were incurred.
2. You didn't file the claim within the Plan time limits.
3. The expenses that were denied are not covered under the Plan or the expenses were not actually incurred.
4. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time, for example: a calendar year maximum benefit, a lifetime maximum benefit, etc.
5. No payment, or a reduced payment, was made because some or all of the expenses for which the claim was filed were applied against a deductible.
6. You or the person on whose behalf the claim was filed didn't submit the required subrogation documents which would permit the Plan to process the claim and recover payment from any other source (see "Subrogation" on page 64).
7. Another plan was primarily responsible for paying benefits for the expenses (see "Coordination of Benefits" on pages 61-64).
8. The Plan of Benefits was terminated.

The preceding list is not an all-inclusive listing of the circumstances which may result in denial or loss of benefits. It is only representative of the types of circumstances, in addition to failure to meet the regular eligibility requirements, that might cause denial of a claim for benefits. If you have any questions about a claim denial, contact the Plan Office.

SUBROGATION AND REIMBURSEMENT

If the Plan pays or will pay benefits to or on behalf of a covered person and the person, or the guardian, representative or trustee of such person, (collectively, "you") receives or is entitled to receive any recovery from another source, the Plan is entitled to reimbursement in full of amounts paid to the extent that the Plan has paid or will pay benefits to you or on your behalf, but not more than the amount that you recovered from the other source. This right of recovery applies on a priority, first-dollar basis to any recovery, regardless of whether it is a full or partial payment and regardless whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses. Once the Plan makes or is obligated to make payments on your behalf, you agree that the Plan has an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment that you receive from any source.

You will be required to sign an agreement before payments will be made on the claim. The agreement recites your obligations under the terms of the Plan. The Trustees may, in their discretion, withhold benefits until receiving the fully signed agreement. Additionally, if you do not provide the required signed agreement, the Trustees may, in their discretion, suspend all future benefit payments for you, the Employee of whom you are a Dependent or any other Dependent of that Employee. Among other things, the agreement says that you agree that:

- ***You will repay the Plan*** the amount of benefits which the Plan pays or is obliged to pay on the claim out of any recovery that you may receive; and
- ***The Trustees may participate in any legal action you may file against a third party to recover the expenses.*** If you do not pursue any recovery from a third party, the Trustees may act in your place to recover the expenses. If the Trustees act in your place as noted in the agreement you sign, the Trustees' expenses, costs and incurred attorneys' fees will also be paid out of any recovery or settlement.

The Plan does not require you to repay more than the benefits that the Plan pays or is obliged to pay on the claim or more than the amount you receive in recovery.

If the Plan Office pays or is obliged to pay benefits on a claim and you then receive a recovery from any source,

whether by judgment, settlement or otherwise, you must first repay the Plan up to the amount of benefits it paid or is obliged to pay. If you don't, the Plan Office has the right to reduce benefits on claims for you and your family, or reduce the amount you can claim under the Special Fund, until the proper amount has been recovered by the Plan. This right does not limit the Plan's right to seek reimbursement by any other means permitted under the Plan document.

The subrogation and reimbursement procedure applies to any type of payment you may receive from any source which reimburses you for expenses incurred for treatment of an eligible family member's injuries or sicknesses, including, but not limited to a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an Employer under the provisions of a Workers' Compensation Act or Occupational Disease Law or an individual policy of insurance maintained by you. This includes voluntary settlements with a Workers' Compensation carrier in situations where it is reasonable to conclude that an injury was work-related.

The Plan may enforce its subrogation and reimbursement rights through any appropriate legal or equitable remedy which, for example, can mean through a lawsuit, a constructive trust, a claim for equitable lien by agreement, or a reduction of the amount that you could claim under your Special Fund account.

You are solely responsible to pay any legal fees or expenses incurred in connection with any recovery to which the Plan's subrogation and reimbursement rights apply. The Plan's recovery will not be reduced by your legal fees or expenses, unless the Trustees, in their discretion, have agreed in writing to discount the Plan's claim by an agreed upon amount of such fees and expenses.

The Plan does not recognize any claims that you may assert under any federal or state common law defense to the Plan's subrogation and reimbursement rights. This means that the Plan's claims will not be reduced or limited by the make whole doctrine, the common fund doctrine or any other such defense.

(The above rules apply to a dependent in the same way they apply to a retiree or employee. If the person involved in subrogation is legally unable to act on his or her own behalf (such as a minor dependent child), the person's parent, guardian, legal representative or trustee is responsible for signing all necessary documents and for repaying the Plan from any recovery or settlement received behalf of such person.)

ADDITIONAL PLAN PROVISIONS

Payment of Benefits

Health care benefits are payable individually for you and each of your dependents up to but not to exceed the maximum benefits shown on the Schedule of Benefits according to the following provisions:

1. All bills from hospitals and doctors who participate with BCBSM will automatically be sent to Blue Cross Blue Shield of Michigan (BCBSM), which pays the Plan's share of the expenses to the hospital or doctor. You will get an EOB (Explanation of Benefits) from BCBSM telling you what BCBSM has paid. The hospital or doctor will bill you for the remaining amount of the bill not paid by BCBSM. You are responsible for paying this amount.
2. Doctors who do not participate with BCBSM and some other service providers may not agree to send their bills directly to BCBSM.
3. When you receive an Explanation of Benefits (EOB) from BCBSM, please review it carefully.
4. All benefit payments for BCBSM PPO providers will be made directly to the providers.
5. If the Trustees decide that a person isn't mentally, physically, or otherwise capable of handling his business affairs, benefits may be paid to his guardian or to the individual who has assumed his primary care and maintenance, if there is no guardian. If the person dies before all due amounts have been paid, the Trustees may make payment to his estate, to his surviving spouse, parent, child, or children, or to any individual the Trustees believe is entitled to the benefits.
6. In determining the satisfaction of any deductible amounts and the amount of benefit payments, a charge for any service, treatment, or supply will be considered to have been incurred on the date that it was provided to the patient.
7. Any payments made by the Plan in accordance with these provisions will fully discharge the Plan's liability to the extent of the payments. You are responsible for paying any deductibles and copayment percentages not paid by the Plan or BCBSM.

Release of Information

You must provide the Plan Office or BCBSM with any required verbal or written authorization for release of necessary information relating to any claim you have filed.

Examinations

The Trustees have the right to have a doctor of their choice examine a person for whom benefits are being claimed, and to ask for an autopsy in the case of a death, provided an autopsy is not forbidden by law. They also have the right to examine any and all hospital or medical records relating to a claim.

Free Choice of Doctor

You will have free choice of any doctor who meets this Plan's definition of a doctor. However, no reimbursement will be made for charges made by a doctor beyond the coverage specifically provided under the Plan.

Workers' Compensation Not Affected

This Plan is not in place of and does not affect any requirement for coverage under any Workers' Compensation Law, Occupational Diseases Law, or similar law. (Benefits which would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws.)

Plan Discontinuation or Termination

This Plan of Benefits may be discontinued or terminated under certain circumstances—for example, if future collective bargaining agreements and participation agreements don't require employer contributions to the Plan. In such event, benefits for covered expenses incurred before the termination date will be paid on behalf of eligible family members as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

If there are any assets remaining after payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees according to the Trust Agreement. However, any disposition of assets will be made only for the benefit of former Plan participants and for the purposes set forth in the Plan.

Right of Offset

If any payment is made by the Plan to or on behalf of a person who is not entitled to the payment or to the full amount of such payment, the Plan has the right to suspend or withhold current and/or future claim payments due to that person or his covered family members. The Plan will not withhold more than the amount of the erroneous payment and the amount incurred by the Plan in pursing collection of the overpayment. This right of offset will not limit the right of the Plan to recover such erroneous payments in any other manner.

Legal Actions

You may not file legal action against the Plan to recover loss until all of the proper claim and claim appeal procedures have been followed. In addition, no such action may be brought more than three years after the time written proof of loss or claim is to be furnished to the Plan Office.

Falsified or Fraudulent Claims

All claims, enrollment forms and other information submitted or provided to the Plan, directly or indirectly, must be accurate and complete. If the Trustees find at any time that false or inaccurate information has been submitted or provided to the Plan, directly or indirectly, in support of a claim, such claim will be denied and the Trustees can offset the amount improperly paid and/or terminate future coverage for the affected individual and his covered family members.

INFORMATION REQUIRED BY ERISA

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another plan. When you lose coverage under the Plan, you should be provided a certificate of creditable coverage. A certificate of creditable coverage will be provided whenever: (1) you lose coverage under the Plan and, therefore, become entitled to elect COBRA continuation coverage; (2) your COBRA continuation coverage ceases; (3) you request it before losing coverage; or (4) you request it up to 24 months after losing coverage. The certificate will be provided free of charge. Without evidence of creditable coverage, you may be subject to a preexisting 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 participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights - If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you believe that Plan fiduciaries misuse the Plan's money, or if you believe you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued

to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. If you have any questions about your Plan, you should contact the Administrative Manager.

Assistance With Your Questions - If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrative Manager, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue New., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also find answers to your questions and a list of EBSA field offices at the website of the EBSA at www.dol.gov/ebsa.

How to Read or Get Plan Material - You can read the material listed in the previous section by making an appointment at the Plan Office during normal business hours. This same information can be made available for your examination at certain locations other than the Plan Office. The Plan Office will inform you of these locations and tell you how to make an appointment to examine this material at these locations. Also, copies of the material will be mailed to you if you send a written request to the Plan Office. There may be a small charge for copying some of the material. Before requesting material, call the Plan Office to find out the cost. If a charge is made, your check must be attached to your written request for the material. The Plan Office address and phone number are shown on the inside front cover of this booklet.

HIPAA CERTIFICATES OF CREDITABLE COVERAGE FROM THIS PLAN

Upon termination of coverage, a covered person should receive a Certificate of Creditable Coverage from this Plan which may be used to reduce the application of a preexisting condition limitation under a new health plan. Within 24 months of termination of coverage, a covered person may also request a Certificate of Creditable Coverage by contacting the Plan Office at the address listed on the inside front cover of this booklet.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice - April 14, 2003

The Michigan Electrical Employees' Health Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI);
2. Your privacy rights with respect to your PHI;
3. The Plan's duties with respect to your PHI;
4. Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1. Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures - Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations - The Plan and its business associates will use PHI without your authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the

Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require your written authorization - The Plan will obtain your authorization before releasing your PHI in those circumstances where the law or the Plan's privacy practices do not otherwise permit disclosure. For example, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you prepared by your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release - Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

1. The information is directly relevant to the family member or friend's involvement with your care or payment for that care; and
2. You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Additional rules and exceptions apply with family members. You may request additional information from the Plan.

Uses and disclosures for which your consent, authorization or opportunity to object is not required - The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally by made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required

by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgement.

10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Section 2. Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI - You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official at:

6011 West St. Joseph, Suite 401
Lansing, MI 48917

Right to Request Confidential Communications - The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official at:

6011 West St. Joseph, Suite 401
Lansing, MI 48917

Right to Inspect and Copy PHI - You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses

and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official at:

6011 West St. Joseph, Suite 401
Lansing, MI 48917

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI - You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official at:

6011 West St. Joseph, Suite 401
Lansing, MI 48917

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures - At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (including to business associates pursuant to a business associate agreement and to the Trustees as authorized by the Plan or the HIPAA privacy regulations); (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official at:

6011 West St. Joseph, Suite 401
Lansing, MI 48917
(517) 323-9250

Right to Receive a Paper Copy of This Notice Upon Request - You have the right to obtain a paper copy of this Notice.

Such requests should be made to the Plan's Privacy Official at:

6011 West St. Joseph, Suite 401
Lansing, MI 48917
(517) 323-9250

A Note About Personal Representatives - You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. A power of attorney for health care purposes, notarized by a notary public;
2. A court order of appointment of the person as the conservator or guardian of the individual; or
3. An individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exer-

cise their rights under these rules and who may be subject to abuse or neglect.

Section 3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective April 14, 2003, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard - When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

1. Disclosures to or requests by a health care provider for treatment;
2. Uses or disclosures made to the individual;
3. Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. Uses or disclosures that are required by law; and
5. Uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information - This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information - The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official at:

6011 West St. Joseph, Suite 401
Lansing, MI 48917

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy official. Such questions should be directed to the Plan's Privacy Official at:

6011 West St. Joseph, Suite 401
Lansing, MI 48917
(517) 323-9250

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

INFORMATION ABOUT YOUR PLAN

Name of Plan/Fund - The name of this Plan is the Michigan Electrical Employees' Health Plan.

Plan Sponsorship and Administration - Your Plan is sponsored and administered by a joint labor-management Board of Trustees, divided equally between Trustees selected by the Union and by Trustees appointed by contributing employers. You may write to the Plan Office to find out if an employer or union is a sponsor of the Plan, and, if so, to find out the Plan sponsor's address. The Board of Trustees is the Plan Administrator. The legal address of the Board of Trustees and the Trustees as of the date of this booklet are shown on pages 74-75.

The Trustees are assisted in the administration of the Plan by a contract administrator (Administrative Manager), Zenith Administrators, Inc., which is responsible for administration duties and some processing of claims and benefit payments. The address of the Administrative Manager is on the inside front cover. The Trustees are also assisted by Blue Cross Blue Shield of Michigan (BCBSM) for most medical claim processing and benefit payments. In overall terms, the "Administrator" of your Health Plan is the Board of Trustees. However, the Trustees have divided certain functions into two areas of responsibility and have delegated them either to the Plan Office or to BCBSM. The addresses for these organizations are on the inside front cover.

Service of Legal Process - The agent for service of legal process is shown on page 75. Legal process may also be served on the Administrative Manager or on any Trustee.

Source of Financing/Plan Participation - The Fund receives contributions from employers under collective bargaining agreements with the various Local Unions, from employers who have special participation agreements with the Trustees, and from employees, retirees and dependents who make self-payments. An employee or retiree can get a copy of a collective bargaining agreement, or the agreement can be read at the Plan Office (see "How to Read or Get Plan Material" on page 68).

You (the employee) are entitled to participate in this Plan if you work under one of the collective bargaining agreements and if your employer is required to make monthly contributions to the Plan on your behalf. Other persons entitled to participate in this Plan are certain retirees, officers and employees of the Unions, employees of the Association, employees of the Health Plan, and employees of such other organizations as may participate in the Plan under the provisions of a participation agreement.

Accumulation of Assets/Payment of Benefits - Employer contributions and employee, retiree and dependent self-payments are received and held in trust by the Trustees pending the payment of benefits and administrative expenses. The Health Plan is a multiemployer group health plan and provides medical, prescription drug and disability benefits on a self-funded basis. An insured retiree program that is supplemental to Medicare is provided by Blue Cross Blue Shield of Michigan.

The self-funded benefits payable by the Plan, as described in this Summary Plan Description, are limited to Plan assets available for such purposes. This Benefit Plan is not an insurance policy and no benefits are provided by or through an insurance company.

Plan Year - The Plan's financial records are maintained on a 12-month fiscal year basis, beginning September of each year and ending on August 31 of the following year.

Plan Identification Numbers - The Employer Identification Number (EIN) assigned to the Plan by the Internal Revenue Service is 38-2106878. The Plan Number (PN) is 501.

BOARD OF TRUSTEES

UNION TRUSTEES

Mr. Bryan Johnson
Local Union No. 1070, IBEW
119 South Front Street
Marquette, MI 49855

Mr. Bob Koerschner
Business Manager
Local Union No. 219, IBEW
205 East Fleishiem
Iron Mountain, MI 49801

Mr. Charles Marshall
Business Manager
Local Union No. 948, IBEW
1251 West Hill Road
Flint, MI 48507

Mr. Thomas Ryder
Business Manager
Local Union No. 692, IBEW
1300 West Thomas Street
Bay City, MI 48706

EMPLOYER TRUSTEES

Mr. Robert Biallas
B&B Electric, Inc.
627 Circle Drive
Iron Mountain, MI 49801

Mr. Mark Hunt
Hi-Tech Electric Company
P.O. Box 550
Portage, MI 49081

Mr. Paul Kelley
Michigan Chapter, NECA
8360 Apple Blossom Lane
Flushing, MI 48433

Mr. Bob Schumaker
Michigan Chapter, NECA
809 Pendleton
Comstock Park, MI 489321

Alternate Union Trustees

Mr. Jeff Bush
Business Manager
Local Union No. 498, IBEW
3912 Blair Townhall Road West
Traverse City, MI 49684-8720

Mr. Walt Christophersen
Business Manager
Local Union No. 275, IBEW
140 North 64th Avenue
Coopersville, MI 49404

Mr. Scott Clark
Business Manager
Local Union No. 665, IBEW
5205 South Pennsylvania
Lansing, MI 48911

Alternate Employer Trustees

Mr. Brian Fleming
Genesee Electric
14309 Fenton Road
Fenton, MI 48430

Mr. Wayne Gardner
MJ Electric
P.O. Box 686
Iron Mountain, MI 49801

Mr. William Nelson, III
William Nelson Electric, Inc.
111 Hoyt Street
Saginaw, MI 48607

Alternate Union Trustees (cont.)

Mr. Steve Claywell
Business Manager
Local Union No. 445, IBEW
1375 West Michigan Avenue
Battle Creek, MI 49017

Mr. Patrick Klocke
Business Manager
Local Union No. 131, IBEW
1473 North 30th Street
Galesburg, MI 49053

Mr. Tom Lippens
Business Manager
Local Union No. 979, IBEW
1219 First Avenue, South
Escanaba, MI 49829

Mr. Robert Orr
Business Manager
Local Union No. 557, IBEW
7303 Gratiot
Saginaw, MI 48609

Alternate Employer Trustees (cont.)

Mr. Donald Surnbrock
10273 Burgundy Boulevard
Diamondale, MI 48821

Administrative Manager

Zenith Administrators, Inc.
6011 West St. Joseph
Suite 401
Lansing, MI 48917
(Office hours: 8:30 a.m.-4:30 p.m.)

Agent for Service of Legal Process

Office Manager
Michigan Electrical Employees' Health Plan
6011 West St. Joseph
Suite 502
Lansing, MI 48917

Service may also be made on any Trustee.

To write to the Board of Trustees or file a claim appeal, address your letter to the Board of Trustees, using the complete Plan name and address shown for the Plan Office on the inside front cover. (See pages 54-55 for more information about filing an appeal.)

To write to the Plan Office, address your letter to: Administrative Manager, Michigan Electrical Employees' Health Plan, at the address shown above.

Local Unions Participating in this Plan

Kalamazoo Local Union No. 131
Iron Mountain Local Union No. 219
West Michigan Local Union No. 275
Battle Creek Local Union No. 445
Traverse City Local Union No. 498
Saginaw Local Union No. 557
Lansing Local Union No. 665
Bay City Local Union No. 692
Flint Local Union No. 948
Escanaba Local Union No. 979
Marquette Local Union No. 1070

Reciprocity

The Michigan Electrical Employees' Health Plan is a participating trust fund in the Electrical Industry Health and Welfare Fund Reciprocal Agreement. If you need information about how to transfer hours worked, contact the Plan Office.