Emergent Holdings, Inc.
Non-Bargaining Unit Retiree Medical Summary Plan Description

Simply Blue PPO 500

Simply Blue HDHP 1600

Medicare Plus Blue Group PPO

Non-Bargaining Unit (NBU) Eligible Retirees,
NBU Eligible Surviving Spouse(s) and Dependents

January 2025

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Introduction

The BCBSM Retiree Medical Benefit Plan (Plan) provides Emergent Holdings Inc. (EH) retirees and their eligible dependents with a comprehensive health care benefits package that includes basic medical, hospital, surgical and prescription drug benefits. **Dental, vision and hearing care benefits are not provided to retirees, eligible spouses, eligible surviving spouses and eligible dependents; and therefore are not included in this Plan.**

This Summary Plan Description (SPD) explains the health care benefits under the Blue Cross Blue Shield of Michigan Retiree Medical Benefit Plan for eligible non-bargaining unit retirees of EH. spouses, surviving spouses, and dependents pursuant to the provisions of the Plan.

This SPD is written in clear and informal language. A Glossary of Health Care Terms is included to assist you. The Plan is governed by an official legal plan document and certificates/riders. If there is a difference between the legal plan document and certificates/riders and information in either this SPD or in any explanation from Plan representative, the legal plan document and certificates/riders will be used to determine your rights and benefits under the Plan.

If you are not certain that you have the most recent SPD or would like to request a copy contact Employee Benefits atHRRequest@emergentholdingsinc.com or call 1-517-708-5400.

For copies of benefits booklets such as Benefits at a Glance, certificates and riders or other related materials, visit the BCBSM website at www.bcbsm.com and log in as a Member.

EH reserves the right to amend or terminate its retiree benefit plan(s) and programs at any time without consent of individuals entitled to the benefits. The Plan Administrator shall have the authority to approve all technical, administrative, regulatory and compliance amendments to the Plan, and any other amendments that will not increase the cost of the Plan to the Company, as the Plan Administrator shall deem necessary or appropriate.

Section 1: General Information

ID Cards

BCBSM issues ID cards once the subscriber completes enrollment. Having an ID card assists with obtaining services covered under the Plan. Only the subscriber's name appears on the ID card. However, the card is for all covered members. ID cards are unique to each contract.

ID cards contain the following information:

1. The **Issuer code** (5 digits) identifies BCBSM as a health insurance carrier, and the number (10 digit number) identifies BCBSM as the issuer of the card.
2. The plan coverage type
3. The "**Rx**" logo indicates prescription drug benefits are administered by BCBSM and drug claims are processed by Optum Rx.
4. The "**RxBIN**" and "**RxGrp**" numbers help the pharmacist administer prescription drug claims.

ID Card Helpful Hints:

ID cards should be carried at all times to help avoid delays when medical attention is needed.

- To request a new or additional ID card logon to www.bcbsm.com. Select "My ID Card".
- Only the subscriber and eligible dependents may use the card issued for the contract. Lending ID cards to anyone not eligible to use it is illegal and is subject to possible fraud investigation and/or disciplinary action up to and including termination.
- In the event an ID card is lost or stolen services can still be rendered by giving the provider the contract number to verify the health plan.

  ***NOTE**: In the event dental and/or vision coverage is elected through COBRA (Consolidated Omnibus Budget Reconciliation Act) separate ID cards for these coverages will be received.*

To obtain a BCBSM contract number contact:

Employee Inquiry Unit:
232 S. Capitol Ave., Mail Code L03B
Lansing, MI 48933-1504
(888) 288-1718

Choosing A Provider

Find a provider by visiting www.bcbsm.com and selecting “Find a Doctor”. Choose a plan as listed on the subscriber’s ID card. Online directories are updated continually and are available 24 hours a day, seven days a week. In order to check the status of a claim, view an Explanation of Benefits (EOB) or access other health related items.

Explanation of Benefits (EOB)

An EOB statement is a record of paid or rejected claims. It also lists any amounts applied to deductibles and/or copays. All health insurance carriers will accept the EOB statement to process any available benefits for coordination of benefits. They can be used to keep track of medical expenses for tax purposes.

Each month, BCBSM processes medical claims under each contract number and members will receive an *Explanation of Benefits* (EOB) statement. **This statement is not a bill.**

If the member has registered for an online account at www.bcbsm.com EOBs will automatically be e-mailed to the e-mail address on file. Once online EOB statements are chosen, members can choose to elect paper statements by visiting www.bcbsm.com. If the member has not registered for an online account, EOBs will be mailed to the home address reported on the claim BCBSM receives from the provider. Therefore, it is very important for providers to have the member’s correct mailing address.

If members have a question about an EOB statement and have a BCBSM plan, contact:

Employee Inquiry Unit
232 S. Capitol Ave., Mail Code L03B
Lansing, MI 48933-1504
(888) 288-1718

Section 2: Eligibility Guidelines

Eligibility Guidelines

This SPD applies to the following (all NBU Non-Medicare retirees and NBU Medicare eligible retirees who retired prior to January 1, 2005):

1. Retirees who meet the following criteria:

- Employees who were eligible for retirement (age 55 with 10 years of service) as of January 1, 2005, OR who had 30 years of continuous Eligibility Service as of January 1, 2005.
- Employees hired prior to January 1, 2005, who were not eligible for retirement as of January 1, 2005, must have 10 years of continuous Eligibility Service after age 45 or 5 years of continuous Eligibility Service if hired after age 60.
- Employees hired on or after January 1, 2005, must have 15 years of continuous Eligibility Service after age 45.

2. All eligible spouses, surviving spouses and dependents referred to in this SPD as "eligible spouses and dependents" of **non-bargaining unit**:

a. Retirees

b. Active employees who at the time of their death had met the eligibility requirements of number one above.

Plan Provisions

EH bargaining unit Retirees who retire on or after January 1, 2011 are required to enroll in Medicare Advantage upon becoming Medicare eligible.

Medicare eligible Retirees and their Medicare eligible dependents are required to enroll in Medicare A and B and enroll in a Medicare Advantage plan once Medicare eligible.

Health care benefits are provided for the following dependents when they meet all eligibility requirements:

1. Spouse

2. Dependent Child(ren)

3. Principally Supported Child(ren)

4. Sponsored Dependent(s)

5. Child(ren) for which a Qualified Medical Child Support Order exists

> ***NOTE:*** *If the eligible Retiree is still living they must be enrolled to allow eligible dependents to enroll in the plan. Health care coverage is provided for eligible surviving spouses and eligible dependents, if at the time of death the active employee was eligible for retirement or the Retiree was receiving retirement benefits.. Health care benefits will continue as long as such persons continue to meet the eligibility requirements under a new contract number. New ID cards will also be issued. Health care coverage will not be provided to the new spouse of a surviving spouse if he or she re-marries.*

Eligible dependents may enroll if:

1. The Retiree is also enrolled in a EH group sponsored plan

2. The proper documentation is provided to verify dependent status, including a social security number within 30 days of enrollment or 30 days of having a qualifying life event **AND**

3. The dependent meets all the eligibility requirements

> ***NOTE:*** *If the dependent does not yet have a Social Security number, one must be provided within 60 days, unless the process is delayed for reasons beyond the subscriber's or dependent's control. A social security number is not required for a dependent who is not a U.S. citizen and therefore does not have a Social Security number. If the dependent becomes eligible for a Social Security number, one must be provided as soon as it is received.*

Eligible Spouse

An eligible spouse is an eligible person to whom the Retiree is lawfully married.

> ***NOTE:*** *A decree of divorce requiring the Retiree to provide health coverage for an ex-spouse does not make the Retiree's ex-spouse eligible for coverage under this Plan.*

Eligible Dependent Child(ren)

Eligible dependent children include:

1. The Retiree or his or her eligible spouse's children by birth, legal adoption or legal guardianship until the end of the calendar year in which they attain age 26, regardless of school, marital or residential status.

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

   NOTE**:** *A foreign exchange student is **NOT** eligible for coverage as a dependent.*

2. An unmarried Dependent Child and a Dependent under a Qualified Medical Child Support Order who becomes 26 while enrolled and who is totally and permanently disabled, before their 26th birthday, may continue health care coverage if they meet all of the following criteria:

   a. The child is incapable of self-sustaining employment because of a mental or physical condition; and

b. The child relies primarily on the Retiree for financial support.

Physician certification, verifying the child's disability and that it occurred prior to the child's 26th birthday, must be submitted in writing to EH by the end of the calendar year in which the child turns age 26.

Disabled dependents must enroll in Medicare Part A and Medicare Part B once eligible.

> ***NOTE:*** *A Dependent Child whose disability is due to a learning disability or substance abuse does not qualify for health care coverage beyond the end of the calendar year in which they attain age 26.*
>
> ***NOTE:*** *Spouses and dependents who satisfy the criteria listed above are referred to as eligible spouses and dependents.*

Qualified Medical Child Support Orders

If the child does not meet any of the above definitions, he or she can be covered if there is a Qualified Medical Child Support Order that requires the Plan to provide medical coverage for that child. A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by an appropriate court that:

1. Provides for child support or health benefit coverage for the Retiree's child and is made according to a state domestic relations order

2. Meets federal requirements for qualification and requires group health benefits under the Plan

3. Creates (or recognizes) the child's right to receive health benefits under the Plan

4. Meets the following requirements:

- **a.** Clearly specifies the Retiree's name and last known mailing address and the name and mailing address of each child covered by the order
- **b.** Clearly describes the type of coverage to be provided to each child
- **c.** Clearly specifies the period to which the order applies
- **d.** Clearly specifies the plan to which the order applies
- **e.** Does not require the Plan to provide any type or form of benefit not otherwise provided by the Plan

If EH receives a Qualified Medical Child Support Order, the subscriber will be notified of any changes in his or her contract resulting from the processing of the order.

Dependents under a Qualified Medical Child Support Order are eligible for Coverage until the end of the calendar year in which they turn 26 years old.

Eligible Principally Supported Children

A **principally supported child** is one that is not a dependent child but is related to the Retiree by blood or marriage. To be eligible the child must meet **all** the following requirements:

1. Must be under the age of 27

2. Must be **unmarried**

3. Must live full-time in the Retiree's home

4. Must not be eligible for Medicare or other group coverage and

5. Must be claimed as an exemption on the Retiree's most recent federal income tax return

   NOTE: *If the child began living with the Retiree after the last tax return was filed, the child must qualify in the current tax year as an exemption on the Retiree's current federal tax return.*

6. Must be principally supported by the Retiree for a minimum of nine consecutive months. An application for coverage should be submitted to EH after six months of support is established.

   NOTE*: The nine-month residency waiting period is waived for principally supported grandchildren. A birth record and "Declaration of Dependency" (available from Employee Services) are required.*

Sponsored Dependent Coverage

A **sponsored dependent** is any other dependent who is related to the Retiree by blood or marriage, **and** who resides with the Retiree as a member of the household. To be eligible the individual must meet **all** the following requirements:

1. Must be age 19 years or older

2. Must also be a dependent as defined in the Internal Revenue Code and claimed as an exemption on the Retiree's most recent federal income tax return or qualify in the current tax year as an exemption.

3. Reside full-time in the Retiree's household

   NOTE: *A sponsored dependent covered on the Retiree's contract can remain on the Retiree's health care coverage if the sponsored dependent moves from the Retiree's household into a licensed custodial or long term care facility such as a nursing home.*

Coverage for a sponsored dependent will be effective on the **first day of the month following 90 days after the date that the application is submitted to EH** provided they meet **all** the eligibility requirements stated above. *For example, if the application is submitted to EH for Sponsored Dependent Coverage on June 10, coverage for the sponsored dependent is effective October 1.*

The Retiree is responsible for paying the full cost of coverage for each sponsored dependent.

Sponsored dependents eligible for Medicare are required to have both Medicare Part A and Part B.

Medicare information must be provided to Employee Benefits. A sponsored dependent eligible for Medicare would not be covered under this SPD.

Section 3: Coverage Guidelines

Coverage Categories

The following categories of coverage apply:

- No coverage (waive)
- Subscriber only
- Subscriber + One Dependent
- Family

Enrolling for Coverage

You may enroll for coverage under one of the following conditions:

- **Initial Enrollment:** On the Retiree's pension commencement date or on the first of the month following the death of an eligible active employee.
- **Annual Open Enrollment:** During the annual open enrollment period established by EH .
- **Special Enrollment Periods (Qualifying Life Event)**: If a Retiree, eligible spouse or eligible dependent declines enrollment because of other health insurance coverage, the Retiree, their eligible spouse, or eligible dependents may enroll in the Plan, outside of the annual open enrollment period under the following conditions:

  1. Other coverage is terminated as a result of loss of eligibility or termination of employer contributions for the other coverage, provided that enrollment is requested within 30 days after the other coverage or the employer contribution toward that coverage ends. This is not applicable to loss of coverage due to failure to pay premiums or termination of coverage for cause, such as making a fraudulent claim.

  2. A new dependent is eligible as a result of marriage, birth, adoption or placement for adoption, provided that the enrollment is requested within 30 days after the event.

  3. The Retiree or the Retiree's eligible dependent would have 30 days to enroll in the Plan under the following two circumstances:

  a. If the Retiree or the Retiree's eligible dependent's CHIP (Children's Health Insurance Program) or Medicaid coverage is terminated due to loss of eligibility **or**

  b. The Retiree or the Retiree's eligible dependent becomes eligible for the State's premium assistance program

  NOTE: *Receipt of the required documentation is necessary to complete enrollment.*

  NOTE: *An eligible dependent cannot be enrolled if the Retiree is not enrolled.*

If enrollment is declined because of enrollment in COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation coverage under another plan, COBRA coverage must be exhausted before enrolling in this Plan.

When Coverage Begins

Retiree medical coverage will be effective on the Retiree's pension commencement date. For example, if the Retiree's pension commencement date is April 1st, the retiree medical coverage begins April 1st.

Surviving spouse and eligible survivor dependent medical coverage begins on date of death of the eligible active employee or Retiree.

Dual Coverage

If the Retiree and the Retiree's eligible spouse are both employees and/or retirees of EH, BCBSM, or one of its subsidiaries, each will receive coverage as a subscriber or as a dependent, but not both. For instance, each can maintain their own individual contract or may wish to have one common contract with one retiree as the subscriber and the spouse as the dependent. Additionally, if a dependent child's parents are both employees and/or retirees of EH, BCBSM, or one of its subsidiaries, then the child can only be a dependent on one of the parent's contract.

Health Care Cost Sharing

Subscribers may be responsible for paying for a percentage of their healthcare premiums. The monthly cost is based on retirement date and years of service of the Retiree. For the current rates contact Employee Benefits at (517) 708-5400 or HRRequest@emergentholdingsinc.com .

HealthEquity will mail an invoice to the subscriber at the beginning of each month. Payment must be received by HealthEquity before the invoice due date. If payment is more than 45 days delinquent, coverage and participation in the health care plan will be terminated.

Coverage terminated for non-payment can only be reinstated during an open enrollment period.

Changing Coverage

Coverage cannot be changed until the annual open enrollment period unless there is a qualifying life event. ***(See Special Open Enrollment Period).***

NOTE: *If a surviving spouse remarries, the new spouse is not eligible for Retiree medical benefits.*

Reporting Membership Changes

When the Retiree has a change in family status, they have 30 days from the date of the change in their family status to notify EH and enroll or change their elections under the Plan and 30 days to submit proof document(s). Status changes include:

1. Marriage
2. Divorce
3. Childbirth, adoption, legal guardianship or principally supported child(ren)
4. Change in dependent's eligibility status
5. Death

> ***NOTE**: Under IRS rules, the Retiree's election change must be consistent with their family status change. For example, if the Retiree gets married, the Retiree can add their spouse to their current coverage but cannot change to a different health care option.* ***Eligible surviving spouses cannot add a new spouse to this Plan.***

To make family status changes submit a completed Health Care form to Employee Benefits within 30 days of the change. Contact Employee Benefits at HRRequest@emergentholdingsinc.com or call 1-517-708-5400to obtain a Health Care Form.

> ***NOTE:** Receipt of the required documentation is necessary to complete the enrollment.*

Reporting an Address Change

Address and telephone number changes need to be immediately communicated to EH when they occur. To report an address or telephone number change, Retirees, eligible spouses, and dependents need to provide written documentation via email to HRRequest@emergentholdingsinc.com

Adding a Dependent

The chart below shows examples of coverage effective dates when adding an eligible spouse or eligible dependent.

When adding a…	For changes made within 30 days of the event, coverage will be effective as indicated below, if the required documentation is received
Spouse	On the date of marriage.
Newborn	On the date of birth.
Adopted child	On the date of placement. Placement occurs when the subscriber becomes legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.
Principally supported child	Nine months from the date support began. ***Note**: The nine-month residency waiting period is waived for principally supported* ***grandchildren**.*
Child under legal guardianship	On the date legal guardianship is granted or when the date of petition for legal guardianship and residency is established.
Sponsored Dependent	On the first day of the month following 90 days after the date the application is approved.

Please ensure that all individuals listed on the contract are eligible for coverage as the Retiree's dependent. If inaccurate or fraudulent information is provided, the Retiree will be required to reimburse EH for any claims and/or expenses paid for the dependent after he or she is no longer eligible, and the Retiree may be subjected to other disciplinary actions up to and including termination from the Plan.

Removing a Dependent

Here are some important points to remember:

1. A dependent must be removed from the Retiree's contract if he or she no longer meets the eligibility guidelines under the Plan.

2. An ex-spouse is **not eligible** for coverage after a divorce and **must** be removed.

3. If the Retiree fails to remove a dependent within 30 days of the date they no longer meet the eligibility requirements, the Retiree may be liable for any payments made by EH on behalf of the dependent for benefits that have been provided subsequent to the date they no longer meet the eligibility requirements.

The chart below shows examples of coverage termination dates when removing a spouse or dependent.

When removing…	Because of…	Coverage will end…
Spouse	Divorce or death	On the date of the divorce or on the day following the date of death
Any dependent	Death or ineligibility	On the day following the date of death or ineligibility
Dependent	26th Birthday	On the last day of the year in which the dependent turns 26

Military Service Continuation Coverage

If called into military service for peace keeping services and placed on a military peacetime leave status, health coverage will continue. EH will continue to be **primary** for all members on the contract unless the Retiree, eligible spouse or dependents elect to use TRICARE for the provision of health care services.

Filing A Claim

When hospital and medical services are received, **always remember to show the BCBSM ID card.** In most cases, when Blues participating providers are used, the plan participant does not have to file a claim for payment of covered services. The hospital or physician will file a claim for the plan participant and will submit it to BCBSM. If the health care professional is unable to bill BCBSM directly, the member may file a claim for payment. **In either case, all claims are handled with the utmost confidentiality**.

When to File a Claim

A claim may need to be filed in the following situations:

1. If services are received from a nonparticipating provider who will not file a claim for the member.

2. If services are received outside of Michigan and the BlueCard Program is not used.

3. If services are received outside the United States and the BlueCard Worldwide Program is not used.

***NOTE:**. Do not file a claim if the provider accepts BCBSM ID cards and is billing BCBSM for the service.*

Claim Filing Procedure

Members have 12 months to file a medical claim for those not filed by their health care professional. Follow these steps to file a claim independently:

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

   a. Patient's name – NO NICKNAME
   b. Subscriber's name and contract number (as it appears on the BCBSM ID card)
   c. Provider's name, address, phone number and federal tax ID number
   d. Date and description of service or date of purchase
   e. Prescription number (if applicable)
   f. Individual cost for each procedure/prescription
   g. Diagnosis (nature of illness or injury) or metric quantity
   h. 11-digit national drug code (if applicable)
   i. Admission and discharge dates for hospitalization

   ***NOTE**: If medical services are received out of the county, try to get all receipts itemized in English. Cash register receipts, canceled checks, or money order stubs may accompany the itemized statement, but may not substitute for an itemized statement.*

2. Complete a claim form for medical services. This form is available online at www.bcbsm.com.

   a. Log in under "I am a Member"
   b. Click on "Claims Forms"
   c. Select the form based on your Plan (PPO)

3. Keep copies of all statements, receipts, and forms for future reference. Enclose the original billing statement with the claim forms.

4. Send all claims and receipts to the address on the claim form.

   ***NOTE:** Payment will be sent directly from BCBSM. The check will be in subscriber's 's name, not the name of the patient, if different.*

Coordination of Benefits (COB)

Coordination of Benefits is how plans coordinate benefits when covered by more than one group plan. When the Retiree or a family member has such duplicate coverage, benefits will be coordinated between the two plans.

How COB Works

When a member is covered by two plans, one of the plans is considered primary and the other plan is secondary. The primary plan pays its benefits without regard to the other plan(s). The secondary plan then may pay benefits according to its provisions. Those benefits may be reduced based on the benefits paid by the primary plan.

BCBSM determines who should pay first **before** a claim is processed. If BCBSM is primary, it will pay for full benefits under the Plan (less applicable co-pays and deductibles). If BCBSM is secondary, it will provide payment towards the balance of the cost of covered services – up to the **total** allowable amount determined by both plans.

BCBSM uses the NAIC guidelines (as adopted by BCBSM) to determine which carrier pays first.

The following guidelines are used to determine which plan pays first:

1. If a group health plan does not have a Coordination of Benefits provision, that plan is primary.

2. The plan covering the subscriber will be primary to any plan covering the same individual as a dependent.

3. If a child is covered under both parent's plans, the plan of the parent (or legal guardian) whose birthday (month and day only) is earlier in the year is primary. If the birthdays are identical, the plan that has covered the dependent longer is primary.

4. If a child's parents are divorced, separated, or never married, benefits will be paid according to any court decree. If no court decree exists or the court decrees does not specify health care, benefits are determined in the following order:

   a. Custodial parent (physical custody)

   b. Custodial stepparent (if custodial parent has remarried)

   c. Non-custodial parent

   d. Non-custodial stepparent (if non-custodial parent has remarried)

5. Group health plan coverage is primary to any coverage under CHIP.

6. If a person is covered as a Retiree under his or her former employer's employee health plan and is also covered as an active employee under another plan, the health plan that covers the person as an active employee pays first. If the same person has family health coverage for his or her dependent children, the active plan pays primary for children and the retiree plan is secondary.

COB and Workers' Compensation

Benefits under this Plan exclude services and treatment for any work-related injury to the extent that benefits are paid or payable under any Workers' Compensation program.

COB with Auto Insurance

The following guidelines apply when determining an auto insurance carrier's liability for health care claims when members are injured as a result of an auto accident:

1. **Coordinated No-Fault Auto Policy (Excess Medical Coverage)** — BCBSM coverage is primary and the auto policy will pay for the reasonable and necessary expense not covered by BCBSM.

2. **Non-Coordinated No-Fault Auto Policy (Full Medical Coverage)** — BCBSM will only pay what members are legally obligated to pay. The auto insurance carrier is solely responsible for the member's medical care rendered as a result of a motor vehicle accident.

Members who are being treated for an injury or illness from a motor vehicle accident may also be eligible for health care coverage through their auto insurance based upon the type of medical coverage they have with their auto insurance carrier.

Members must file within one year.

Filing COB Claims

In most instances the health care provider will bill the primary and secondary plans directly. However, if services are received from a nonparticipating provider the provider will not file the claim, the member will need to file. **Always submit claims to the primary plan first.**

When claims need to be submitted to the secondary plan, follow these steps:

1. Obtain an EOB from the primary plan. Make sure the EOB matches the receipts being submitted.

2. Ask the provider for an itemized receipt or a detailed description of the services, including charges for each service.

3. If payments were made for the service, provide a copy of the receipt received from the healthcare provider.

4. Make sure the provider's name and complete address are on **all** receipts.

5. Keep copies of **all** statements, receipts, and forms for future reference. Enclose the original billing statement with the claim form.

6. BCBSM PPO members must complete the Coordination of Benefits form online by logging into their account at www.bcbsm.com.

***NOTE**: If any required information is missing, claims processing may be delayed.*

File COB claims as soon as possible. Below are the filing limitations for submitting COB claims:

- Hospital and facility claims -- 12 months from the date of service
- Professional (physician) claims -- 18 months from the date of service

Processing COB Claims

When BCBSM receives COB claims, a determination is made as to which plan is primary and then claim is processed as follows:

1. If BCBSM is primary, it will pay for covered services up to the maximum amount allowed under the benefit plan, less applicable deductibles and copays.

2. If the other health plan is primary, BCBSM will return the claim to the healthcare provider, indicating that BCBSM is not primary. The healthcare provider can bill the other group health plan. BCBSM will also send the member an EOB stating it is not the primary carrier.

3. If BCBSM is secondary and the primary plan has already paid, either the member or healthcare provider can submit a claim to BCBSM for consideration of any balances. Be sure to include the EOB that was received from the primary plan.

4. If BCBSM is both primary and secondary, it will process the professional claim first under the primary plan, and then automatically process the same claim under the secondary plan.

Updating COB Information

BCBSM routinely checks its records to ensure it has up-to-date health coverage information for its members. If the information has not been updated for more than one year, BCBSM will hold payment on any pending claims over a certain dollar amount. BCBSM then sends a request for updated information. **The member has 45 days to respond**. If no response is received within 45 days, the claim(s) will be rejected, and the member will receive an EOB stating that payment has been denied due to lack of current COB information. Once BCBSM receives the COB information, the claim(s) will then be reprocessed for payment.

Contact the COB Department in the following situations:

1. To indicate additional health care coverage

2. To determine which health care coverage is primary or secondary

3. To determine the auto insurance carrier's liability for health care when the injury is a result of an auto accident

4. If no response is received within 45 days, the claim(s) will be rejected and the member will receive an EOB stating that payment has been denied due to lack of current COB information. Once BCBSM receives the COB information, the claim(s) will then be reprocessed for payment.

Subrogation

BCBSM contracts contain subrogation language that grant BCBSM the right to recover its payments from responsible third parties. A member may suffer an illness or injury caused by a third party or a third party may be responsible for payment of medical expenses. A third party is any person or organization, including an insurer, other than the member.

By accepting benefits from BCBSM for payment of services for an injury or illness caused by a third party, the member automatically assigns to BCBSM any right to recover payments from any third party (including any payments made to you). The member is required to do whatever is necessary to help BCBSM enforce its right of recovery.

BCBSM has a right of first reimbursement (first priority lien) on any amount the member recovers from any settlement proceeds and recoveries from litigation, arbitration, or any other legal proceeding, regardless of whether the payment is designated as a medical expense. BCBSM reserves the right to independently sue for recovery of any benefit payments. Additionally, BCBSM reserves the right to join any action filed by or on behalf of the member in order to recover its benefit payments.

If the member does not reimburse BCBSM from any settlement, judgment, or insurance proceeds, BCBSM may reduce any benefit for current or future covered services payable to or payable on the member's behalf until BCBSM has been fully reimbursed. If the member recovers amounts from the third party that exceed the benefit payments BCBSM already made, BCBSM may reduce its payment for future services relating to the applicable injury or illness by the excess.

BCBSM's subrogation and reimbursement rights apply to any benefits paid by BCBSM on the member's behalf as a result of an injury or illness that results from a third party.

Please remember that if an attorney is hired to represent the member in such a situation, or if the member recovers amounts from a third party, the member or his or her attorney should always call BCBSM at (517) 325-4658.

Termination of Coverage

Health care coverage for the Retiree, spouse, and dependents will end if the Retiree is no longer eligible under the Plan. Coverage will end whenever any of the following events occurs:

1. Death of Retiree, surviving spouse, or dependent.

> ***NOTE****: Health care coverage is provided for eligible surviving spouses and eligible dependents, if at the time of death the active employee was eligible for retirement or the Retiree was receiving retirement benefits. Health care benefits will continue as long as such persons continue to meet the eligibility requirements under a new contract number. New ID cards will also be issued. Health care coverage will not be provided to the new spouse of a surviving spouse if he or she re-marries.*

2. Termination of the Plan.

3. If the Retiree, eligible spouse, or eligible dependent children misuse the BCBSM ID card or commit a fraudulent act against the Plan.

4. If the Retiree, eligible spouse, or eligible dependents enrolls in Medicare health care benefits will be provided under a different coverage option. A description of the benefits is available in a separate SPD. Contact Employee Benefits to request a copy of the SPD.

5. If premium payment is more than 60 days delinquent, medical coverage and participation in the health care plan will be terminated. Coverage terminated for non-payment can only be reinstated during an open enrollment period.

In addition, health care coverage for an eligible spouse and any eligible dependents will end if any of the following events occur:

1. Death of an eligible spouse or eligible dependent

2. Divorce from an eligible spouse

3. An eligible dependent no longer meets eligibility requirements as defined under Section 2: Eligibility Guidelines

4. An eligible dependent child is no longer considered totally and permanently disabled

5. Eligible dependent ceases to be a dependent as defined in the Plan

Under the conditions described in items 1 through 5 above, an eligible spouse and eligible dependents are entitled to elect COBRA coverage.

Continuing Coverage

Health care coverage for the Retiree, eligible spouse, and eligible dependents will end when they are no longer eligible for health care benefits under the Plan. Coverage may be continued under one of these options:

1. Continue **temporary** coverage through federal legislative act known as **COBRA**, **or**
2. Convert to individual coverage, called **Group Conversion**.

An explanation of both options is provided below. The Retiree will need to contact Employee Benefits to clarify eligibility dates and to review coverage options. Employee Benefits will send the Retiree, eligible spouse, and eligible dependents this information when there is a status change.

COBRA Continuation Coverage

COBRA coverage applies to the Retiree, an eligible spouse, or any eligible dependents including children born or adopted after the Retiree becomes eligible for COBRA if they are enrolled timely and premiums are paid in accordance with COBRA. The individual who lost the group coverage is called a “qualified beneficiary”.

Employee Benefits will notify the Retiree, the eligible spouse, and eligible dependent children when COBRA benefits become available. To continue coverage, the Retiree must notify Employee Benefits within 60 days after termination of their coverage or receipt of notification, whichever is later. In cases of divorce the Retiree or their former spouse must notify BCBSM within 30 days in order to be eligible for COBRA.

The qualified beneficiary is responsible for paying the premium for the coverage elected *plus* a small administrative fee.

1. **Continuation coverage** — Continuation coverage is available for up to 29 months if:

    a. The Retiree, or any qualified beneficiary, have been determined to be disabled by the Social Security Administration at the time coverage is terminated **or**

    b. The Retiree, or any qualified beneficiary, are determined to be disabled by the Social Security Administration any time during the first 60 days of COBRA coverage.

2. **Other continuation coverage** — The Retiree's eligible spouse or eligible dependent children have the right to continue their coverage for up to 36 months when they are no longer eligible under the Plan because:

    a. The Retiree dies.

    b. The Retiree becomes entitled to Medicare, and the Retiree's eligible spouse or eligible dependent loses group coverage as a result.

    c. The Retiree divorces his or her eligible spouse causing the spouse to lose coverage.

    d. The Retiree's eligible dependent no longer meets dependent eligibility requirements under the Plan.

3. **Level of coverage** — If the Retiree, eligible spouse, or eligible dependent children elect COBRA continuation coverage through EH, they will be offered the same level of benefits that active non-bargaining unit employees have. COBRA coverage may be continued until the earliest of the following:

    a. The end of the 18 month, 29 month or 36 month continuation period

    b. The date EH no longer provides coverage to any of its employees and/or retirees.

    c. The date premiums for COBRA continuation coverage are not paid within the 30 or 45 day grace period

    d. The date the Retiree, eligible spouse, or eligible dependent children become covered under another group health care plan (unless that plan includes exclusions and/or limitations that cannot be satisfied by creditable coverage)

    e. The date the Retiree, eligible spouse, or eligible dependent children become entitled to Medicare. COBRA coverage will be the same benefits the Retiree, eligible spouse, or eligible dependents had on the day prior to the qualifying life event. Members are not permitted to change to another health care option until the next annual enrollment period.

At the enrollment period, the Retiree, eligible spouse, or eligible dependents may make a separate election and may elect coverage under any of the health coverage options available to non-bargaining unit retirees and surviving spouses.

4. **Premiums** — The first premium payment will cover the period from the date of the qualifying event until the date payment is made. This payment should be sent with the election form,

but must be made no later than 45 days after COBRA coverage is elected. Subsequent premium payments are due on the first day of each month. Premiums must be paid within 30 days after the due date. If premiums are not paid within the 30 day grace period, COBRA coverage will cease.

The cost for COBRA coverage is 102 percent of the EH premium. The cost for coverage from the 19th month through the 29th month for a disabled individual is 150 percent of the premium. The dollar amount of this premium varies and may change from year to year. The subscriber will be notified of any change in your premium rates.

Group Conversion Coverage

Individual coverage, called Group Conversion, is available to qualified beneficiaries as either:

1. An **alternative** to COBRA continuation coverage when one first becomes eligible for COBRA **or**

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

The benefits may change under Group Conversion Coverage, and the coverage will be limited to the Retiree's eligible immediate family, but there will be no interruption of coverage provided the Retiree pays the initial and subsequent bills in a timely manner. The Retiree must be a Michigan resident for at least six months out of each year to be eligible for this type of coverage.

To ensure continuous coverage, the Retiree must apply for Group Conversion within 60 days from the date the subscribers are no longer eligible for group coverage **or** within six months before the COBRA coverage ends. For additional information on how to apply for this coverage, contact Employee Benefits.

BlueCard PPO Program (Coverage Outside of Michigan)

When medical care is needed outside of Michigan, call 800-810-BLUE (800-810-2583) to be directed to the nearest Blue PPO Provider. The number is listed on the back of ID cards. By accessing the Blue Cares website at www.bcbsm.com to find BlueCard PPO providers anywhere in the United States.

If services are received from an out-of-state participating PPO provider, the host plan will pay the provider and not reduce its payment by the amount specified under the Plan for services provided by a non-network provider.

If the provider is not a participating PPO provider, BCBSM will notify the host plan to reduce its payment by the amount specified under the Plan for services provided by a non-network provider unless:

1. The Retiree was referred to that provider by the participating PPO provider (the referral must be obtained before receiving the referred service or the service will be subject to out-of-network deductible and copay requirements) or

2. Care is needed for an accidental injury or medical emergency

***NOTE**: In either case, the Retiree will not be responsible for required deductible and copays.*

The Host Plan can pay provider specialties recognized within the Host Plan's state (even if BCBSM does not contract with the particular provider specialty). If the Host Plan's contracts with a provider specialty and the services being performed by this provider are covered under the terms of the BCBSM policy, then this provider specialty can be paid.

BlueCard Worldwide Program (Coverage Outside of the United States)

The BlueCard Worldwide Program assists EH members traveling or living outside of the United States in obtaining medical care services; provides access to a worldwide network of health care providers; and includes claims support services.

***NOTE:** A PPO network is not available outside the United States.*

Medical Assistance Services
If members need medical services while traveling or living outside of the United States, they are responsible for contacting the BlueCard Worldwide Service Center at **800-810-BLUE** (or call collect at 804-673-1177 if they are calling from outside the United States) to assist them with information on participating hospitals and physicians and by providing medical assistance services. Failure to contact the BlueCard Worldwide Service Center could result in payment reductions or non-payment of services.

***NOTE:** Reference to participating or nonparticipating hospitals or physicians, means participating or nonparticipating in the BlueCard Worldwide Program.*

Section 4: Appeals Procedure

If there is a concern related to medical care the member should discuss it with their PCP first. Members may also contact BCBSM directly with any questions or concerns. If BCBSM is unable to immediately resolve the issue, they will research the issue and provide the member with a written response.

If the concern is not resolved to the members satisfaction, the member may request a formal grievance. The member may also appeal the decision not to reimburse a claim. Appeals must be started within two years from the date the problem was discovered.

Appeal Procedure for BCBSM Medical and Prescription Drug Coverage

The Right to Request Review of an Adverse Benefit Determination
Most questions or concerns about decisions BCBSM makes on claims or requests for benefits can be resolved by contacting Employee Inquiry Unit at **(888) 288-1718** or visiting www.bcbsm.com and logging in as a member.

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

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. This can include a denial based on the member's eligibility to participate in the employer's retiree medical health plan. An adverse benefit determination also includes a rescission of coverage. The member may request review of an adverse benefit determination for any rescission of coverage or on a pre-service claim, an urgent care claim, or a post-service claim.

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

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

A claim will be considered an urgent care claim if a physician with knowledge of the member's medical condition determines that the claim is one involving urgent care, absent a determination by the member's physician; we will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

"Post-service claim" is any claim other than "pre-service claims" or "urgent care claims."

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

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

Review Procedure

A. Review Procedure – Post-service claims

Under the review procedure for post-service claims, the member is entitled to a one-step internal appeal process. BCBSM must provide the member with a written determination within 60 calendar days of its receipt of the member's written request for review.

The review procedure for post-service claims provides one level of internal appeal as well as the right to file an independent external review if the member disagrees with the internal appeal decision.

Internal Review: To initiate an internal review, the member or the member's authorized representative must send BCBSM a written statement explaining why the member disagrees with the BCBSM determination. Please include in the request all documentation, records, or comments the member believe supports their position. The member can also include notarized statements, declarations, or testimony but these are not required. The member must request review no later than 180 calendar days after the member receives the BCBSM decision on their claim for benefits. Mail the written request for review to the appeals address on the member's Explanation of Benefit Payment, or to the address contained in the letter BCBSM sends the member to notify them that BCBSM has not approved a benefit or service they are requesting. BCBSM will respond to the member's request for review in writing within 60 days. If the member agrees with the BCBSM response, it becomes the BCBSM final determination and the review ends.

External Review: If the member disagrees with the internal review decision, or BCBSM fails to provide it within the 60-day timeframe or otherwise fails to comply with the review procedures, the member has the right to an external review from an Independent Review Organization (IRO). To obtain this external review, the member will need to complete the form mailed with the BCBSM determination on your internal appeal to the address noted on that form. The member's request for review will then be distributed at random for handling by one of the IROs under contract to review appeals. The member will receive notice by mail from the IRO directly regarding their final determination within 45 days of their receipt of the request.

If the member disagrees with the final determination by the IRO, they have the right to bring a civil action under ERISA section 502(a).

B. Review Procedure – Pre-service claims

Internal Review: The review procedure for pre-service claims is identical to the review procedure for post-service claims, except that BCBSM must provide the member with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a one-step process. BCBSM will issue its determination within 30 calendar days of receipt of the request for review.

External Review: If the member disagrees with the BCBSM final determination, or if BCBSM fails to issue the BCBSM determination within the 30-day time frame or otherwise fails to comply with the review procedures, the member has the right to an independent external review from an IRO. The same procedure noted above in the post-service claim section applies.

If the member disagrees with the final determination by the IRO, they have a right to bring a civil action under ERISA section 502(a).

C. Review Procedure – Urgent care claims

The review procedure for urgent care claims is as follows:

The member or the member's physician may submit a request for an internal review orally or in writing.

Internal Review: BCBSM will provide the member with its decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review. All necessary information, including the BCBSM decision on review, will be transmitted to the member or the member's authorized representative by telephone, facsimile, or other available similarly expeditious method. If the BCBSM decision is communicated orally, BCBSM must provide the member or the member's authorized representative with written confirmation of its decision within two business days.

External Review: If the member disagrees with the BCBSM final determination, or if BCBSM fails to issue its determination within 72 hours, or otherwise fails to comply with the review procedures, the member has the right to file for an external review by an IRO. The IRO will inform the member directly of the determination within 72 hours of receiving the member's request, and if the member disagrees with the determination, the member has the right to bring a civil action under section 502(a) of ERISA to obtain their benefits.

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

A. The member may authorize in writing another person, including, but not limited to, a physician, to act on their behalf at any stage in the standard internal review procedure.

B. BCBSM does not impose any fees or costs as a condition to requesting review.

C. Although BCBSM has set timeframes within which to give the member the BCBSM final determination on all three types of claims, the member has the right to allow BCBSM additional time if they wish.

D. BCBSM will provide the member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the member's claim for benefits.

E. BCBSM will provide the member at no charge with new or additional information or rationales on which BCBSM would make a final adverse benefit determination (i.e., the decision rendered upon internal appeal), sufficiently in advance of that decision to allow the member to respond if they wish.

F. The member may submit written comments, documents, records, testimony, and other information relating to the member's claim for benefits, and BCBSM will consider this information even if it was not submitted or considered in the initial benefit determination.

G. The member may submit notarized statements, declarations, and testimony, but these are not required.

H. The person who reviews the member's adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The initial determination BCBSM made on the member's claim will not be given deference.

I. If the member's request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, BCBSM will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

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

K. On review, BCBSM will advise the member of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.

L. If BCBSM relies on an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, BCBSM will so advise the member and provide the member a copy of the rule, guideline, protocol, or other similar criterion free of charge upon request.

M. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, BCBSM will so advise the member and provide the member an explanation of the scientific or clinical judgment free of charge upon request.

Section 5: Other Important Information

Notice of Privacy Practices for Medical Coverage
The Notice of Privacy Practices (NPP) details BCBSM's privacy practices and your rights with respect to the handling of your personal information in accordance with Health Insurance Portability and Accountability Act (HIPAA). Members can obtain a copy of the Notice of Privacy Practices online at www.bcbsm.com.

Affiliated Entities Covered by this Notice
This notice applies to BCBSM's privacy practices that may share your Protected Health Information as needed for treatment, payment, and health care operations.

Our Commitment Regarding Protected Health Information
We understand the importance of Protected Health Information (hereafter referred to as "PHI") and follow strict policies (in accordance with state and federal privacy laws) to keep your PHI private. PHI is information about you, including demographic data, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care.

In this notice, we explain how we protect the privacy of your PHI, and how we will allow it to be used and given out ("disclosed"). We must follow the privacy practices described in this notice while it is in effect. The most recent copy can be found at www.bcbsm.com.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. These revised practices will apply to your PHI regardless of when it was created or received. Before we make a material change to our privacy practices, we will mail a revised notice to our subscribers.

Where multiple state or federal laws protect the privacy of your PHI, we will follow the requirements that provide greatest privacy protection. For example, when you authorize disclosure to a third party, state law requires BCBSM to condition the disclosure on the recipient's promise to obtain your written permission to disclose to someone else.

Our Uses and Disclosures of Protected Health Information
We do not sell your PHI to anyone or disclose your PHI to other companies who may want to sell their products to you (e.g., catalog or telemarketing firms).

We must have your written authorization to use and disclose your PHI, except for the following uses and disclosures:

1. **To You and Your Personal Representative**: We may disclose your PHI to you or to your personal representative (someone who has the legal right to act for you).

2. **For Treatment**: We may use and disclose your PHI to health care providers (doctors, dentists, pharmacies, hospitals, and other caregivers) who request it in connection with your treatment.

3. **For Payment:** We may use and disclose your PHI for our payment-related activities and those of health care providers and other health plans, including for example:

    a. Obtaining premiums and determining eligibility for benefits

    b. Paying claims for health care services that are covered by your health plan

    c. Responding to inquiries, appeals and grievances

    d. Coordinating benefits with other insurance you may have

4. **For Health Care Operations:** We may use and disclose your PHI for our health care operations, including for example:

    a. Conducting quality assessment and improvement activities, including peer review, credentialing of providers and accreditation

    b. Performing outcome assessments and health claims analyses

    c. Preventing, detecting, and investigating fraud and abuse

    d. Underwriting, rating, and reinsurance activities

    e. Coordinating case and disease management activities

    f. Communicating with you about treatment alternatives or other health-related benefits and services

    g. Performing business management and other general administrative activities, including systems management and customer service

We may also disclose your PHI to other providers and health plans who have a relationship with you for certain of their health care operations. For example, we may disclose your PHI for their quality assessment and improvement activities or for health care fraud and abuse detection.

5. **To Others Involved in Your Care:** We may under certain circumstances disclose to a member of your family, a relative, a close friend or any other person you identify, the PHI directly relevant to that person's involvement in your health care or payment for health care. For example, we may discuss a claim determination with you in the presence of a friend or relative, unless you object.

6. **When Required by Law:** We will use and disclose your PHI if we are required to do so by law. For example, we will use and disclose your PHI in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We will disclose your PHI when required by the Secretary of Health and Human Services and state regulatory authorities.

7. **For Matters in the Public Interest:** We may use or disclose your PHI without your written permission for matters in the public interest, including for example:

   a. Public health and safety activities, including disease and vital statistic reporting, child abuse reporting, and Food and Drug Administration oversight

   b. Reporting adult abuse, neglect, or domestic violence

   c. Reporting to organ procurement and tissue donation organizations

   d. Averting a serious threat to the health or safety of others

8. **For Research:** We may use your PHI to perform select research activities, provided that certain established measures to protect your privacy are in place.

9. **To Our Business Associates:** From time to time, we engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

10. **To Group Health Plans and Plan Sponsors:** We participate in an Organized Health Care Arrangement with our underwritten group health plans. These plans, and the employers or other entities that sponsor them, receive PHI from us in the form of enrollment information. Certain plans and their sponsors may receive additional PHI from BCBSM. Whenever we disclose PHI to plans or their sponsors, they must follow applicable laws governing use and disclosure of your PHI.

Disclosures You May Request

You may instruct us, and give your written authorization, to disclose your PHI to another party for any purpose. We require your authorization to be on our standard form. To obtain the form, call the customer service number printed on the back of your membership ID card or **(313) 225-9000**.

Individual Rights

You have the following rights. To exercise these rights, you must make a written request on our standard form. To obtain the form, call the customer service number printed on the back of your membership ID card or **(313) 225-9000**. Forms are also available online at www.bcbsm.com.

1. **Access:** With certain exceptions, you have the right to look at or receive a copy of your PHI contained in the group of records that are used by or for us to make decisions about you, including our enrollment, payment, claims adjudication, and case or medical management notes. We reserve the right to charge a reasonable cost-based fee for copying and postage. If you request an alternative format, such as a summary, we may charge a cost-based fee for preparing the summary. If we deny your request for access, we will tell you the basis for our decision and whether you have a right to further review.

2. **Disclosure Accounting:** You have the right to an accounting of certain disclosures of your PHI, such as disclosures required by law. This accounting requirement applies to disclosures we make beginning on and after April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a fee covering the cost of responding to these additional requests.

3. **Restriction Requests:** You have the right to request that we place restrictions on the way we use or disclose your PHI for treatment, payment, or health care operations. We are not required to agree to these additional restrictions; but if we do, we will abide by them (except as needed for emergency treatment or as required by law) unless we notify you that we are terminating our agreement.

4. **Amendment:** You have the right to request that we amend your PHI in the set of records we described above under Access. If we deny your request, we will provide you a written explanation. If you disagree, you may have a statement of your disagreement placed in our records. If we accept your request to amend the information, we will make reasonable efforts to inform others, including individuals you name, of the amendment.

5. **Confidential Communication:** We communicate decisions related to payment and benefits, which may contain PHI, to the subscriber. Individual members who believe that this practice may endanger them may request that we communicate with them using a reasonable alternative means or location. For example, an individual member may request that we send an Explanation of Benefits to a post office box instead of to the subscriber's address. To request confidential communications, call the customer service number printed on the back of your membership ID card or **(313) 225-9000**.

Questions and Complaints
If you want more information about our privacy practices, or a written copy of this notice, please contact us at:

Blue Cross Blue Shield of Michigan
600 East Lafayette, Mail Code **1924**
Detroit, MI 48226-2998
Attn: HIPAA Privacy Office
Telephone: **(313) 225-9000**

For your convenience, you may also obtain an electronic (downloadable) copy of this notice online at www.bcbsm.com.

If you are concerned that we may have violated your privacy rights, or you believe that we have inappropriately used or disclosed your PHI, call us at **(800) 552-8278**. You also may complete our form online at www.bcbsm.com.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address to file your complaint upon request. We support your right to protect the privacy of your PHI. We will not take action against you if you file a complaint with us or with the U.S. Department of Health and Human Services.

Section 6: ERISA Information

This Plan is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA), and as such, the following information is required to be provided to you as a Plan participant. This information is furnished by the Plan Administrator and is not a part of any Group Policy or Certificate or any Administrative Services Contract with BCBSM.

Plan Information: Plan Name, Type of Plan, Plan Number, and Plan Year Ends
Please use the following names and numbers if you need to contact a governmental agency about your benefits:

Plan Name	Type of Plan	Plan Number	Plan Year Ends
BCBSM Retiree Medical Benefit Plan	Welfare Plan	504	December 31

Employer Identification Number

BCBSM's identification number is:
38-2069753

Plan Administrator
The Plan Administrator for the Plan is responsible for answering questions, interpreting the Plan, and determining the application of Plan provisions. All requests, appeals, elections, and other communications should be in writing and should be hand delivered or sent by certified mail to the Plan Administrator at:

Emergent Holdings Inc. 200 N Grand
Avenue, Mail Code **0128**
Lansing, MI 48933
1-517-708-5400

Plan Sponsor and Agent for Service of Legal Process
The Plan Sponsor and Agent for Service of Legal Process for the Plan is BCBSM. However, service of legal process may also be made on the Plan Administrator at:

Blue Cross Blue Shield of Michigan
Office of the General Counsel
600 East Lafayette, Mail Code **1925**
Detroit, MI 48226-2998

Type of Administration
BCBSM administers the Plan under a self-funded arrangement, except for the Blue Care Network Option, which is administered under an insured arrangement.

Type of Funding
Payment of administrative costs and claims for the Plans is funded through contributions by EH except to the extent of member copayments, deductibles, and applicable employee cost sharing.

Amendments
EH reserves the right to amend the Plan at any time or from time to time. If the Plan is amended, notice will be sent to all participants in the Plan within the time period required by ERISA.

Statement of ERISA Rights
As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants in the Plan shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and other specified locations, all documents of the Plan, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and descriptions of the Plan.

2. Obtain copies of all documents and other information of the Plan upon written request to the Plan Administrator.

3. Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of a Summary Annual Report.

Group health plans and health insurance carriers offering group health coverage may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require a provider to obtain authorization from the plan or insurance carrier for prescribing a length of stay not in excess of the above period. However, the doctor may, after consulting with the mother, discharge the mother or the newborn sooner than the 48/96-hour minimum.

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 the 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 benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to a review and reconsideration of any denied claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file a suit in a federal court. In such 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 Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court. However, if applicable, you must first exhaust any other remedies provided by the Plan before filing suit.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may file a suit in a federal court. The court will decide who should pay the 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, for example, it finds your claim to be frivolous.

If you have questions about this statement or about your rights under ERISA, you should contact:

1. The nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or

2. The Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Section 7: Glossary of Terms

Accident

A condition that occurs from an external source and requires prompt medical attention.

Accidental Injury

Any physical damage caused by an action, object, or substance outside the body. This includes strains, sprains, cuts, and bruises; allergic reactions caused by an outside force such as bee stings or another insect bite; extreme frostbite, sunburn, and sunstroke; poisoning; drug overdosing; inhaling smoke, carbon monoxide or fumes; and attempted suicide.

Acute Care Facility

A facility that provides acute care. This facility primarily treats patients with conditions that require a hospital stay of less than 30 days. The facility is not used primarily for:

1. Custodial, convalescent, tuberculosis, or rest care
2. Care of the aged or substance abusers
3. Skilled nursing or other nursing homes

Allogeneic (Allogenic) Bone Marrow Transplant

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

Ambulatory Surgery Facility (ASF)

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

Approved Amount

The BCBSM maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

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

Approved Facility

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

Approved Hospice

A participating hospice provider that meets all state licensing and BCBSM approval requirements and has made an agreement with BCBSM to provide services to BCBSM members.

Approved Hospital

A hospital that meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations and has been approved as a provider by BCBSM.

Autologous Transplant

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

Benefit

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

Blue Cross and Blue Shield Association (BCBSA)

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

Blue Cross Blue Shield of Michigan (BCBSM)

A non-profit, independent licensee of the Blue Cross Blue Shield Association that provides and administers health benefits. It is managed and controlled by a board of directors comprised of a majority of community-based public and subscriber members.

Blue HealthLine (formerly HealthCall)

A BCBSM free, 24-hour telephone health information resource hotline that members can use to their discretion. Members can speak with a registered nurse or listen to taped information about health topics. All calls are strictly confidential.

Care Management

A department that manages health care services such as preauthorizing and evaluating services for members.

Case Management

A voluntary program that provides personalized support to members living with chronic conditions or recovering from an acute illness in collaboration with the member's physician to ensure all appropriate care.

Certificate

The legal plan document that lists the terms, benefits, and limitations of the subscriber's BCBSM contract.

Certified Nurse Midwife

A graduate of an approved, accredited school of nursing who is licensed to practice in the state of Michigan and has satisfactorily completed an approved nurse midwifery course by the American College of Nurse Midwives. The person must be certified by the American College of Nurse Midwives and document continuing education to maintain certification required by the respective association or state.

Claim Form

A statement listing services rendered the date of service and an itemization of charges. The completed form serves the insurer as a basis of payment of benefits.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

COBRA is a federal law that affects all employers with 20 or more employees. It extends the opportunity for continued group coverage to all qualified beneficiaries when such coverage is lost due to a qualifying event.

Contraceptive Device

A device such as, but not limited to, a diaphragm, intrauterine device or contraceptive implant, such as Norplant designed to prevent pregnancy.

Contract Provider

A provider under contract and paid by BCBSM to provide a service for BCBSM members.

Coordination of Benefits (COB)

A program that coordinates your health benefits when you have coverage under more than one group health plan.

Copay or Copayment

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

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

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

Covered Drug

Injectable insulin, a state-controlled drug or any federal legend drug, if the following conditions are met:

1. A prescription must be issued by a prescriber who is legally authorized to prescribe drugs for human use.
2. The cost of the drug must not be included in the charge for other services or supplies provided to you.
3. The drug is not entirely consumed at the time and place where the prescription is written.
4. The drug is not listed as non-preferred on the co-branded formulary.

***Note**: Any compound medications that have at least one federal legend drug ingredient are covered if they meet all the above requirements.*

Covered Services

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

Custodial Care

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

1. Routine nursing care
2. Training in personal hygiene and other forms of self-care
3. Care supervised by a physician

Custodial Parent

The parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to temporary visitation.

Deductible

The amount you are required to pay for covered services under any certificate before benefits are payable.

Dental Care

Care given to diagnose, treat, restore, fill, remove or replace teeth or the structures supporting the teeth, including changing the bite or position of the teeth.

Dentist

A provider licensed to detect and treat diseases and conditions of the mouth, teeth, and jaw, and practicing within the scope of his or her license to perform other related dental services.

Dependent

An eligible family member who is enrolled for health care Coverage. A family Dependent includes Dependent Children and a Dependent under a Qualified Medical Child Support Order but does not include a Principally Supported Child.

Dependent Child

An eligible individual less than the age of 26 who is the son or daughter in relation to the Subscriber or spouse by birth, legal adoption, or for whom the Subscriber or spouse has legal guardianship. ***Note****: A Principally Supported Child is not a Dependent Child for purposes of this SPD. See definition of Principally Supported Child below.*

Designated Transplant Facility

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

Diagnostic Agents

Substances used to diagnose rather than treat a condition or disease.

Durable Medical Equipment (DME)

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

Eligible Retiree

An individual who has met the eligibility criteria defined by EH in Section 2: Eligibility Guidelines in this Retiree Medical SPD.

Eligibility

The requirements that must be fulfilled in order to be enrolled through a BCBSM health care program.

Emergency

A condition that occurs suddenly and unexpectedly, such as a heart attack or stroke. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury.

Emergency First Aid

The initial examination and treatment of conditions resulting from accidental injury.

Employee

A regular employee of the Employer.

Employer

EH or any subsidiary organization that has adopted this Plan.

End Stage Renal Disease (ESRD)

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

ERISA

Employee Retirement Income Security Act of 1974.

Experimental or Investigational

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

1. Opinions of local and national medical societies, organizations, committees, or governmental bodies
2. Accepted national standards of practice in the medical profession
3. Scientific data such as controlled studies in peer review journals or literature
4. Opinions of the BCBSA or other local or national bodies

Federal Legend Drug

Any medicinal substance which bears the legend: “Rx Only.”

Freestanding Facility

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

Freestanding Outpatient Physical Therapy Facility (OPT)

An independently owned and operated facility, separate from a hospital that provides outpatient physical therapy services and occupational or functional occupational therapy or speech and language pathology.

Global Referral

With one referral, the PCP authorizes most visits and services required by a specialist to diagnose and treat a patient condition. Guidelines apply.

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Gynecological Examination

A history and physical examination of the female genital tract.

High Dose Chemotherapy (HDC)

A procedure that involves giving a patient cell destroying drugs in doses higher than approved by the FDA for therapy.

Home Health Care Agency

An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient’s home.

Hospice

An agency or facility that is primarily involved in providing care to terminally ill individuals.

Hospital

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

Hygienist

A person licensed to perform specific dental procedures under the supervision of a licensed dentist including, but not limited to, scaling and root planning, teeth cleaning and fluoride.

Impotence Drugs

Drugs that improve sexual potency.

Independent Physical Therapist (IPT)

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

Intern

An employee who attends a college, university of post-graduate institution and works part-time or full- time for Blue Cross Blue Shield of Michigan during an identified work period and is on the company payroll

Mammogram

A low dose X-ray of the breast, two views per breast. The radiation machine must be state authorized and specifically designed and used to perform mammography.

Mail Service Prescription Drug Program

Allows members to purchase up to a 90-day supply of medication for treatment of chronic diseases for a single copay.

Medical Management

Health care professionals that promote high-quality, cost-effective health care through such activities as utilization management, quality management and risk management.

1. **Medical necessity for payment of services of other providers:**

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

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

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

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

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

   5. The BCBSM determination of medical necessity for **payment** purposes is based on standards of practice established by physicians.

Member

Any person eligible for health care benefits under the Plan. This includes you as the subscriber and any of your eligible dependents listed in BCBSM membership records.

Network Pharmacies

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

Nonformulary

A prescription drug not included in the BCBSM Custom Formulary.

Non-Network Pharmacies

Pharmacies that are **not** a member of the Preferred Rx network or Traditional Rx Network (in Michigan) or the Medco Pharmacy Network (outside Michigan). Non-network pharmacies have **not** agreed to accept the BCBSM approved amount as payment in full for covered drugs or services provided to covered members. Members must file a claim for reimbursement for payment.

Non-Occupational

With respect to any injury, an injury that does not arise out of, and in the course of, any employment for wage or profit. With respect to disease, “non-occupational” means a disease for which a person is not entitled to benefits under any Workers’ Compensation or similar law.

Nonparticipating Providers

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

Occupational Therapy

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

1. Develop, improve or restore the performance of necessary neuro-musculoskeletal functions affected by an illness or injury, or following surgery.
2. Help the patient apply the newly restored or improved function to meet the demands of daily living or
3. Design and use splints, orthoses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raise toilet seats).

Outpatient

A patient who receives treatment at a hospital or clinic without becoming an inpatient.

Partial Hospitalization Program

A day or night care facility, such as a Mental Health or Substance Abuse treatment center.

Participating Providers

Providers that have signed participation agreements with BCBSM to accept the BCBSM approved amount for covered services as payment in full.

Patient

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

Per Claim Participation

A non-network or nonparticipating provider's acceptance of the BCBSM approved amount as payment in full for a specific claim or procedure.

Peripheral Blood Stem Cell Transplant

A procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.

Physical Therapy

Treatment that is intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination, and general mobility.

***Note**: Physical therapy is **not** covered when services are principally for the general good and welfare of the patient (e.g., developmental therapy or activities to provide general motivation).*

Physician

A medical doctor (MD), doctor of osteopathy (DO), or doctor of podiatric medicine (DPM).

Plan

The BCBSM Retiree Medical Benefit Plan.

Preauthorization

A process that allows physicians and other professional providers to determine, before treating a patient, if BCBSM will cover the cost of a proposed service.

Preauthorization is needed for services that may be experimental, or not always medically necessary, or over utilized.

Primary Care Physician (PCP)

The physician chosen by a member to coordinate all of his or her health care.

Principally Supported Child

An individual less than 27 years of age for whom principal financial support is provided by the Subscriber in accordance with Internal Revenue Service standards, and who has met the eligibility standards for at least six full months prior to applying for Coverage. A Principally Supported Child must meet the following requirements:

1. Must be under the age of 27
2. Must be unmarried
3. Must live full-time in your home
4. Must not be eligible for Medicare or other group coverage and
5. Must be claimed as an exemption on your most recent federal income tax return

   Note: *If the child began living with you after the last tax return was filed, the child must qualify in the current tax year as an exemption on your current federal tax return.*

6. Must be principally supported by you for a minimum of nine consecutive months. An application for coverage should be submitted to EH after six months of support is established.

   Note: *A Principally Supported Child is not the same as a Dependent* Child.

Professional Provider

A medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), or a fully licensed psychologist.

Provider

A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

Qualifying Life Event

As determined by the IRS, a life change that would support an adjust to an existing plan consistent with the event.

Retiree

For purposes of this Plan, an individual who has commenced benefits under the Blue Cross Blue Shield of Michigan Employees' Retirement Account Plan and who has satisfied the eligibility requirements under Section 2: Eligibility Guidelines of this Retiree Medical SPD.

Rider

A legal document that amends a certificate by adding, limiting, or clarifying benefits.

Routine Service

Procedures or tests that are ordered for a patient without direct relationship to the diagnosis or treatment of a specific disease or injury.

Skilled Nursing Facility

A facility that provides convalescent and short- or long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. It must meet all applicable local and state licensing and certification requirements.

Specialty Hospital

A hospital, such as a children's hospital, a chronic disease hospital, or a psychiatric hospital, that provides care for a specific disease or population group.

Speech Therapy

Active treatment of speech, language, or voice impairment due to illness, injury, or as a result of surgery.

Sponsored Dependent

A person, age 19 or older related to the employee by blood or marriage **and** lives with the employee as a member of the household. To qualify, the person must be a dependent as defined in the IRC **and** be claimed as an exemption on the employee's most recent federal income tax return or qualify in the current tax year as an exemption.

Spouse

A person to whom you are lawfully married

State-Controlled Drugs

Drugs that are not federal legend drugs and are normally sold over-the-counter, but require a prescription under state law when large quantities are dispensed

Subrogation

The act of transferring responsibility for the payment of health care service from one party to another. Especially relevant in situations where one party (e.g. BCBSM) pays a claim and learns another carrier (generally Workers' Compensation or an Automobile insurance company) has primary responsibility. Subrogation attempts to collect back the monies paid to the carrier.

Subscriber

The person who signed and submitted the application for coverage.

Substance Abuse

Taking alcohol or other drugs in amounts that can:

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

Substance Abuse Treatment Program

A residential or outpatient program that provides medical and other services for substance abusers, meets all state license and approval requirements and has entered into an agreement with BCBSM to provide those services.

Temporary Employee

An employee on company payroll who is scheduled to work part-time or full-time for a limited period of time

You and Your

Used when referring to any person covered under the Employee's contract.

Section 8: Important Contacts

Contacting Blue Cross Blue Shield of Michigan

Please visit the BCBSM website at www.bcbsm.com and log in as a Member if you would like to view eligibility, request an additional ID card, view claim status, or view EOBs.

Please contact the **BCBSM Employee Inquiry Unit** if you have additional questions concerning your **BCBSM PPO health care benefit** or **claims issues.** Please call the Employee Inquiry Unit at (888) 288-1718. You may also send a written inquiry to:

Employee Inquiry Unit
(888) 288-1718
Blue Cross Blue Shield of Michigan
232 S. Capitol Ave., Mail Code L03B
Lansing, MI 48933-1504

If you have questions concerning **membership changes (such as adding or deleting a dependent) or COBRA,** you should contact **Employee Benefits**. You can also send an electronic inquiry at HRRequest@emergentholdingsinc.com

Employee Benefits
(517) 708-5400
Emergent Holdings Inc.
200 N Grand Avenue
Lansing, MI 48933

If you have questions concerning **this Summary Plan Description (SPD)** you should contact **Employee Benefits**. You can also send an electronic inquiry at HRRequest@emergentholdingsinc.com

Employee Benefits
(517) 708-5400
Emergent Holdings Inc.
200 N Grand Avenue
Lansing, MI 48933

If you have any questions regarding coordination of benefits, you should contact Coordination of Benefits (COB) Membership.

Coordination of Benefits (COB) Membership
600 East Lafayette, Mail Code 610J
Detroit, MI 48226-9942

If you have any questions regarding retirement eligibility, pension or 401(k) contact the **Retirement Administration**. You can also send an electronic inquiry at RetirementAdministration@bcbsm.com

Retirement Administration
(800) 922-0699
Blue Cross Blue Shield of Michigan
600 East Lafayette, Mail Code **0126**
Detroit, MI 48226-2998

Special Servicing Numbers

Blue Cross Blue Shield of Michigan have the following dedicated telephone numbers for your convenience:

BCBSM Anti-Fraud Hotline **800-482-3787**

BCBSM Privacy Compliance Hotline **800-552-8278**
Blue Cross Health& Wellness **800-637-2972**

Optum Rx **855-430-5548**

Health Education **800-637-2972**

WebMD tobacco cessation **855-326-5102**

BCBSM Hearing-impaired members with TTY equipment **800-240-3050**
Human Organ Transplant Program **800-242-3504**

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