BAC of MICHIGAN
Health and Welfare Fund

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To: Active Participants, Early Retirees and Surviving Spouses of the BAC of Michigan Health and Welfare Fund (the Plan)

Re: 2025 Summary of Benefits and Coverage & Annual Notices

Date: December 2024

This notice ("Notice") clarifies certain rights and provides reminders about important features of your Plan. Please read this Notice and any associated documents carefully and keep them with your personal records and your copy of the Summary Plan Description ("SPD").

- **Summary of Benefits and Coverage (SBC)**

  Included with this Notice is the Summary of Benefits and Coverage ("SBC") for **2025**. The SBC outlines several of the benefits available to you under the Plan. Please share the SBC with your family members who are eligible for coverage under the Plan. The Patient Protection and Affordable Care Act ("PPACA") requires that all group health plans provide participants and beneficiaries with the SBC on an annual basis. The SBC is designed to provide a general description of some of the Plan's benefits and associated costs. The PPACA requires use of a strict form template with detailed rules on the format and content of the SBC. For this reason, the SBC does not cover all the benefits provided by the Plan. We recommend you refer to the SPD for a more complete description of the benefits provided by the Plan, as well as the eligibility rules.

- **Auto & Motorcycle Exclusion**

  Michigan changed its no-fault auto insurance laws on July 1, 2020, to allow you to opt-out or buy reduced medical coverage on your auto policy. To opt-out or buy reduced medical coverage on your auto policy, the new law requires you to have medical coverage elsewhere for injuries related to auto accidents. **THIS PLAN DOES NOT COVER INJURIES RELATED TO AUTO ACCIDENTS; THEREFORE, YOU ARE NOT ELIGIBLE TO OPT-OUT OR BUY REDUCED MEDICAL COVERAGE ON YOUR AUTO INSURANCE POLICY. INJURIES RELATED TO MOTORCYCLE ACCIDENTS ARE ALSO EXCLUDED FROM COVERAGE UNDER THE PLAN.**

  Injuries related to recreational vehicle accidents (such as quad sports and snowmobiles that are **NOT** licensed for road use) **ARE** covered by the Plan. Again, if you incur medical claims because of an accident involving any type of vehicle that can be licensed for road use in Michigan (has a license plate or equivalent road use permit), this Plan will **NOT** cover those medical claims.

  Be sure that you inform your insurance agent about these coverage exclusions and limitations in your Plan! When you are purchasing no-fault automobile or motorcycle insurance**, BE SURE TO INCLUDE MEDICAL COVERAGE IN YOUR AUTOMOBILE AND MOTORCYCLE POLICIES, SO THAT YOU DO NOT RUN THE RISK OF HAVING NO COVERAGE FOR MEDICAL CLAIMS RESULTING FROM AN AUTOMOBILE OR MOTORCYCLE ACCIDENT**. You may want to take this notice to your insurance agent, when purchasing that coverage, to better explain your current medical coverage to your insurance agent.

- **Women's Health and Cancer Rights Act Annual Notice:** As required by the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), the Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information call the Plan Office at (248) 828-6000.

- **Newborns' and Mothers' Health Protection Act:** The Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act") is a Federal Law that contains important protections for mothers and their newborn children concerning the length of the hospital stay following childbirth. The Plan may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours

following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours after delivery (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

- **New Protections against Surprise Billing:** As a result of a new federal law, the No Surprises Act (the NSA), you now have protections against "surprise billing" from out-of-network providers in certain circumstances. The intent of the NSA is to provide greater transparency for health plan participants to better understand billing practices and prevent surprise billing (or balance billing) in certain situations. Specifically, the NSA provides that: 1) your cost sharing for out-of-network emergency facilities is to be the same cost-sharing as in-network emergency facilities; 2) if you go to an in-network facility (for either emergency or non-emergency service), your cost-sharing for out-of-network providers within that facility will be no more than your in-network cost sharing amount; and 3) cost-sharing for out-of-network air ambulance services will also be limited to cost-sharing for in-network air ambulance services. The Plan has been updated to reflect these changes. Hospitals and doctors are also required to provide you with notice of your rights and protections under the NSA. If you receive a balance bill after receiving these services covered by the NSA (for example, you are charged the out-of-network cost-sharing for an emergency air ambulance), you may be able to appeal this charge under the Plan's claims and appeals procedures, which are outlined in the Summary Plan Description.

- **Dental Coverage**

  Effective January 1, 2026, the Plan will no longer offer the DenCap Managed Care plan as an option for dental coverage, and all participants will automatically be moved to the Delta Dental plan. Only those participants currently enrolled in the DenCap Managed Care plan have the option to remain under this plan for the 2025 calendar year. If you are currently enrolled in the DenCap Managed Care plan and wish to be moved to the Delta Dental plan, please contact the Plan Office at (248) 828-6000. If you do not wish to change your dental coverage, you do not need to take any action.

  Receipt of these documents does not constitute a determination of your eligibility, nor is it a contract. Additional limitations and exclusions may apply. If you have any additional questions about your benefits, please call the Plan Office at (248) 828-6000.

Sincerely Yours,

Board of Trustees
BAC of Michigan Health and Welfare Fund

BAC of Michigan Health and Welfare Fund: BCBSM

Coverage for: Eligible Participants & Dependents | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.BACLocal2Benefits.org or by phone at 248-828-6000. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-Of-Network	
What is the overall deductible?	$250/ Individual or $750/ family	$250/ Individual or $750/ family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes.	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No. There are no other specific deductibles.	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Coinsurance maximum for medical benefits: $1,000 individual / $2,000 family; "True" OOP max: $7,900 Individual / $15,800 Family	Coinsurance maximum for medical benefits: $3,000 individual / $6,000 family; "True" OOP max: $15,800 Individual/ $31,600 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met
What is not included in the out-of-pocket limit?	"True" OOP max: premiums, balance-billing, and health care this plan doesn't cover. Coinsurance max for medical benefits: fixed dollar and private duty nursing Copayments, deductibles, premiums, balance-billing charges, and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit

Will you pay less if you use a network provider?	**Yes.** See bcbsm.com/find-a-doctor website for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/office visit	Not Covered	Deductible does not apply.
	Specialist visit	$25 copay/office visit	Not Covered	
	Preventive care/screening/ immunization	No charge	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription-drug-coverage **prescription drug coverage** is available at www.bcbsm.com/druglists (800) 437-3803	Generic drugs	$5 copay/retail No charge/mail order	25% of the approved amount, after the $5 copayment	Prescription Drug Benefits are available only for Active Participants, COBRA Participants, and non-bargaining unit Participants. **Non-Medicare Eligible Retirees and their Dependents are not eligible for Prescription Drug Benefits.** Prior authorization is required for specialty drugs; dispensing of specialty drugs must be through a retail pharmacy that participates in the BCBS Preferred Rx Pharmacy program. Mail orders must use the designated Specialty Drug Vendor. Initial fill of Select Controlled Substance drugs are limited to a 5-day supply. (Additional refills for these medications will be limited to no more than a 30-day supply) A 90-day supply of Maintenance medications is covered using mail order or at a Smart90 retail pharmacy ONLY. To locate one, log in at www.express-scripts.com and click Find a Pharmacy in the menu under Prescriptions. Smart90 network pharmacies will be noted in your search results. Or call Express Scripts at (800) 918-8011. If you obtain your 90-day supply of maintenance medications from any other provider, you may be responsible for the total cost.
	Preferred brand drugs	30% coinsurance for retail or mail order	25% of the approved amount, after the 30% copayment	
	Non-preferred brand drugs	30% coinsurance- for retail or mail order	25% of the approved amount, after the 30% copayment	
	Specialty drugs	Generics: $5 copay/retail No charge/mail order Brands: 30% coinsurance for retail or mail order	25% of the approved amount, after the 30% copayment	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$250 copay/visit; then 20% coinsurance after deductible	$250 copay/visit; then 40% coinsurance after deductible	Co-pay waived if from a covered accident, patient admission or undergoes surgery in the course of the Emergency room visit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Ground transportation only.
	Urgent care	$50 copay/visit, then 20% coinsurance after deductible	$50 copay/visit, then 40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If emergent admission, please contact BCBSM at (800) 572-3413.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Service must be performed by a licensed Psychiatrist (M.D. or D.O.) or certified licensed psychologist (Ph.D., Ed.D or M.A.) or social worker or other professional counselor licensed as a Licensed Professional counselor in the State of Michigan.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If emergent admission. Please contact BCBSM (800) 762-2382
If you are pregnant	Office visits	No charge	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). For participants' dependent daughters, only one pregnancy per daughter is covered. Charges on behalf of the child of a dependent daughter are not covered.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Physical therapy limited to 25 visits per calendar year, per occurrence. Occupational Therapy and/or Speech Therapy benefits are payable only if the treatment follows Hospital confinement for an accident (except for accidents that are work or auto/vehicular related), or stroke, cancer or heart-related problem, or is the result of diagnoses of Childhood Apraxia of Speech (CAS) or Autism Spectrum Disorder (ASD). *See SMM for additional information. Occupational Therapy and/or Speech Therapy to treat ASD is subject to the Adaptive Behavior Treatment hour limitation. The Fund does not cover Occupational or Speech Therapies under any other circumstances.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	None
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	None
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	The Fund covers rental or purchase (whichever is most economical and the Fund's option) with prescription and physician's statement of medical necessity.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Covered only if prognosis of six months or less of life; and the concurrent opinion of the attending physician and hospice that the care and treatment to be provided will not exceed the cost of any other alternative treatment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need hearing care	Audiometric exam	No charge after deductible and coinsurance	Not Covered	Coverage for Active members only. Coverage only provided once every 12 months. Member may be responsible for the difference in cost between the approved amount of a hearing aid and the charge of the hearing aid.
	Hearing aid evaluation	No charge after deductible and coinsurance	Not Covered	
	Hearing aid conformity test	No charge after deductible and coinsurance	Not Covered	
	Hearing aid	$500	Not Covered	
If you need dental or eye care	Eye exam	Covered under a separate plan.		Dental and vision coverage is provided under a separate plan. Please call the Fund Office at (248-828-6000) or visit www.BACLocal2Benefits.org for terms and conditions applicable to this benefit.
	Glasses			
	Dental checkup			

For more information about limitations and exceptions, see the SMM or SPD document at www.BACLocal2Benefits.org.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture (if prescribed for rehabilitation purposes) • Cosmetic Surgery • Automobile or motor vehicle accident • Infertility Treatment	• Long Term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing	• Treatment for TMJ (covered under Dental Only) • Weight Loss Programs • Work related injury
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Organ transplants	• Chiropractic Care • Autism Spectrum Disorders (Minor)	• Routine eye care (Adult) • Routine Foot Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Fund Office at 248-828-6000or www.BACLocal2Benefits.org. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

For more information about limitations and exceptions, see the SMM or SPD document at www.BACLocal2Benefits.org.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$250
■ Specialist copayment	$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$20
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,330**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
■ Specialist copayment	$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$1,379
Coinsurance	$199
What isn't covered	
Limits or exclusions	$255
The total Joe would pay is	**$2,083**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
■ Specialist copayment	$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$50
Coinsurance	$291
What isn't covered	
Limits or exclusions	$37
The total Mia would pay is	**$628**

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Important Fund Information