BAC of MICHIGAN
Health and Welfare Fund

P.O. Box 99490 • Troy, MI 48099-9490 • Phone (248) 828-6000 • Fax (248) 828-6001

To: All Participants in the BAC of Michigan Health and Welfare Fund (the Plan)

Re: 2024 Open Enrollment, Annual Notices & Summary of Material Modifications

Date: November 2023

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)**

  Also included with this Notice is the Summary of Benefits and Coverage ("SBC") for 2024. 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 Newborn's and Mothers' Health Protection Act of 1996 ("Newborn's 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 (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).

- **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.

- **Benefit Improvement - Change in Eligibility Requirements for Weekly Disability Benefits:** Participants are not eligible for Weekly Disability Benefits after 4 consecutive months of self-payments. Previously, months in which you had some work hours and made a partial self-payment toward continuing coverage ("short-hours" payment) were considered self-payments for this purpose. As a result of this benefit improvement, now only full self-payments (months in which you have no work hours and made a self-payment to continue coverage) will be counted against the limit of 4 consecutive self-payments. For more information on Weekly Disability Benefits, please refer to your copy of the Summary Plan Description.

- **Dental Enrollment for 2024**

  2024 Open Enrollment has begun for dental coverage. The Plan will coverage under the following two (1) Delta Dental or (2) Dencap Dental (formerly Golden Dental). Please see the enclosed brochures for further details.

  1. **What do I Need to do?**

     If you are currently enrolled under the dental plan of your choice and you **DO NOT** wish to change your coverage, you **DO NOT** need to take any further action.

     If you wish to **CHANGE** your dental coverage or **DECLINE** dental, please complete the enclosed Dental Enrollment Form with your selected coverage choice and return it to the Benefits Office at the following address:

     BAC of Michigan
     Health and Welfare Fund
     PO Box 99490, Troy, MI 48099-9490

     The Benefits Office must receive the dental and vision election form no later than **12/20/2023**

  2. **What if I want to decline coverage?**

     If you decline dental and vision benefits: (1) you will **NOT** have dental or vision coverage through the Plan; (2) you cannot enroll in dental and vision coverage until the next open enrollment period; (3) you will **NOT** receive any funds back on your check; (4) your initial and continuing eligibility requirements will remain the same; and (5) your employer's contribution to the Plan will remain the same.

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

IMPORTANT NOTICE
SUMMARY OF MATERIAL MODIFICATIONS
BAC OF MICHIGAN HEALTH AND WELFARE PLAN
NOVEMBER 2023

To: All Plan Participants

Re: Clarification on Experimental or Investigational treatments, Medically Necessary, and Gene therapy

---

Why am I Receiving this Notice?

This Summary of Material Modifications ("SMM") clarifies the Plan's provisions related to what is considered an experimental or investigational treatment, when a treatment is medically necessary, and defines federally approved gene, cellular, and CAR-T therapies. The definitions are included below, as follows:

Experimental or Investigational

Shall mean any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

a. Items within the research, investigational, or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

b. Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials or at least one or more large, controlled, national, multi-center, population-based studies;

c. Items based on anecdotal and unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

d. Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes; and

e. FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered experimental, investigational, or unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology, TM or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications), is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

The foregoing definition shall not apply to any clinical trials or other experimental services required to be covered under the Patient Protection and Affordable Care Act (PPACA).

Medically Necessary

Shall mean any health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by the Trustees or their designee, within their sole discretion:

a. In accordance with Generally Accepted Standards of Medical Practice; and

b. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the Participant's illness, injury, mental illness, substance use disorder, or disease or its symptoms; and

c. Not mainly for the person's convenience or that of the person's doctor or other health care provider; and

d. Is the most appropriate, most cost-efficient level of service(s), supply, or drug that can be safely provided to the person and that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the person's illness, injury, disease, or symptoms.

The fact that a Medical Provider has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggests a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. The Trustees reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Medical Provider specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within the Trustees' sole discretion.

Gene, Cellular, and CAR-T Therapies

These treatments are covered when prescribed by a physician and the treatment must be approved by the Food and Drug Administration for the use it is being prescribed for at the time the treatment is provided, and the Participant must comply with all applicable step-therapy and prior authorization protocols. The Participant must also comply with, and participate in, the Fund's case management programs. Coverage is provided for all phases of related treatment, including but not limited to, genetic testing, treatment, procedures, services, supplies, and medicines provided in connection with admission, cell extraction, administration of the medication, as well as any necessary treatment and follow up care. Approved treatments will be subject to the Fund's cost sharing provisions (deductibles, copayments, coinsurance) as applicable. Cost sharing requirements will vary if the treatment is administered by out of network providers, subject to any applicable restrictions of the No Surprises Act.

How Will This Notice Affect Me?

The clarifications added to the Plan provisions do not affect your benefit coverage under the Plan, unless you are undergoing or receiving treatments that are considered within the definition of, what are experimental or investigational treatments, or the treatments are not medically necessary.

If you are considering a gene, cellular, or CAR-T therapy, which is used to correct defective genes in order to cure a disease or help your body fight disease, the Plan covers the treatments provided they are approved by the Food and Drug Administration for the condition proscribed, and requires that the participant comply with the Plan's disease management programs, such as case management.

What Do I Need to Do?

You do not need to take any action. If you have any questions, please contact the Fund Office at (248) 828-6000.

Important Reminder

This SMM is a summary and is **not** an official plan document. The actual terms of the Plan are contained in the plan document, which is available from the Fund Office. In the event of any ambiguity in or omission from this SMM, or any conflict between this SMM and the official plan document, the official plan document will govern. In addition, retiree coverage is not a vested benefit. The coverage can be modified or eliminated entirely at any time. If you have any questions, please contact the Plan Administrator at (248) 826-6000.

Sincerely,
The Board of Trustees

BAC of MICHIGAN
Health and Welfare Fund

P.O. Box 99490 • Troy, MI 48099-9490 • Phone (248) 828-6000 • Fax (248) 828-6001

ENROLLMENT FORM – Effective 1/1/2024

OPTION #1 - **DELTA DENTAL** This option allows for up to $1,000 of Dental Benefits coverage, per person, per calendar year. *(As a default, all newly eligible participant are automatically enrolled in this Dental Delta Dental Benefit option)*

Class I Benefits: 100% coverage -Diagnostic & Preventive services: exams, cleanings, x-ray's
Class II Benefits: 80% coverage – Basic Care & Procedures: Fillings, Root Canals
Class III Benefits: 80% coverage – Major care & Procedures: Crowns, Bridges, Dentures
Class IV Benefits: 50% coverage – Orthodontia: Braces

Non-network provider claims based on Delta Dental Fee Schedule.

If currently enrolled in the Golden Dental Managed Care/Dencap and would like to switch to Delta Dental for 2024, please mark here _____, sign, date and return the form.

OPTION #2 – **DENCAP/GOLDEN DENTAL MANAGED CARE PLAN** This option allows up to $1,500 of Dental Benefit coverage, per person per calendar year.

Class I Benefits: 100% coverage - Exams, X-rays and Cleanings
Class II Benefits: 75% coverage Fillings, Extractions and Root Canals
Class III Benefits: 75% Crowns, Bridges, Partials and Dentures
Class IV Benefits: 50% Specialty Care - Orthodontic Savings $1,800.00 max Child and Adults

You must use your specific Dencap/Golden Dental Managed Care Plan Dentist, no coverage for out of network providers. If you live outside a Golden Dental Provider service area and do not wish to commute, do not select Option #2.

If you are currently enrolled in Delta Dental and would like to switch to Dencap/Golden Dental Managed care for 2024, please mark here _____, sign, date and return the form.

_____ _____ _____
First Name (Print) **Last Name (Print)** **Subscriber ID#**

X_____ _____
Signature **Date**

(____)_____
Your Phone Number

- If electing a change to your current Dental coverage, please complete this Form and return it to the Fund office no later than Dec 20, 2023, allowing time for ID cards to be ordered and delivered to you by the 1/1/2024 effective date. The completed form can be mailed to: BAC of Michigan H&W Fund at P.O. Box 99490, Troy MI 48099, or email to: BACFUND@Bricklayers.org, or Fax to: 248-828-6001.

BAC of Michigan Health and Welfare Fund

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

Important Questions	Answers		Why This Matters:
	In-Network	Out-Of-Network	
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/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 of usual, customary and reasonable (UCR)	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance of (UCR)	

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. 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	30% - 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.
	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

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 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 (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	$25 copay/visit	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. $500 for hearing aids for Active Participants only (one or more hearing aids every three years)
	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 your child needs dental or eye care	Children's eye exam Children's glasses Children's dental checkup	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.

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
- Dental Care
- Chiropractic Care
- Hearing Aids (Active Participant only)
- 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.

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**