BAC OF MICHIGAN
HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

January 1, 2022

BAC OF MICHIGAN
HEALTH AND WELFARE FUND

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IMPORTANT NOTICE

This Summary Plan Description booklet describes the Plan of the BAC of Michigan Health and Welfare Fund as it is in effect on January 1, 2022. If you have questions about the Plan or your rights under the Plan, contact the Fund Office.

One word of caution:
NO ONE HAS THE AUTHORITY TO SPEAK FOR THE BOARD OF TRUSTEES IN EXPLAINING THE ELIGIBILITY RULES OR BENEFITS OF THE FUND, EXCEPT THE FULL BOARD OF TRUSTEES.

IN CASE OF CONFLICT, THE PLAN, WHICH INCORPORATES THE FUND'S INSURANCE AND OTHER CONTRACTS WITH ITS SERVICE PROVIDERS, NOT THIS SUMMARY, WILL GOVERN. ADDITIONAL LIMITATIONS AND EXCLUSIONS MAY BE FOUND IN THE PLAN, WHICH IS ATTACHED AT THE END OF THIS SPD AND AVAILABLE FREE OF CHARGE AT THE FUND OFFICE.

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IMPORTANT ADDRESSES AND PHONE NUMBERS
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Spence Brothers
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Saginaw, MI 48607

The Board of Trustees is the legal Fund Administrator.

FUND OFFICE/ADMINISTRATIVE MANAGER
BAC of Michigan Health and Welfare Fund

Office Address: 700 Tower Drive, Suite 215, Troy, Michigan 48098

Mailing Address: P.O. Box 99490, Troy, Michigan 48099-9490

Phone Number (local): (248) 828-6000; Phone Number (toll-free): (800) 435-4080
Fax Number: (248) 828-6001

Web Site Address: www.baclocal2benefits.org

OFFICE HOURS
Monday through Friday
7:00 a.m. to 4:00 p.m.

Introduction

This Summary Plan Description is issued to describe and summarize your health care benefits. The full terms and conditions governing coverage under the Plan are stated in the Plan documents, which include the Trust Agreement, Collective Bargaining Agreements, Participation Agreements and contracts with certain service providers. The benefits as outlined in this Summary are effective only if you are eligible for coverage and remain eligible according to the provisions of the Plan.

The benefits payable in the event of your illness or a covered dependent's illness are provided by the BAC of Michigan Health and Welfare Fund. Your claims will be processed by the Fund Office, whose personnel are trained in this type of work.

We expect you to use your benefits when you, or one of your covered dependents, are ill or injured. It is important that you do not abuse the Plan. Money paid from the Plan, like any other expense, is an operating cost. In short, we trust you will treat the Plan's money as if it were your own.

The Board of Trustees of the BAC of Michigan Health and Welfare Fund reserves the right, at any time, to modify, amend or terminate any existing or future benefit or condition of eligibility or self-payment or any other term or condition of the BAC of Michigan Health and Welfare Fund.

As you read the Summary, keep in mind that it is an effort to summarize, simply, the principal provisions of the Fund's coverage and eligibility rules. **It is not intended to cover every detail or every situation that might occur**. We have tried to make the Summary accurate and complete, but it does not describe Plan changes that occurred after the book was printed. If any discrepancy exists between this Summary and the other formal documents governing the terms of the Fund's coverage and eligibility rules (including certain contracts entered into by the Fund), the provisions of those other documents will govern. This Summary Plan Description supersedes and replaces any Summary Plan Description previously issued by the Fund.

Each year, you will receive a Summary of Material Modifications, which includes a statement of significant changes in the Plan after January 2022, if any material changes are made to the Plan. Like this Summary, it is intended as a general statement of the changes and is not a substitute for other formal documents governing the terms of the Fund's coverage and eligibility rules.

You should read this material carefully and keep it for reference. It will help you to understand how the Plan works, what rights and benefits it provides for you and your family, and how to obtain those benefits.

We hope the benefits available through the Fund will serve your needs and those of your family.

Respectfully yours,
THE BOARD OF TRUSTEES

January 2022

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Plan Information

BAC OF MICHIGAN
HEALTH AND WELFARE FUND
Office Address: 700 Tower Drive, Suite 215, Troy, Michigan 48098
Mailing Address: P.O. Box 99490, Troy, Michigan 48099-9490
Phone Number (local): (248) 828-6000; Phone Number (toll-free): (800) 435-4080
Fax Number: (248) 828-6001
Web Site Address: www.baclocal2benefits.org

SUMMARY PLAN DESCRIPTION

General Information Applicable to Plan Number 501

Employer Identification Number: 38-2073681

The Fund is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the employer's contributions to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefits paid on your behalf are not tax deductible and are not part of your personal income.

Obviously, such tax exemption works to the benefit of both employer and employee. In effect, it means that money that otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses.

The Board of Trustees are well aware of these advantages and will take whatever steps are necessary to keep your Plan tax exempt under Internal Revenue Service rules.

Administration

The Board of Trustees of the BAC of Michigan Health and Welfare Fund is the Plan Administrator and Plan Sponsor and is responsible for overall Plan administration. There are eight Trustees appointed by the Union and eight Trustees appointed by the Employer Associations. The Board of Trustees has delegated some of the day-to-day responsibilities for Plan administration to the Plan Manager.

Union

Bricklayers' and Allied Craftworkers' Local Union No. 2 of Michigan ("BAC Local #2").

Employer Association

AGC of Michigan
Associated Concrete Contractors of Michigan
Mason Contractors Association, Inc.

Agent for Service of Legal Process

The person designated as Agent for Service of Legal Process shall be:

Joseph Pawlick, Esq., Legal Counsel
Watkins, Pawlick, Calati & Prifti, PC
1423 East 12 Mile Road
Madison Heights, Michigan 48071

Legal process may also be served on any Trustee or on:

BAC of Michigan Health and Welfare Fund
Office Address: 700 Tower Drive, Suite 215, Troy, Michigan 48098
Mailing Address: P.O. Box 99490, Troy, Michigan 48099-9490

Plan Manager

The Board of Trustees has delegated certain administrative functions to a professional administrative manager. The Plan Manager is BeneSys, Inc.

Named Fiduciary

A Named Fiduciary is the person or persons who have the authority to control and manage the operation and administration of the Fund. The Named Fiduciary for the Fund is the Board of Trustees of the BAC of Michigan Health and Welfare Fund.

Plan Name

Plan of the BAC of Michigan Health and Welfare Fund.

Type of Plan

The Plan is an employee welfare benefit plan providing hospitalization, medical, prescription drug, dental, vision, weekly disability, death and accidental death and dismemberment benefits. The Plan is subject to the Employee Retirement Income Security Act of 1974, as amended, usually referred to as ERISA. As a participant in the BAC of Michigan Health and Welfare Fund, you are entitled to certain rights and protections under ERISA, as described in the ERISA RIGHTS section of this booklet.

Rights to Modify, Amend and Terminate

The Board of Trustees may modify, amend or terminate the Plan at any time in its sole discretion. Amendments or modifications that affect participants will be communicated to participants in writing. Such amendments or modifications may have the effect of limiting, expanding or

eliminating any benefit or changing the conditions, eligibility or co-payment required for any benefit. In the event of termination, any remaining assets of the Fund (after all obligations are met) will be distributed in a manner which, in the opinion of the Board of Trustees, best accomplishes the purposes of the Fund.

Collective Bargaining Agreements

The Plan is maintained pursuant to collective bargaining agreements. A copy of such agreement(s) may be obtained upon written request to the Fund Office, which may make a reasonable charge for copying. Copies are also available for examination by participants and beneficiaries at the Fund Office.

Source of Plan Contributions

The Plan is funded through the Trust Fund, which receives contributions made by employers at rates specified in collective bargaining agreements between the Associations and the Union, and special participation agreements with the Fund. Contributions are held in trust by the Board of Trustees pending the payment of benefits and administrative expenses. Employees, retirees, spouses and other dependents may make payments to the Fund under certain circumstances in order to continue eligibility. Any participant, surviving spouse, or beneficiary may receive, upon written request to the Fund Office, information about whether a particular employer is contributing to the Fund and, if so, the employer's address. You have a right to receive a copy of a collective bargaining agreement or to read it at the Fund Office.

Welfare Trust Assets and Reserves

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses. The benefits provided by the Fund are a combination of insured and self-funded (i.e., not covered through an insurance policy). Benefits payable are limited to Fund assets available for such purposes.

Plan Year

The Plan Year, for purposes of maintaining the Plan's fiscal records, begins on the first day of May and ends on the last day of April of each calendar year. The Benefit Year, for purposes of administration of the Plan, begins on the first day of January and ends on the last day of December of each calendar year.

Eligibility and Benefits

The Plan's eligibility rules with respect to participation and benefits are generally described in this booklet.

The Board of Trustees may change the eligibility rules and/or benefit provisions of the Plan at any time. The benefits provided by the Fund are limited to the assets of the Fund that are available to

pay for such benefits. **No participant, dependent or retiree has any vested right to any benefit provided by the Fund, now or at any time in the future.**

Summary Plan Description

The Summary Plan Description is this booklet.

Administrative Responsibilities

The Plan Administrator, as a legal matter, is the Fund's Board of Trustees. The Plan Administrator employs an administrative staff (the "Fund Office") to operate the program on a day-to-day basis. The **Fund Office** is responsible for the following:

- Financial and record-keeping functions for the Fund;
- All matters pertaining to eligibility;
- Processing self-payments;
- Processing claims for benefits **other than** prescription drug benefits and dental benefits for participants who elect the Golden Dental Managed Care Program and Blue Cross Blue Shield Medicare Advantage (see pages 40-41 of this summary regarding Golden Dental Managed Care Program);
- Reviewing and presenting appeals to the Board of Trustees.

Network Provider

Blue Cross Blue Shield of Michigan PPO Provider Network ("BCBSM") is the Fund's Primary Network and is responsible for providing network discounts for medical, hospital and surgical services provided by in-network providers. As a network provider, BCBSM is not providing insurance.

Pharmacy Benefit Manager

The Fund has a contract with Blue Cross Blue Shield of Michigan to administer all prescription drug benefits and to be the Fund's Pharmacy Benefit Manager ("PBM"). Such benefits are paid by the Fund (self-funded); they are not insured.

Insurance

Finally, the Board of Trustees has purchased insurance through Golden Dental for some of the dental benefits offered under the Plan and Blue Cross Blue Shield Medicare Advantage for health and prescription drug coverage for Medicare Eligible Retirees.

Trustee Authority

The Board of Trustees has full discretion and authority to increase, reduce or eliminate benefits and to change the eligibility rules and all other provisions of the Plan at any time. However, the Board of Trustees intends that the terms of the Plan are legally enforceable while they are in effect, including those relating to coverage and benefits. The right to change or eliminate any and all aspects of benefits provided under this Plan to all participants, including retirees and their dependents is a right specifically reserved to the Board of Trustees.

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

Only the full Board of Trustees is authorized and has the discretion to interpret the Plan and the benefits described in this Summary Plan Description. The Board's interpretation is final and binding on all persons dealing with the Fund or claiming a benefit from the Fund. If a decision of the Board of Trustees is challenged in court, that decision will be upheld, under current law, unless it is determined by the court to have been arbitrary and capricious. No agent, representative, officer or other person from the Union, the Associations, or an employer has the authority to speak for the Board of Trustees or to act contrary to the written terms of the governing Plan documents.

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

Participant Responsibilities

As a participant, this Plan not only enables you with certain rights to benefits but it requires you to fulfill certain responsibilities for the protection of those rights.

General Responsibilities

You must:

- Read this book. You and your dependents should take the time to read this benefit book and familiarize yourselves with the eligibility and benefit rules.

- Keep the Fund Office informed. One of your most important responsibilities is to make certain that the Fund Office always has current and accurate information about you and your dependents.

- Complete a Vital Information Form, including other supporting information as determined by the Fund, immediately and return it to the Fund Office if you are a new participant.

- Follow the proper procedures for receiving benefits, filing claims and submitting appeals. Review the information on claims processing in this Summary. When in doubt, before incurring any non-emergency expense, ask the Fund Office about claims processing and benefits.

- Carry your card. You should have a benefit card. Be certain to carry this benefit card and show it whenever you receive medical, hospital and surgical benefits, dental or vision care or get a prescription.

- Keep copies of all bills and EOBs. It is important that you keep any bills and Explanations of Benefits ("EOBs") that you receive. These can be valuable in making claims and for filing appeals. They might also represent your only record of the benefits and care that you have received.

- Keep notices you receive from the Fund. After the publication of this Summary, you will receive notices of benefit changes as they occur. You should keep those together with this Summary booklet so that you will have a complete record of the Plan's communications to you regarding your benefits.

- Keep track of your employer contributions submitted to the Fund on your behalf. Your eligibility depends on it. Carefully review the monthly slips provided by the Fund Office and report any errors immediately.

- Identify yourself. When you write to the Fund Office, please be sure to include your name, Subscriber ID number (or alternate ID) and trade in your letter. If you call, please be sure to have your Subscriber ID number handy. Please note that due to privacy concerns, the

Fund Office will not release your protected health information ("PHI") to your spouse or dependents unless you have a signed authorization form on file with the Fund Office.

- Notify the Fund Office when you or one of your dependents becomes eligible for Social Security benefits and/or Medicare coverage. You must sign up for Medicare Parts A and B, and send a copy of the Social Security Award letter and/or the Medicare Card to the Fund Office immediately.

- Notify the Fund Office if you are working outside the area covered by BAC Local #2. If your employer is making health care contributions on your behalf, check with this Fund Office to find out whether there is a reciprocity agreement with the health care fund in the area where you are working and what you must do to have those contributions transferred to this Fund.

- Protect your COBRA rights and the COBRA rights of your dependents. Your surviving or divorced spouse, and/or your children who no longer qualify as eligible dependents must notify the Fund Office within 60 days of the date on which the event occurred that resulted in their loss of eligibility that they want to continue their coverage under the Fund through self-payments under COBRA. If the Fund does not receive notice within the 60-day period, they will lose their right to continue coverage through self-payments under COBRA.

Notification Responsibilities

To avoid delays and loss of coverage or rights for you or your dependents, the Fund Office must be notified of the following events as set out below as soon as possible.

Marriage

To add a spouse to your coverage, your marriage must be reported to the Fund Office. If you report your marriage **within 30 days** of its occurrence, your spouse will be covered from the date of marriage - if your marriage is reported later, your new spouse's coverage may be delayed. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice. A copy of the certificate of marriage must be filed with the Fund Office.

Births

To add a newborn as an eligible dependent, the child's birth must be reported to the Fund Office with a proper birth verification. If you report your child's birth **within 30 days** of its occurrence, your child will be covered from birth – if the birth is reported later, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice. A copy of the birth certificate, if not submitted at the time the child's birth is reported to the Fund, must be filed with the Fund Office within 60 days. Upon review, further evidence of parentage may be required.

Adoptions, Step-Children and Legal Guardianship

To add a child as an eligible dependent, the adoption, marriage (for stepchildren) or guardianship must be reported **within 30 days** of its occurrence, and one or more of the following must be filed with the Fund Office: 1) a copy of the legal adoption or Court Order placing the child in your home for adoption; 2) certificate of marriage to the child's parent, proof of the child's birth, and proof that adoption proceedings have commenced; and/or 3) order of legal guardianship. The child will be covered from the moment of adoption (or placement for adoption), marriage to the child's parent, or establishment of guardianship, if the event is reported **within 30 days** of its occurrence. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice.

Change of Address

Any change of address, or name change, must be reported immediately, in writing, signed by you, to BAC Local #2. BAC Local #2 is responsible for informing the Fund Office of your new address.

Deaths

Deaths must be reported immediately to the Fund Office. A copy of the death certificate is required for benefits to be payable to a beneficiary.

Divorce

Divorce must be reported immediately and a complete copy of the Judgment of Divorce, and any amendments to the Judgment, must be filed with the Fund Office. If the Fund pays benefits for a former spouse because you did not notify the Fund of your divorce, you will be personally liable to the Fund for the amount of those benefits.

Birthdays

You must inform the Fund Office immediately when your dependent attains the age of 26.

Other Coverage

Notice of other coverage must be reported to the Fund Office **within 30 days** of the date you or your dependents obtain such coverage.

You should also notify the Fund Office if:

- You are unable to work due to accident or illness;

- Your disability has terminated;
- Your employment with a contributing employer has terminated and you wish to continue your insurance by self-payment;
- You have applied for family or medical leave from your employer;
- A court has entered a qualified medical child support order directing that health care coverage be provided for your child(ren) through the Fund;
- You or your dependent(s) are eligible for or have received benefits under another health care plan, insurance contract, program or statute; or
- You or your dependent(s) enter the military or other uniformed services of the United States.

Payment of Benefits

You have the free choice of any provider. However, the amount of benefits paid by the Fund may vary and/or be limited based on the provider you choose and the provider's participation in a preferred provider organization utilized by the Fund.

Benefits up to but not in excess of the maximum benefits shown in this Summary are payable individually for you and for each of your dependents according to the following provisions:

Hospital, Surgical, Medical, Dental, Vision Care and Prescription

Hospital, surgical, medical, certain dental, and vision care benefits payable under this Plan for Active Participants, non-Medicare Eligible retirees (also referred to as "Early Retirees") and their non-Medicare Eligible beneficiaries are self-funded (i.e., not covered through an insurance policy). Although Blue Cross and Blue Shield of Michigan provides access to networks of health care providers and provides some administration services for benefits provided through those networks, it does not insure coverage for those who are not Medicare Eligible retirees. The Fund is responsible for the payment of these claims, changes in Plan benefits, and enrollment. Benefits payable are limited to Fund assets available for such purposes.

Prescription drug benefits payable under this Plan for Active Participants and their beneficiaries are self-funded (i.e., not covered through an insurance policy). The Fund has a contract with Blue Cross Blue Shield of Michigan to administer all outpatient prescription drug benefits and to be the Funds Pharmacy Benefit Manager ("PBM"). Any claims for prescription drug benefits that you may have that are not processed in this manner may be submitted to Blue Cross Blue Shield of Michigan.

Visit www.bcbsm.com/pharmacy for more information about the pharmacy benefits through BCBSM.

Early Retirees and their dependents are not eligible for prescription drug benefits.

Hospital, surgical, medical and prescription drug benefits available under this Plan for Medicare Eligible Retirees and Medicare-Eligible Dependents are provided through an insurance contract(s)

with Blue Cross Blue Shield of Michigan Medicare Advantage Part D (MAPD) plan, the terms of which are incorporated by reference as if printed verbatim herein.

Dental Benefits Provided through Golden Dental

In addition to the traditional dental benefit coverage, the Fund has a contract with Golden Dental Managed Care Program to provide insured dental benefits.

Payment of Other Benefits

Generally, bills from hospitals and doctors from out-of-network providers will be sent directly to you. You should forward those claims to the Fund Office. Please be sure to include the participant's name, Subscriber ID number (or alternate ID), trade, local union information (BAC Local #2) and the name of the person who received treatment, if different.

Any payment made by the Fund in accordance with these provisions will fully discharge the Fund's liability to the extent of the payment.

Explanation of Benefits

After you make a claim for benefits, you should receive an "Explanation of Benefits" ("EOB") from the Fund Office stating what has been paid. You are responsible for paying any amount remaining due, and you should contact the Fund Office with any questions regarding your EOB.

Payment of Benefits to a Personal Representative

If a person is not mentally, physically or otherwise able to handle his/her business affairs, the Fund may pay benefits to the legally appointed guardian, conservator or person holding the power of attorney. You are responsible for providing the Fund with any information and documentation regarding someone who has or may have authority to act in your place.

Eligibility And Coverage

Initial Eligibility Requirements for Bargaining Unit Employees

To be initially eligible for benefits under this Plan, you must be employed by an employer who is obligated by a collective bargaining agreement to make contributions on your behalf to the Fund for covered work you perform in the geographic jurisdiction of BAC Local #2. You will be initially eligible for benefits on the first day of the month in which you have been credited with 390 hours of work and contributions within the immediately preceding six (6) consecutive months or less.

> **Example:** If the Employee works a total of 390 hours for a contributing Employer(s) in covered employment in April, May, June and July and the contributions and hours

reflecting this are received by the Fund on September 15, the Employee becomes eligible September 1 and has coverage for September, October and November.

If the Fund receives employer contributions on your behalf from another Fund with which the Fund has a reciprocity agreement before you have become initially eligible, those contributions will be accepted and applied toward your reaching the initial eligibility requirements upon confirmation by the Fund Office that you are member of BAC Local #2. See page 16 for information regarding reciprocity.

For all Employees except Fund Employees, Hours of Work are determined based on the work hours received at the contribution rate required for journeymen in the Agreement between Bricklayers' and Allied Craftworkers Local No. 2 of Michigan, Bricklayers and Allied Craftworkers International Union of North America, AFL-CIO and Labor-Management Cooperation Committee ("Bricklayers Agreement"). If contributions are received at a lower rate than the one specified in the Bricklayers Agreement, Hours of Work shall be pro-rated accordingly.

When you become eligible, you will receive a Vital Information Form on which you can report all of your eligible dependents. This Form should be completed and returned to the Fund Office as quickly as possible. Be certain to report all changes (i.e., additions and deletions) among your dependents to the Fund Office immediately.

Employees of Newly-Organized Employers

An Employee of a newly organized Employer shall become eligible for benefits on the first day of the first full month for which that Employer is obligated to contribute to the Fund, if the Employer satisfies certain requirements. The Fund Office will notify you if your Employer satisfied those requirements.

Non-Bargaining Unit Employees

The eligibility provisions applicable to Owners and other Non-Bargaining Unit Employees, collectively ("NBUEs"), are set forth on pages 19-21 of this Summary.

Continuing Eligibility Requirements

Bargaining Unit Employees:

Continuation by Working

Once you have established initial eligibility for benefits, you will continue to be eligible for benefits in any month (the "eligibility month") in which you were credited with 130 hours of work and contributions for the third calendar month prior to the eligibility month.

Example: You will have coverage for the September eligibility month if you work (and contributions are received for) a total of at least 130 hours in June.

A bookkeeping period has been instituted for accounting, reporting and notification of eligibility to Employees. Eligibility will be determined according to the following schedule:

Hours worked during the month	will determine eligibility for the Eligibility Month of . . . below . . .
June	September
July	October
August	November
September	December
October	January
November	February
December	March
January	April
February	May
March	June
April	July
May	August

Continuation by Hour Bank

Once you have established initial eligibility for benefits, you can continue your eligibility based on months when you have **not** been credited with 130 hours of work and contributions through use of your **"hour bank",** provided that you are available for work and that the Fund has not received information that you are working in non-covered employment.

Your **"hour bank"** will be credited with the hours of covered work you perform (for which employer contributions are received) in excess of 130 hours in any month, and drawn upon to keep you eligible for benefits when you are credited with fewer than 130 hours in a later month or are out of work.

Example: You are credited with employer contributions for 162 hours of work in June; 130 are applied to continue your eligibility for the month of September and 32 are deposited in your hour bank. By October, you have accumulated 157 hours in your hour bank. You work only 53 hours in October, so the Fund draws 77 hours from your hour bank (130 – 53 = 77) to continue your eligibility for January, which leaves a balance of 80 (157 – 77 = 80) hours in your hour bank.

If you have fewer than 130 hours in your hour bank, you can continue coverage for one month only by making a self-payment to the Fund equal to the hourly contribution rate multiplied by the number of hours needed to reach 130 hours for that month**,** provided that you are available for

work and that the Fund has not received information that you are working in non-covered employment.

> **Example:** You have 100 hours in your hour bank, and you do not work in June at all. To continue coverage for September, you must make a self-payment equal to the hourly employer contribution rate multiplied by 30 (the number of hours by which your hour bank is short). Then, the 100 hours will be removed from your hour bank and, with your payment, you will be eligible for September only on this basis.

No more than 520 hours can be accumulated in your hour bank, except if you were grandfathered at a higher reserve bank pursuant to the Plan changes made effective March 1, 2004. So it is possible for you to be eligible for a total of four (4) months if you have 520 hours in your hour bank, even if you have not worked for four months.

> **Example:** If you have 520 hours in your hour bank and you do not work in September, October, November and December, the 520 hours in your hour bank will be used to keep you eligible for the months of December, January, February and March.

Continuation by Self-Payments

If you would otherwise lose your eligibility because you have not been credited with sufficient hours of work and contributions, you may continue your eligibility by making self-payments at a rate established by the Board of Trustees. That rate may change from time to time at the discretion of the Board of Trustees. You may make self-payments to continue your eligibility only if you have become ineligible and continue to be ineligible because of a lack of available employment or because you are not working sufficient hours to remain eligible, even though you are currently working for a contributing employer. While you are making self-payments, you must submit a certification letter to the Fund Office from BAC Local #2 every three months verifying that you are unemployed or underemployed but available for work. (You are not eligible for continuation by self-payments if you are a Retiree, unless you are working under the jurisdiction of the collective bargaining agreements that require contributions to the Fund.)

You may make self-payments for a period up to 12 consecutive months, provided that you are available for work (as described above) and not working in non-covered employment. If you work outside the jurisdiction of the collective bargaining agreements that require contributions to the Fund, you will no longer be considered available for work and you will no longer be permitted to continue coverage by self-payments, unless you are working outside of your "home area" for an employer who participates in a fund that has entered into a Reciprocity Agreement with the BAC of Michigan Health and Welfare Fund. (See page 16 of this Summary.)

If you are about to lose eligibility, the Fund Office will mail a Monthly Status Report and a notice regarding self-payment rights to your last known address on file at the Fund Office. **Remember that you must report your change of address, in writing with your signature, to BAC Local #2. BAC Local #2 then informs the Fund Office of your new address. It is your responsibility to keep BAC Local #2 and Fund Office informed of your current address.**

If you elect to continue coverage by self-payment, the required self-payment must be received in the Fund Office no later than the date indicated on the notice. You should make the required self-payment when due even if you think that you should be eligible by way of employer contributions. If, after your self-payment is made for a month, the Plan receives further contributions on your behalf for that month, and such contributions are sufficient to continue your eligibility, the self-payment will be held as credit toward future self-payments only if it is needed to continue your eligibility for the next eligibility month; a refund is issued to you if it is not needed to continue your eligibility for the next eligibility month.

If you have made self-payments for the 12 consecutive months permitted by the Fund **or** you elect not to make self-payments and, as a result, your eligibility is terminated, you will have the opportunity to continue coverage under COBRA (see page 28 of this Summary).

If your eligibility terminates, whether or not you elect to continue coverage under COBRA, and you remain ineligible for at least 12 consecutive months, you will not be eligible to make self-payments again until you once again establish eligibility under the initial eligibility requirements (see page 11 of this Summary).

Please remember, to avoid an interruption of benefits, you must submit any required self-payment before the due date of the 25th day of each month.

Self-Pay Rates

Active Participants

All self-payments are based on a 20% discount from the active contribution obligation.

Non-Medicare Retirees, Widows, and Permanent and Total Disability

All self-payments for those who are not eligible for Medicare will be based on a 35% discount from the active contribution obligation.

Non-Bargaining Unit (Participation Agreement)

All self-payments will be based on 160 hours multiplied by the current contribution rate for monthly eligibility.

Medicare Retirees, Widows, and Permanent and Total Disability

All Medicare eligible participants have the option to enroll in the BCBS Medicare Advantage plan with self-payment rates equal to the MAPD premium rate. These rates are subject to change and you will be notified in advance of such changes.

Continuation While Working Outside Home Area (Reciprocity)

The Board of Trustees has entered into Reciprocity Agreements with other funds. These Agreements provide a way in which an Employee who performs covered work outside of his "home area" (the jurisdiction in which he regularly works) can have that work recognized by his "home fund". The "home fund" of an Employee is the Fund that handles health care coverage for the Local Union to which the Employee belongs.

If you are working outside of your home area and would like reciprocal coverage, you must contact the Fund Office or the Local Union to which you belong to determine your "home fund" and the procedures to follow in order to have work hours transferred to your "home fund." Thereafter, the "home fund" will determine your eligibility and right to benefits.

The final authority to determine the home fund of any Employee will rest with the Administrators of the funds involved. These Administrators may consider the home address of the Employee claiming benefits and other factors they consider relevant. Transfers will be made for the periods considered by each fund for purposes of maintaining eligibility.

The Board of Trustees has the exclusive authority to enter into this or any other type of reciprocity agreement that it believes will benefit participants.

Continuation during Short Term Disability (Loss-of-Time Credit)

You will be eligible to receive a Loss-of-Time Credit equivalent to 32.5 hours of work for each week you:

- are eligible to receive Weekly Disability Benefits under this Plan (see page 43 of this Summary for an explanation of those Benefits) **or**
- are not eligible to receive Weekly Disability Benefits under this Plan because
  - your injury or illness was work related **or**
  - your injury was suffered in an auto/vehicular accident

provided you are eligible for benefits under this Plan at the time of the injury or illness.

Loss-of-Time Credits are applied to keep you eligible under the rules for Continuation by Working.

You must submit an application to the Fund Office for loss-of-time credits as soon as reasonably possible after the accident or sickness, but no later than 180 days after the accident or onset of sickness.

If you remain disabled after you have exhausted your eligibility for loss-of-time credits (based on the maximum of 26 weeks eligibility for Weekly Disability Benefits), then you will have six months of coverage from the Plan without any cost to you ("six-month extension"). If you remain disabled after you have exhausted the six-month extension, then you may exhaust the credits in your hour bank to continue coverage.

Finally, if you remain disabled after you have exhausted the credits in your hour bank, you may continue coverage one of two ways. If you meet the requirements for Permanent and Total Disability Coverage (see page 17 of this Summary), you may continue coverage by making self-payments at the rate for disabled employees. If you do not meet the requirements for Permanent and Total Disability Coverage, you may continue coverage by making self-payments at the rate for active employees for a period up to 12 consecutive months, as described on page 14 of this Summary.

If you elect not to make self-payments and, as a result, your eligibility is terminated, you will have the opportunity to continue coverage under COBRA (see page 28 of this Summary).

Permanent and Total Disability

Eligibility

To qualify for Permanent and Total Disability coverage under the Fund, you must meet each of the following requirements, and make timely monthly payments in an amount established by the Board of Trustees from time to time, which amount is subject to change by the Board at any time:

Disability

You must have become disabled while covered under the Fund and be a member of a bargaining unit represented by BAC Local #2 or be an Employee of a contributing employer who has signed a participation agreement in effect with this Fund. You must not be eligible for coverage as a Retiree. You must not have become disabled as a result of non-covered employment or during the commission of a felony. The eligibility of a participant who is determined to be permanently and totally disabled but does not have a Social Security Disability Award is limited to twenty-four (24) months (subject to all other requirements and limitations in this Plan for eligibility).

Physical or Mental Condition

You must have a physical or mental condition which, on the basis of satisfactory medical evidence, permanently and totally prevents you from engaging in any regular occupation or employment in the bricklaying, cement mason and/or tile, marble and terrazzo trades for wages or profit (except for rehabilitation as approved by the Board of Trustees) and which is expected to be permanent and continuous during the remainder of your life. You will not be deemed to be permanently and totally disabled for purposes of the Fund if your incapacity was contracted, suffered, or incurred while working in non-covered employment or while you were engaged in a felony.

Hours of Work and Contributions

You must have been credited with at least 500 hours of work and contributions prior to the date of application and must have been eligible for benefits as an active participant for at least one month in the prior twenty-four consecutive months immediately preceding the date of application for Permanent and Total Disability coverage. In the alternative, if you have at least 10 years of service or more with the Bricklayers Pension Trust Fund – Metropolitan Area, the Michigan BAC Pension Fund, the Cement Masons Pension Trust Fund – Detroit and Vicinity, or, for tile setters, the Bricklayers and Trowel Trades International Pension Fund, or at least 10,000 hours of work with employer contributions to the this Fund; you must have received a Social Security Disability Award within 30 months of your last month of active employment; and maintained coverage with the Fund via self-payments and/or COBRA continuation coverage.

Completed Application

You must complete an application for Permanent and Total Disability coverage, accompanied by your Social Security Disability Award Letter, and all IRS Forms W-2, 1099 and 1040 received by or submitted by you, as applicable, from the date of your last covered employment through the date of application. If you do not have a Social Security Disability Award, your eligibility is limited to twenty-four months. You are required to notify the Fund immediately in the event of any change in your status with respect to Social Security disability eligibility.

Termination of Permanent and Total Disability Coverage

Once you are granted Permanent and Total Disability coverage, your coverage will continue until the earliest date any of the following occur:

- you engage in an occupation or in employment (except for rehabilitation as determined by the Board of Trustees) which is inconsistent with the finding of total and permanent disability;
- you refuse or fail to submit, upon request from the Board of Trustees which it shall make no more frequently than annually, proof of continuing receipt of Social Security Disability Benefits, and copies of all IRS Forms W-2, 1099 and 1040 received by or submitted by you, as applicable, from the date of commencement of your eligibility for Permanent and Total Disability Coverage through the date of the request;
- you become employed in an effort at rehabilitation as allowed under paragraph (a) hereof, but fail to provide satisfactory evidence of income when requested by the Board of Trustees;
- the Fund Office does not receive your monthly payment for coverage in the amount required, and when due;

- after twenty-four (24) months, if you do not have a Social Security Disability Award
- you become eligible for coverage as a Retiree; or
- the Fund no longer provides Permanent and Total Disability coverage.

Owners and Other Non-Bargaining Unit Employees

Fund Office employees, Union employees, owners and other persons employed by a contributing Employer outside the bargaining unit ("non-bargaining unit employees" or "NBUEs") may participate in the BAC of Michigan Health and Welfare Fund subject to the provisions of the Fund's Plan and the following rules:

- The contributing Employer, if not the Fund Office or Union

  - ➢ is a party to a current collective bargaining agreement requiring contributions to the Fund, and
  - ➢ enters into a Participation Agreement (sometimes called a "Health Agreement") with the Fund for its NBUEs.

- If an Employer chooses to contribute on NBUEs, it must contribute on all NBUEs it employs except the following:

  - ➢ NBUEs participating in another collectively bargained health care plan; ➢ NBUEs with health care coverage through a family member's employer; and ➢ at the Employer's option , NBUEs who perform only clerical work for the Employer.
  - ➢ Retirees who return to work in non-bargaining unit position

- If an Employer chooses to contribute on NBUEs who are Owners and the Owners are husband and wife, the Employer will be required to make contributions on only one of the spouses. If one of the Owner-spouses is a tradesperson, the Employer must make contributions on the Owner-spouse who is a tradesperson.

- The Fund will not accept contributions or self-payments on behalf of a NBUE if the Employer is delinquent in paying contributions on bargaining unit employees, except where there is a payment schedule in effect that has been approved by the Fund or ordered by a court.

- All NBUEs to be covered by the Fund's Plan must be listed on the Participation Agreement at the time it is signed, and the Employer must notify the Fund Office of any change in NBUEs upon whom the Employer is contributing.

- NBUEs will be classified as follows:

S-1 Owners who are not working with the tools ("Non-working Owners"), estimators, general superintendents, designated managing partners, and non-Owner non-bargaining unit employees, including, but not limited to, those who perform only clerical work for the Employer.

An S-1 non-bargaining unit employee meets the initial eligibility requirements on the first day of the first month following a period of three (3) consecutive months or less in which he is credited with at least 480 Hours of Work and Employer contributions. Once initial eligibility is met, that person will continue to be eligible for benefits if he or she is credited with Employer contributions based on at least 160 hours of work during a month according to the applicable continuation of eligibility schedule.

S-1 non-bargaining unit employees will not have an "hour bank" or be eligible for Weekly Disability Benefits (including loss-of-time credits).

S-2 Corporate Owners and non-managing partners who are working with the tools ("Working Owners").

An S-2 non-bargaining unit employee meets the initial eligibility requirements on the first day of the first month following a period of three (3) consecutive months or less in which he is credited with at least 480 Hours of Work and Employer contributions. Once initial eligibility is met, that person will continue to be eligible for benefits if he or she is credited with Employer contributions based on at least 160 hours of work during a month according to the applicable continuation of eligibility schedule.

Working Owners will have an "hour bank" and will be eligible for Weekly Disability Benefits (including loss-of-time credits).

S-3 Sole Proprietors.

An S-3 non-bargaining unit employee meets the initial eligibility requirements on the first day of the first month following a period of three (3) consecutive months or less in which he is credited with at least 480 Hours of Work and Employer contributions. Once initial eligibility is met, that person will continue to be eligible for benefits if he or she is credited with Employer contributions based on at least 160 hours of work during a month according to the applicable continuation of eligibility schedule.

Sole Proprietors will not have an "hour bank", but they will be eligible for Weekly Disability Benefits (including loss-of-time credits).

S-4 Fund Employees. A Fund Employee meets the initial eligibility requirements on the first day of the month following the completion of the Fund Employee's

probationary period, as that period is defined under the terms of the Fund's collective bargaining agreement with the Fund Employees or any contract of employment into which the Fund may enter.

Fund Employees will not have an "hour bank", but they will be eligible for Weekly Disability Benefits (including loss-of-time credits).

S-5 Union Employees. A Non-Bargaining Unit Employee who is a Union Employee meets the initial eligibility requirements on the first day of the first month following a period of three (3) consecutive months or less in which he is credited with at least 480 Hours of Work and Employer contributions. Once initial eligibility is met, that person will continue to be eligible for benefits if he or she is credited with Employer contributions based on at least 130 hours of work during a month according to the applicable continuation of eligibility schedule.

Union Employees will have an "hour bank" and will be eligible for Weekly Disability Benefits (including loss-of-time credits).

Termination of Eligibility

Your coverage under this Plan shall immediately terminate on the earliest of the following dates:

- The date you are no longer eligible for coverage under the terms of the Plan;
- The date you fail to make self-payments, if required;
- The date the Plan terminates;
- The date you are inducted into the Armed Forces; or
- If you are a NBUE, the date you or your employer violates the terms of the Participation Agreement that provides for contributions on your behalf.

Reinstatement of Eligibility

The rules on reinstating eligibility by working after your eligibility has lapsed vary based on how long you were ineligible.

If you have been ineligible for fewer than 12 consecutive months: If you have not been eligible by working for fewer than 12 consecutive months, you will again become eligible on the corresponding eligibility month following three (3) or fewer consecutive months during which you are credited with 130 hours of work and contributions (or such other requirement applicable to NBUEs).

If you have been ineligible for 12 or more consecutive months: If you have not been eligible by working for 12 or more consecutive months, you must again satisfy the Initial Eligibility Requirements.

Eligibility of Retirees

If you retire, you will remain eligible for benefits from the BAC of Michigan Health and Welfare Fund as an active participant by drawing on your Hourly Reserve Bank, if any, until the hours in your Hourly Reserve Bank fall below 130 Hours of Work. Thereafter, you may remain eligible for retiree benefits by making a monthly self-payment if you meet certain requirements. The type of benefits that you will receive is based on whether or not you are eligible for Medicare. If you are receiving an early retirement benefit from the Bricklayers Pension Trust Fund – Metropolitan Area, the Michigan BAC Pension Fund, the Cement Masons Pension Trust Fund – Detroit and Vicinity, or, for tile setters, the Bricklayers and Trowel Trades International Pension Fund, the requirements for eligibility for retiree coverage are described in the section below entitled "Eligibility for Early Retirees." If you are age 65 or over, your eligibility requirements are described in the section below entitled "Eligibility for Medicare-Eligible Retirees."

Retiree benefits do **not** include Accidental Death and Dismemberment Benefits, Weekly Disability Benefits or Loss-of-Time Credits under the provisions for Continuation of Eligibility during Short-Term Disability.

If you do not elect Retiree coverage when you become eligible, you will not have another chance to elect retiree coverage unless you return to covered employment and either reinstate or re-establish eligibility. However, if you did not elect retiree coverage because you had health coverage through your spouse's employment and then you lose that coverage, you may elect retiree coverage under this Fund so long as you

- request to return to coverage within **30 days** after the date on which you lost coverage under your spouse's employment-related health care coverage, and

- provide proof that you maintained your health care coverage continuously from the date you first became eligible for retiree coverage through the date you requested to elect retiree coverage under the Fund.

Early Retirees Eligibility

To be eligible for benefits for yourself and your dependents as an Early Retiree, you must:

- Notify the Fund Office when you apply for early retirement benefits from the Bricklayers Pension Trust Fund – Metropolitan Area, the Michigan BAC Pension Fund, the Cement Masons Pension Trust Fund – Detroit and Vicinity, or, for tile setters, the Bricklayers and Trowel Trades International Pension Fund, and that you would like to receive Retiree coverage by completing an application (**this notice is required at the time you apply for pension benefits even though you may be continuing eligibility based on your hours bank**);

- Be a participant in the BAC of Michigan Health and Welfare Fund who has been eligible for benefits from the Fund based on work hours or self-payments at least once in each of

the four rolling calendar years immediately preceding the date of your application; (in the case of Fund Employees, the participant has ten or more years of employment with the Fund and is employed by the Fund on the date of retirement and for Union Participants, the participant is eligible for benefits on the date of the application) and

- Be receiving early retirement benefits from the Bricklayers Pension Trust Fund – Metropolitan Area, the Michigan BAC Pension Fund, the Cement Masons Pension Trust Fund – Detroit and Vicinity, or, for tile setters, the Bricklayers and Trowel Trades International Pension Fund.

When you become eligible for Retiree coverage, your hour bank will be exhausted, and then you will be required to make monthly self-payments in an amount determined by the Board of Trustees from time to time, which amount is subject to change by the Board at any time.

Coverage as an Early Retiree will terminate when you become eligible for Medicare. When you become eligible for Medicare, you must elect such coverage, and the Fund will provide coverage as a Medicare-Eligible Retiree, subject to the provisions of this Plan controlling such coverage.

You must notify the Fund Office **immediately** if you return to work. If you return to active employment, you will continue your Early Retiree coverage unless you satisfy the Initial Eligibility requirements, at which time you will be an Active Participant. If you return to covered employment but do not satisfy the Initial Eligibility requirements, your Early Retiree monthly self-payment will be credited with the Employer contributions the Fund receives on your behalf.

Medicare-Eligible Retirees Eligibility

To be eligible for benefits for yourself and your dependents as a Medicare-Eligible Retiree, you must:

- Be at least age 65 or awarded Medicare due to disability;

- Complete and submit an application for Retiree coverage to the Fund Office; and

- Be a participant in the BAC of Michigan Health and Welfare Fund who has been credited with 500 hours of Employer contributions in the each of the five rolling years before you attained age 65 **and** who has been eligible for coverage under the Plan by work hours or self-payments in each of the two rolling calendar months immediately before you notified the Fund Office that you would like to receive Retiree coverage (for Union Employee Participants, the participant is eligible for benefits on the date of the application).

When you become eligible for Retiree coverage, your hour bank, if any, will be exhausted, and then you will be required to make monthly self-payments in an amount determined by the Board of Trustees from time to time, which amount is subject to change by the Board at any time.

These requirements do not apply if you were receiving benefits as an Early Retiree right before you became eligible for Medicare.

You must notify the Fund Office **immediately** if you return to work. If you are covered as a Medicare-Eligible Retiree, you must notify the Fund Office upon returning to covered employment. If you return to active employment, you will continue your Retiree coverage unless you satisfy the Initial Eligibility requirements, at which time you will be an Active Participant.

Dependents of Retirees Eligibility

A Retiree may choose either to cover him or herself only or to cover dependents as well. This choice, once made, cannot be changed. The only exception is where a Retiree's spouse was covered by the spouse's employer-provided group health plan when the Retiree coverage started, and the Retiree chose not to cover dependents. In that case, the Retiree will be allowed to add his or her dependents when the spouse's employer-provided coverage ends, but only if the election to do so is made within **30 days** of the date the spouse's coverage under her employer-provided group health plan ends. Satisfactory evidence that the spouse was in fact covered by his or her employer's group health care plan and the date such coverage terminated will be required.

Post-Retirement Marriage

If you get married after you retire, your new spouse will be eligible for coverage under the Plan on the first day of the month following your marriage, provided that an application is filed with the Fund Office within **30 days** of your marriage with sufficient evidence of such marriage. If you do not apply within 30 days, your spouse will be eligible for coverage under the Plan on the first day of the month following the month the application is received.

Medicare Notice

You (and your spouse) must enroll in Medicare Part A, Part B, and Part D as soon as you (and your spouse) are eligible in order to participate in the Fund's Medicare Advantage Plan.

If a Medicare-Eligible Retiree and Medicare-Eligible Spouse are covered under the Plan and the Medicare-Eligible Retiree elects to receive coverage under the Non-Medical Program for Retirees the Medicare-Eligible Spouse may continue to receive medical coverage under the Plan by continuing to pay the full cost of the policy.

Termination of Retiree Eligibility

Your coverage will terminate on the earliest date one of the following occurs:

- you fail to pay the monthly payment amount in full and when due; or
- you return to active employment and/or withdraw from retirement; or

- the Board of Trustees eliminates retiree coverage, which is within its discretion to do at any time.

Eligibility of Dependents

Dependent coverage does **not** include Accidental Death and Dismemberment Benefits, Weekly Disability Benefits or Loss-of-Time Credits under the provisions for Continuation of Eligibility during Short-Term Disability.

Spouses

Your legal spouse is eligible for coverage from the Fund when you are eligible. You must complete a Vital Information Form with all required information within thirty days of your becoming eligible, listing your spouse, in order for coverage for your spouse to be retroactive to the date of your eligibility. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice.

Coverage for a spouse ends immediately upon divorce from the participant. You MUST report a divorce to the Fund Office immediately and provide the Fund Office with a complete copy of the judgment or decree of divorce. If the Fund pays any benefits for your former spouse after the date of your divorce because the Fund Office did not receive a copy of the judgment or decree of divorce from you, you are personally liable to the Fund for any amounts the Fund pays in benefits for services rendered to or on behalf of your former spouse after the date of the entry of the judgment or decree of divorce but prior to notification to the Fund of the divorce, regardless of whether or not you continue to be eligible for benefits at the time the Fund discovers the divorce.

Children

Your biological children, adopted children (including children placed for adoption), and stepchildren are eligible for coverage from the Fund until the last day of the calendar month in which they reach age 26, regardless of their marital status.

Your totally and permanently disabled dependent children are eligible for coverage from the Fund, regardless of age, if the child is unmarried, incapable of self-sustaining employment by reason a physical or mental condition, he/she became disabled prior to attaining age 26, and is chiefly dependent on you for support and maintenance. You must furnish acceptable proof of such incapacity within thirty-one (31) days of the child's attainment of age 26.

The Fund will also cover a child who is named as an alternate recipient of the Employee under a Qualified Medical Child Support Order. A Qualified Medical Child Support Order ("QMCSO") is a judgment, decree or order (including a court-approved settlement agreement) entered by a court or agency that requires a group health care plan to provide

coverage to a participant's child or children. When the Fund receives an order, judgment, decree or court-approved settlement agreement regarding health care coverage, the Fund Office will make the initial determination of whether that document meets the Fund's requirements for a QMCSO. If the document is determined to be a QMCSO, the Fund will notify the parties. If the document is determined not to be a QMCSO, the Fund will send a letter describing the reason for that determination.

If you or your spouse is named full legal guardian (other than a limited or temporary guardian) of a person who is not your child and who has not yet attained age 18, that person may be eligible for coverage from the Fund under certain circumstances. You should contact the Fund Office for additional information.

NOTE: It is the exclusive responsibility of the participant and any person claiming benefits through a participant to keep the Fund appraised of his or her current address and any change in marital/family status. All documents necessary for payment of benefits and identification of beneficiaries must be submitted to the Fund Office. Medical or other expenses, no matter when incurred, are subject to denial if the Fund Office has incomplete documentation of any nature.

New Dependents

You may enroll a new dependent for coverage under the Plan within **30 days** of the date that person becomes your dependent by giving written notice to the Fund Office and including copies of the birth certificate or other proof of dependent status, such as an order of affiliation, an adoption order, marriage certificates and divorce judgments establishing the dependency of stepchildren, or a Qualified Medical Child Support Order. Eligibility for new dependents begins no sooner than 30 days prior to when notice is received, so it is to your benefit to provide notice to the Fund Office as quickly as possible. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice.

If you do not enroll one or more of your eligible dependent(s) for coverage at the time of your initial eligibility, or when you acquire the dependent, if later, because the dependent(s) has coverage under another health plan, you may enroll such an eligible dependent(s) upon the subsequent loss of the other coverage if you do so within **30 days** of the loss of the other coverage.

Termination of Dependent Eligibility

Coverage of your dependent will terminate when you cease to be eligible as set out above, or when any of the following events occur:

Termination - Spouses

A spouse's coverage ends immediately upon divorce from the participant. Both you and your former spouse have an independent obligation to notify the Fund **immediately** upon your divorce. **If you delay in providing notice of your divorce to the Fund for any reason, and the Fund pays benefits on behalf of your ineligible former spouse, you are personally liable to the Fund for any amounts paid by the Fund.** The Fund reserves the right to recover that amount from you, your former spouse, and/or both of you. It also reserves the right to recover through litigation, termination of your participation in the Fund, offsetting that amount from any future benefits payable to you, and any other lawful means.

Any coverage for a former spouse after the date of entry by the court of a judgment of divorce is available only under the terms of COBRA continuation coverage. If the Fund Office is not notified of a divorce within 60 days of the date of its entry, the Fund has no obligation to offer COBRA coverage. See page 28 for details on COBRA continuation coverage.

A spouse's coverage also ends on the date the spouse enters the Armed Forces of any country.

Termination - Children

Children who qualify as your dependents under this Plan will be eligible for benefits until the last day of the month in which they reach age 26, unless the child became totally and permanently disabled by either a mental or physical condition which commenced prior to the end of the calendar month in which the child reaches age 26, and the child is chiefly dependent upon you for support and maintenance. You must be an eligible participant and submit proof of disability to the Board of Trustees within 31 days of the date the dependent child's coverage would otherwise have terminated.

Coverage may also terminate on the earliest of the following:

- the child becomes eligible for benefits from the Fund as a result of hours worked by the child in covered employment as of the date of eligibility. However, he may be covered as a child under the Fund after losing eligibility as a participant if his parent is eligible for coverage, subject to all child coverage requirements; or

- for stepchildren only, you become divorced from the stepchild's parent as of the date of divorce; or

- the date the child enters the Armed Forces of any country.

Eligibility of Dependents after Death

The Fund offers coverage for dependents after your death that is an alternative to COBRA coverage. By law, the Fund must still offer COBRA continuation coverage. When the Fund Office is notified of the death of a participant, and the surviving spouse is under age 65, the Fund will provide the surviving spouse with a choice between COBRA continuation coverage and the Fund's Surviving Spouse continuation coverage. The Fund's Surviving Spouse continuation coverage will be the same as the coverage for Early Retirees and Permanently and Totally Disabled Participants. The cost for the coverage for surviving spouses and eligible dependents is determined by the Board of Trustees, and can be changed by them from time to time. There is no time limit on the Fund's Surviving Spouse continuation coverage (as long as the payments are received in full and on time, and the Fund continues to offer this coverage); COBRA is limited to a maximum of 36 months.

The surviving spouse has sixty (60) days from the date on the Fund Office COBRA notification to decide which coverage to choose. Once this choice is made, it is final.

Remember, it is **the dependent's** responsibility to notify the Fund Office within 60 days of the participant's death. Failure to do so could result in the dependent forfeiting any rights to continuation of coverage **retroactive to the date of the participant's death.**

COBRA Continuation Coverage

This section of the Summary Plan Description contains important information about your right to COBRA continuation coverage. **It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

COBRA continuation coverage is a temporary extension of coverage under the Plan. COBRA continuation coverage does not include Life Insurance Benefits, Accidental Death and Dismemberment or loss-of-time credits during Short Term Disability. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This is only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office and/or get a copy of the Plan Document.

The Fund Office is responsible for the day-to-day administration of COBRA continuation coverage. Both the Board of Trustees and the Fund Office representatives can be contacted at 700 Tower Drive, Suite 215 Troy, Michigan 48098, (248) 828-6000 (local) or (800) 435-4080 (toll-free). You can use the following mailing address to send any correspondence to the Fund Office or the Board of Trustees: P.O. Box 99490, Troy, Michigan 48099-9490.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA continuation coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;

- The child's parents become divorced (but see Qualified Medical Child Support Orders, page 25); or

- The child stops being eligible for coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is death of the Employee, the Employer must notify the Fund Office of the qualifying event within 30 days of any of these events.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce or legal separation of the Employee and spouse or a dependent child's loss of eligibility for coverage as a dependent child), you must notify the Fund Office. The Plan requires you to notify the Fund Office within 60 days after the qualifying event occurs. The Fund Office may require that you provide evidence that a qualifying event has taken place, such as a copy of the Judgment of Divorce or a birth certificate. You must send notification to the Fund Office, P.O. Box 99490, Troy, Michigan 48099-9490

If any of these events is not reported to the Fund Office within **60 days** from the date you would lose coverage because of the occurrence of one of the events described above **or** you do not make an election within **60 days** from the date you were sent your COBRA election notice, continuation of coverage will **not** be permitted. Note that some qualifying events result in an immediate loss of coverage (such as divorce and loss of dependent status), and some are determined on a monthly basis (such as termination of employment and loss of hours). Therefore, you should **never delay** in notifying the Fund Office of any qualifying event, or you risk losing your rights under COBRA.

How is COBRA Coverage Provided?

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event (for divorce and loss of dependent status), and on the date that Plan coverage would have otherwise been lost (for termination of employment and reduction of hours).

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. When the qualifying event

is the death of the employee, your divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of his Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. **You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must send this notice to the Fund Office, P.O. Box 99490, Troy, Michigan 48099-9490.**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children in your family can receive additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the Employee or former Employee dies, or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event's occurrence. You must send this notice to the Fund Office, P.O. Box 99490, Troy, Michigan 48099-9490.**

If you have a newborn child or have a child placed with you for adoption while your COBRA continuation coverage is in effect, you have the right to elect coverage for such child if the Fund receives notice of that birth, adoption or placement for adoption within 30 days of its occurrence. A child born or placed with you for adoption while you are receiving COBRA continuation coverage will have the same COBRA rights as your spouse or dependents who were covered by the Plan before the event that triggered COBRA coverage. Like all qualified beneficiaries with COBRA coverage, the child's continued coverage depends on the timely and uninterrupted payment of your COBRA payments.

Cost of COBRA

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you would be required to make a monthly self-payment, not to exceed 102% of the Fund's actual cost for coverage, for your continuation coverage. If the Social Security Administration determines that you were disabled at the time of termination or reduction of hours and you elect to continue coverage beyond the 18-month period, the monthly self-payment amount would not exceed 150% of the Fund's actual cost for coverage beginning on the 19th month of coverage.

You will have a grace period of at least 30 days to pay the monthly COBRA payment, except for the first monthly payment, for which you will have a one-time-only 45-day grace period.

Termination of COBRA Continuation Coverage

The law also provides that you or your dependents' COBRA continuation coverage may be **terminated** by the Fund for any of the following reasons:

- The Fund no longer provides coverage for similarly situated employees;
- Your payment for continuation coverage is not received by the Fund in a timely fashion;
- You or your dependent becomes covered under another group health plan that does not include a pre-existing conditions clause that applies to you or to a covered dependent. If you are or become covered under another group health plan, you must notify the Fund Office immediately;
- You are receiving COBRA continuation coverage because of a disability defined under the Social Security Act and Social Security determines that you are no longer disabled. You must notify the Fund Office within 30 days of the date of any final determination by the Social Security Administration that you are no longer disabled; or
- You provide written notice to the Fund Office that you wish to end your COBRA continuation coverage.

Other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Medicare Enrollment instead of COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you

Questions Related to COBRA

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office, P.O. Box 99490, Troy, Michigan 48099-9490. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov

To protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of you and your dependents. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Family and Medical Leave

The Family and Medical Leave Act of 1993 provides for up to 12 weeks of unpaid, job protected leave for certain family and medical reasons. You are eligible for such leave if you have worked for your Employer for at least 12 months **and** for at least 1,250 hours in the 12 months before the leave starts, and if your Employer is both covered by the Act and has at least 50 employees within 75 miles of where you work.

Whether you are eligible for family or medical leave is determined by your Employer, not the Fund. Both you and your Employer are required to notify the Fund if you take family or medical leave and to provide certain other information as required by the Board of Trustees. The Fund will continue coverage during the period of your family or medical leave, provided that your Employer makes contributions to the Fund at the same rate and in the same amount as if you were continuously employed during the period of your leave, and fully complies with all requirements established by the Board of Trustees.

Eligibility when Entering Military or Uniformed Service

If you enter the uniformed services of the United States ("Service") while you are eligible for benefits under the Plan, you may elect to continue coverage for all benefits under the Plan, except Death Benefits, Accidental Death and Dismemberment Benefits and Weekly Disability Benefits, for a period which is the lesser of

- the 24-month period beginning on the date on which your absence begins; or
- the period of your Service plus 90 days.

Unless you elect to use your hour bank first, as described below, continuation of coverage hereunder requires that you make a monthly payment, unless your period of Service is for less than 31 days, in which case you will receive coverage at no cost to you.

If you elect to maintain coverage during your Service by making monthly self-payments, your payment will be at the reduced, active rate for a maximum of 12 months. If you were eligible by self-payment immediately before your Service, those months will be included in this 12-month maximum. After you have made a maximum of twelve monthly self-payments at the reduced, active rate, you may continue coverage by self-payment at a rate of no more than 102% of the Fund's actual cost of coverage, until the end of the lesser of either the 24-month period beginning on the date on which your absence begins *or* the period of your Service plus 90 days.

You may choose to run out your hour bank first when you enter the Service to maintain coverage. When your hour bank becomes depleted, you can continue coverage by making self-payment at

the reduced, active rate for a maximum of 12 months, and after that, at a self-payment rate of no more than 102% of the Fund's actual cost of coverage, until the end of the lesser of either the 24-month period beginning on the date on which your absence begins *or* the period of your Service plus 90 days. The Fund will not use the hours in your hour bank to maintain your coverage without your consent.

It is your responsibility under Federal law to notify the Fund when you are called to Service.

As long as you return to covered employment or register on the Union's Out-of-Work list within 90 days of your discharge under honorable conditions from the Service (or within 24 months if you are recovering from an illness or injury incurred during or aggravated by your Service), you will not be required to satisfy the Plan's initial eligibility rules. However, if the period of your Service exceeds five years, initial eligibility requirements must be satisfied irrespective of when you return to work.

Creditable Coverage for Pre-Existing Conditions

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a Federal law, limits the amount of time that group health plans can exclude coverage for a new enrollee's pre-existing health conditions to 12 months (or 18 months for late enrollees). That waiting period (exclusion period) can be reduced by the number of months the individual was covered previously under another health plan, including COBRA coverage, so long as there has not been a gap of more than 63 days in the individual's coverage.

If your coverage under this Plan ends for any reason, you have the right to receive from the Fund a "Certificate of Group Health Plan Coverage" to present to your new group health plan. That new group health plan will then "credit" your months of coverage under this Plan against any exclusion period for pre-existing conditions imposed by the new plan, provided you did not have a gap of more than 63 days in your coverage. Details regarding your rights under HIPAA's creditable coverage for pre-existing conditions are included on the Certificate.

Benefits

Medical Benefits

Medical benefits under the Plan are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. Active Participants and Pre-Medicare Participants receive coverage under the Plan through the self-funded arrangement with BCBSM. Medicare eligible participants receive coverage under the BCBSM Medicare Advantage Part D (MAPD) policy.

Active and Pre Medicare Participants and Dependents

Summaries of Active and Pre-Medicare Retiree coverage are attached as Exhibit A at the end of this SPD.

The following participants receive medical, hospital and surgical benefits as described in this Summary:

- Active Participants, including those whose eligibility is continuing as follows:
  - by working,
  - by drawing on the hour bank,
  - by self-payments with the exception of self-payments for COBRA continuation coverage, and
  - by use of loss-of-time credits during short-term disability.
- Those whose eligibility is continuing through COBRA continuation coverage.
- Early Retirees who are not eligible for Medicare.
- Those who are eligible under the Non-Bargaining Unit Employee provisions (NBUEs).
- Permanently and Totally Disabled Participants.
- Surviving Spouses.

Please note that, unless stated otherwise, a participant's dependent(s) will receive the same coverage, services, etc. that the participant receives.

Understanding Active Participant and Pre-Medicare Retiree Coverage

This section provides information to help you understand and use your BCBSM coverage. You will find information about the following:

- Provider Networks
- Change in Network Status
- Non-Network Providers
- Nonparticipating Providers

Blue Cross Blue Shield of Michigan PPO Provider Network is designed to provide you with the highest level of benefits and the lowest out-of-pocket costs when you choose network providers. You also have the freedom to receive care from a non-network provider, but with higher out-of-pocket costs.

Provider Networks

Non-Medicare Eligible Participants and Dependents

Non-Medicare Eligible Participants and their Dependents (including Actives, Non-Bargaining Unit (Participation Agreement), Early Retirees, Surviving Spouses and Permanent and Total Disability) have access to the Blue Cross Blue Shield of Michigan PPO Provider Network in the State of Michigan and while traveling out of state. When you use PPO network providers, your out-of-pocket costs for covered services are limited to your deductible, co-insurance and co-payments.

Here is what you need to do when you need medical care:

- Choose a provider from the Blue Cross Blue Shield of Michigan PPO Provider Network (You can access the BCBSM Provider directory through bcbsm.com)
- Make your appointment directly with that provider

You do not have to choose just one provider for your care and you do not have to notify BCBSM if you decide to change physicians. Just remember to select your provider from the directory and you will stay in-network. If you would like to verify if a provider is in-network, please call the number on the back of your BCBSM ID Card.

To receive medical benefits at the in-network level, your care must be received from a Blue Cross Blue Shield of Michigan PPO provider. You do not need to use a Blue Cross Blue Shield of Michigan PPO provider for services where there is no network available. You must, however, follow any coverage requirements outlined in this Summary or the attached Exhibits.

***Special Note for Parents of Students*:** If you have dependents attending school in Michigan, but living away from home, you should help them choose a Blue Cross Blue Shield of Michigan PPO physician near their school. If you need a statewide provider directory, please call the number on the back of your BCBSM ID Card.

Change in Network Status

Your physician is your partner in managing your health care. However, physicians retire, move, or otherwise cease to be affiliated with the PPO network. Should this happen, your physician will notify you that he or she is no longer in the PPO network. If you have difficulty choosing another physician, please contact the Customer Service office for assistance. If you wish to continue care

with your current physician, a Customer Service representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

Non-Network Providers

When you receive care from a provider who is not part of the Blue Cross Blue Shield of Michigan PPO network, without a referral from a PPO provider, your care is considered out-of-network. Before choosing a non-network provider, you should verify if the service would be covered. Some services, such as your preventive care services, **are not covered out-of-network.**

Nonparticipating Providers, Nonparticipating Hospitals, Facilities and Alternative to Hospital Care Providers

Nonparticipating providers, Nonparticipating Hospitals, Facilities and Alternative to Hospital Care Providers have **not** signed agreements with BCBSM. If you receive services from a nonparticipating provider or in Nonparticipating Hospitals, Facilities and Alternative to Hospital Care Providers, you are usually required to pay providers directly and may be required to submit a claim to the Fund Office for payment.

When you use a provider or facilities that **do not participate** with BCBSM:

- You will receive payment directly from the Fund
- The amount you receive from Fund may be significantly less than the amount a nonparticipating provider or facility charges you
- You are responsible for paying the provider or facility
- You are responsible for any difference between Fund's payment and the provider's or facility's charges.

Medicare Eligible Participants and Dependents

Medicare Eligible Participants and all Medicare Eligible Dependents (Retirees, Surviving Spouses and Permanent and Total Disability) may choose to receive medical, hospital and surgical benefits through the BCBS Medicare Advantage Part D ("MAPD") plan. You pay the full cost of the MAPD plan. Summaries of Medicare Eligible Retiree coverage are attached as Exhibit B at the end of this SPD.

If you are a Medicare Eligible Retiree or Medicare Eligible Dependent, you may choose to elect the **"Non-Medical Program for Retirees"** for a special reduced self-payment. That program is described on page 42 of this summary.

Prescription Drug Benefits

The Fund has engaged BCBSM as the Pharmacy Benefit Manager for **Active Participants**. All Medicare-eligible participants, including retirees, surviving spouses, and participants with permanent and total disabilities, must be enrolled and making the required monthly self-payments

to continue coverage in the Fund. If you are or become eligible for Medicare, the Fund will continue to offer you a Prescription Drug Program through the BCBS Medicare Advantage Plan, if MAPD coverage option is elected.

You should use your BCBSM ID card whenever you fill a prescription, and should keep it as safely as you would a credit card. Loss of the card should be reported to the Fund Office immediately. You should use the card only for benefits for you, your spouse and your dependent children. Any unauthorized use of your card could result in revocation and/or the elimination of your right to have new cards issued to you in the future.

The following participants receive prescription drug benefits as described in this Summary:

- Active Participants, including those whose eligibility is continuing as follows:
  - by working,
  - by drawing on the hour bank,
  - by self-payments with the exception of self-payments for COBRA continuation coverage, and
  - by use of loss-of-time credits during short-term disability.
- Those whose eligibility is continuing through COBRA continuation coverage.
- Those who are eligible under the Non-Bargaining Unit Employee provisions (NBUEs).

Please note that unless stated otherwise, a participant's dependent(s) will receive the same coverage, services, etc. that the participant receives.

Pharmacy Savings Program

The Fund's Pharmacy Savings Program, administered by Health Plan Advocate, assists participants by identifying available manufacturer assistance coupons. All participants or beneficiaries with prescription drugs that (1) cost $400 or more and (2) have a manufacturer assistance coupon available (a "program-eligible drug") will automatically be included in the program. Health Plan Advocate will assist participants with program enrollment. Once enrolled, your final cost for any program-eligible drug(s) will be $0. If you do not cooperate with Health Plan Advocate to enroll in the program, a co-pay of up to 50% of the cost of the prescription will apply for any program-eligible drug(s).

Non-Medicare Eligible Retirees, Permanent and Total Disabled participants and Medicare Eligible Retirees who have elected the non-medical Plan (and their dependents) are not eligible for any prescription benefits from the Fund.

Dental Benefits

You may choose between Traditional Dental Benefits or Golden Dental Managed Care Program options. You may elect to decline the Dental Benefits currently offered to you and your family and will be able to do this once per year. However, your self-payment amount and the employer contributions required on your behalf will not change if you decline Dental Benefits.

Traditional Dental Benefits

If a covered person is treated by any licensed dentist, oral surgeon or hygienist (with respect to prophylaxis) the Fund will pay 100% of the Reasonable and Customary amounts for dental treatment up to $400 per Benefit Year for each Eligible Person.

All types of dental services, surgical and non-surgical, are covered under this benefit, including periodontal work, extractions (impacted and non-impacted), radiographs, consultations, orthodontics, exams and cleanings.

No separate enrollment is needed for traditional dental coverage. Benefits are payable in accordance with the Fund's schedule of dental benefits and will be paid directly to the dentist unless you submit a paid, itemized bill for services rendered. Charges in excess of the amount allowed by the Fund's schedule of benefits are your responsibility.

The Fund may enter into agreements with dental preferred provider organizations that agree to charge reduced fees to Eligible Persons. Eligible Persons may choose any licensed dentist from whom to receive services, whether or not connected with a preferred provider organization with which the Fund has an agreement. A current list of the dental preferred provider organizations, if any, can be obtained from the Fund Office.

Golden Dental Managed Care Program Option

Participants may elect, on an annual basis, to participate in the Golden Dental Managed Care Program instead of the traditional dental benefits described above. The Golden Dental Managed Care Program option allows up to $1,500 of dental benefits per Eligible Person per calendar year. If you choose the Golden Dental Managed Care Program option, you must use **your** specific Golden Dental Managed Care Program provider. If you do not use **your** Golden Dental Managed Care Program provider, claims will not be paid on your behalf. If services are performed by **your** Golden Dental Managed Care Program Provider, claims will be processed as follows, up to your yearly maximum:

- 100% of Class I Diagnostic and Preventative (examinations, cleanings, x-rays, prophylaxis and fluoride treatments *every 6 months, up to age 19)*

- 75% of Class II Restorative (fillings, routine extractions & root canals)
- 60% of Class III Prosthetics (crowns, bridges and dentures, & *partials)*
- 50% of Class IV Specialty Care (oral surgery, endodontics, & periodontics)

In addition, Golden Dental will pay 50% of the Orthodontic Coverage expenses for each Eligible Person, up to a lifetime maximum of $1,800 per Eligible Person.

Vision Benefits

The Plan provides coverage for expenses incurred for eye examinations, eyeglass lenses, eyeglass frames and contact lenses up to the amount stated in the Schedule of Benefits. But, you may elect to decline the Vision Benefits currently offered to you and your family. You will be able to do this once per year. Your self-payment amounts, and the employer contributions required on your behalf will not change if you decline Vision Benefits.

This benefit provides for an eye examination, frames and lenses or contact lenses (in lieu of frames and lenses) **once every calendar year** for active participants, COBRA participants, NBUE participants and their eligible dependents.

This benefit also provides for an eye examination, frames and lenses or contact lenses (in lieu of frames and lenses) **once every two calendar years** for Early Retirees, Medicare-Eligible Retirees, Permanently and Totally Disabled Participants, Surviving Spouses and their eligible dependents.

Vision benefits are **not** provided for the following services:

- Sunglasses, unless they are prescribed to be worn at substantially all times;
- Glasses with tinted lenses, scratch coat, UV protection, and other specialty items;
- Routine yearly examinations required by an employer in connection with the occupation of the individual;
- Vision expense for covered services resulting from occupational bodily injury or disease;
- Vision expense for covered services in a hospital owned or operated by the Federal Government or for which the Employee is not required to pay;
- Any vision care to the extent that benefits for the service or supply is payable under any other insurance or group policy;
- A service or supply not furnished by a licensed physician, optometrist or ophthalmologist
- Service or supplies in connection with occupationally related conditions.

The Plan pays l00% of covered expenses up to the following benefit limits once each calendar year (for active participants, COBRA participants, NBUE participants and their eligible dependents) or

once every two calendar years (for Early Retirees, Medicare-Eligible Retirees, Permanently and Totally Disabled Participants, Surviving Spouses and their eligible dependents):

Examination Fee	50.00
Single Lenses (Pair)	75.00
Bifocal Lenses (Pair)	90.00
Trifocal Lenses (Pair)	100.00
Frames	100.00
Contact Lenses (in lieu of frames and lenses)	140.00

You are free to use any provider you wish - eligible persons are not required to go to any specific providers, you are encouraged to shop around for the best arrangement you can make.

Depending on your provider, you may be required to pay up front for whatever services or materials you receive, or the provider may bill the Fund directly. Payment will be in accordance with the Fund's schedule of benefits, but not more than the actual cost.

You will be responsible to pay any amounts charged which are in excess of the applicable maximum amount payable under the Fund's schedule of vision care benefits.

Non-Medical Program for Retirees

Instead of the regular retiree program which includes medical coverage, retirees may elect to enroll in a special non-medical program, and receive the following coverages only, for a special reduced monthly self-payment established by the Board of Trustees. That rate may change from time to time at the discretion of the Board of Trustees. This is one-time option that must be elected at the time of eligibility for retiree benefits.

Dental: Either $400 each calendar year for Traditional Benefits or $1,500 each calendar year if Golden Dental Managed Care Program dental benefits are elected,

Vision: Every two years coverage for up to $50 per exam, $100 for frames, $75 for single vision lenses, $90 for bi-focal lenses, $100 for tri-focal lenses or $140 for contacts in lieu of frames and lenses.

Death Benefit: $1,000 for the Retiree only

The Fund does not provide any prescription drug benefits to Non-Medicare Eligible Retirees.

Weekly Disability Benefits (Active Participants Other Than S-1 NBUES)

All Active Participants (other than **S-1 NBUEs** participants) are eligible for Weekly Disability Benefits (subject to all other terms and requirements on the Fund's Plan).

If you are covered by the Fund and are unable to work because of an accident occurring **off** the job or any illness **not** connected with employment or an auto accident, you will be entitled to $200 in Weekly Disability Benefits for a period of 26 continuous weeks or the period of your disability, whichever is shorter, after you file an application with the Fund Office. You will not be eligible for Weekly Disability Benefits for any weeks in which you are collecting State unemployment benefits. Payment for any one payable day of disability benefits is $1/7^{th}$ of the weekly benefit amount.

If you are eligible for Weekly Disability Benefits, you are also eligible for Loss-of-Time Credit (see page 16 of this Summary for an explanation of that Credit).

If your disability is due to an accident, the accident must have occurred when you were actively employed and eligible for benefits under the Plan based on your active employment. You must also be under the care of a physician or surgeon. However, an Employee who is eligible by reason of self-payment shall not be eligible for Weekly Disability Benefits if his disability is incurred after the first four consecutive months of self-payments and while the Employee is still making self-payments.

Benefits begin on the first day of disability due to an accident, and on the eighth day of disability due to an illness (which include pregnancy and substance abuse). If you are pregnant, your period of disability due to that pregnancy is normally considered to be for the period six weeks prior to the delivery date through the six to eight weeks following the delivery date. You must provide medical documentation deemed sufficient by the Board of Trustees to receive Weekly Disability Benefits for a longer period, not to exceed the twenty-six (26) continuous week maximum.

Note: You must apply for Weekly Disability Benefits within **180 days** from the onset of your disability on a form provided by the Fund Office.

You will not be eligible for a new period of Weekly Disability Benefits until you have been re-employed in Covered Employment on a full-time basis for a minimum of one (1) day (eight hours of work). Under no circumstances will you be eligible for more than three (3) disability periods as a result of disability due to the same cause.

Non-working Owners and other S-1 NBUEs (see page 20 of this Booklet) are <u>not</u> entitled to Weekly Disability Benefits (or continuation of coverage during short-term disability).

Death Benefits

Amounts Payable

The amount of Death Benefits payable from the Fund upon your death varies based on whether you are an Active Participant or a Retired Participant on the date of your death. Death Benefits are payable from Fund assets based on the death of your dependents only while you are an Active Participant, and they are otherwise eligible for coverage (this is not an insured benefit).

Description of Deceased	
• Active Participants (Including those whose coverage is continuing through the hour bank, self-payments or during short term disability and NBUEs)	$10,000
• Dependents of Active Participants (Including Spouse and Dependent Children)	$1,000
• Retiree (Early Retiree or Medicare-Eligible Retiree)	$1,000
• Permanently and Totally Disabled Participant	$1,000
• Surviving Spouse	$500

Benefits are payable upon the death of your dependent only if you are an Active Participant on the date of your dependent's death. The Death Benefit for dependents ends when the dependent loses dependent status (e.g. because the dependent spouse is no longer married to the participant, the dependent spouse or child became eligible for insurance under the Fund as a participant, the dependent child attains age 26).

However, if your coverage terminates due to your death, and your dependents are otherwise eligible for coverage, they will continue to have Death Benefit coverage until your hour bank falls below 130 hours.

Application Procedure

Upon receipt of acceptable proof of death (usually a death certificate), a Death Benefit is payable as stated in the Schedule of Benefits. Written notice of the death must be given to the Fund Office within one year of the date of death; if later, no Death Benefit will be paid.

An application on a form prescribed and furnished by the Plan must be completed by anyone wishing to be considered for a Death Benefit, accompanied by such documentation, identification and proofs as the Board of Trustees may require.

Beneficiaries

Active Participants, Medicare-Eligible Retirees, Early Retirees, Permanently and Totally Disabled Participants and Surviving Spouses: You may designate the beneficiary to whom a Death Benefit shall be paid; if more than one (1) beneficiary is designated, the beneficiaries will share equally.

The designation of your spouse as a beneficiary is automatically canceled upon entry of a judgment or decree of divorce. You may designate a former spouse as your beneficiary, but must make this designation on a beneficiary designation card **after** your divorce to do so. If you die, and your ex-spouse remains designated as your beneficiary, on a card you filled out before you were divorced, any Death Benefit payable on your behalf will be paid as though you had no valid designation on file with the Fund, because that designation automatically terminated upon your divorce.

If, upon your death, no beneficiary has been designated; the designated beneficiary has predeceased you; or the designated beneficiary is your ex-spouse designated as your beneficiary prior to the divorce, any Death Benefit payable will be paid to the first of the following:

(1) your spouse at the time of death, but if none are living,

(2) all children then living in equal shares, but if none are living,

(3) parents in equal shares, but if none are living,

(4) all brothers and sisters then living in equal shares, but if none are living,

(5) any individual(s) that is a beneficiary of the deceased's estate, in equal shares, but if there is no estate,

(6) the individual(s) identified as entitled to a share of the deceased's property in a sworn Affidavit of Decedent's Successor for Delivery of Certain Assets Owned by Decedent with respect to the Participant, in accordance with MCL §§700.3983-700.3984, in proportion to the shares identified on the form.

If there are none of the foregoing, then no Death Benefit is payable.

Beneficiaries for Dependents: You are the beneficiary of the Death Benefit provided for your dependents under the Plan, if you are living. If you are not living, then the beneficiary is your spouse. If your spouse is not living, the dependent's siblings are the beneficiaries in equal shares. If there are no siblings, your dependent's estate is the beneficiary. If there are none of the foregoing, then no Death Benefit is payable on behalf of your Dependent.

Change of Beneficiary: You have the right to change your beneficiary at any time by written notice, submitted directly to the Fund Office, and the change will become effective on the date of receipt by the Fund Office, except that the Fund will not honor any beneficiary designation received by the Fund Office after the date of death.

Burial Expenses: The Plan may pay a benefit to any individual who submits an application accompanied by proof that the individual incurred the expenses in connection with the covered person's burial, which are unreimbursed from any other source. The amount to be paid hereunder shall be equal to the lesser of $500 or the unreimbursed amount and will be subtracted from the full Death Benefit payable.

Any payment that the Fund makes according to the Plan's provisions regarding the designation of beneficiaries will be made in good faith and will fully release the Plan of any further responsibility for such payment.

Time for Filing

Written notice of death must be received by the Fund Office within **one year** of the date of death. If it is not received by then, no Death Benefit will be paid.

Termination of Eligibility for Death Benefit

No Death Benefit will be payable for events that occur after the earliest of the following dates:

- The date the participant's eligibility for benefits under the Plan terminates;
- The date the participant enters the Armed Forces or other uniformed services of any Country or at any time during the period of his service;
- The date the participant elects COBRA continuation coverage; or
- The date this Plan no longer provides this benefit.

Accidental Death and Dismemberment Benefits

Accidental Death and Dismemberment Benefits are payable from the Fund's assets (these benefits are not insured) on behalf of an Active Participant (including a NBUE) who is eligible through working or drawing on his hour bank. Participants maintaining eligibility by self-payment or

through loss-of-time credits, Retired Participants, Totally and Permanently Disabled Participants, Surviving Spouses, and those covered pursuant to the provisions of COBRA continuation coverage and Dependents are not eligible for the Accidental Death and Dismemberment Benefit

Amounts Payable

Description	Benefit
Accidental Death (in addition to Death Benefit)	$10,000
Loss of Both Hands or Both Feet	$2,000
Loss of Entire Sight of Both Eyes	$2,000
Loss of One Hand and One Foot	$2,000
Loss of One Hand or One Foot and Entire Sight of One Eye	$2,000
Loss of One Hand or One Foot	$1,000
Loss of Entire Sight of One Eye	$1,000

With respect to a hand or foot, "loss" means complete severance through or above the wrist or ankle joint. With respect to an eye, "loss" means the irrevocable loss of the entire sight thereof. Accidental Death and Dismemberment Benefits will not be paid for more than one of the losses sustained by the Covered Employee as the result of any one accident.

Benefits under these provisions will be paid directly to you if you are still living. If you are not living, benefits will be paid to your designated beneficiary or beneficiaries. You may designate any person(s) of your choice as your beneficiary (or beneficiaries), and you may change your beneficiary at any time by completing forms that are available at the Fund Office. If you have not named a beneficiary or if your beneficiary predeceases you and you do not name a replacement, your Accidental Death and Dismemberment Benefits will be paid as follows: to your widow or widower; or, if none, to your surviving children in equal shares; or, if none, to your estate.

Termination of Eligibility for Accidental Death and Dismemberment Benefit

No benefits will be issued after the earliest of the following dates:

- The date the you stop being eligible for such benefits as described above;
- The date you enter the military, naval or air force of any country or at any time during the period of your service; or
- The date this Plan no longer provides this benefit.

Time for Filing

Written notice of your death or dismemberment must be received by the Fund Office within **one year** of the date of death or dismemberment. If it is not received by then, no benefits will be paid for accidental death or dismemberment.

Exclusions

Accidental Death and Dismemberment Benefits are **not** paid for losses caused by:

- War or any act of war, whether war is declared or undeclared;
- Disease or infection, except pyogenic or septic infection of visible wound that resulted because of an accident; or
- Loss or injury while participating in or as the result of the commission of a criminal act.

Health Reimbursement Account – Marble Shop Employees

Pursuant to the Merger Agreement with the Tile, Marble & Terrazzo Insurance Trust Fund ("TMT Fund") the Fund agreed to recognize the HRA balances of a subset of TMT Fund Participants (the "Marble Shop Employees") that existed as of January 1, 2017, but it will not permit the addition of funds to the HRAs beyond the funds required to be credited from Marble Shop Employees' work hours for December 2016. The HRA account is a bookkeeping account only – it cannot be cashed out and it does not vest. The Board of Trustees may terminate the account at any time. The HRA balances can be used until they are exhausted as provided below.

Permitted Uses

Marble Shop Employees may use the HRAs to reimburse amounts incurred for qualified medical, dental, vision or prescription drug expenses, as defined in Section 213(d) of the Internal Revenue Code, which are not covered by the Fund due to co-payments, maximum allowable benefits, or services that are not payable under the Plan, and to pay self-payment amounts which may be due to continue coverage. A Marble Shop Employee and/or his Spouse and Dependents, as applicable, shall complete and submit an HRA Claim Form accompanied by all written proofs that the Fund shall request in order to apply for HRA benefits.

Cancellation of HRA Balance

The account balance shall be reduced or cancelled, as applicable, upon the earliest of the following to occur:

i. Use of the HRA as described above.

ii. Twenty-four (24) months after the termination of the Marble Shop Employee's coverage.

iii. Immediately upon a Marble Shop Employee's written election to waive future use of the HRA, which shall be permitted each January 1.

iv. Immediately upon a former Marble Shop Employee's written election to waive future use of the HRA.

v. The latest of:

1. the death of the Marble Shop Employee, or

2. the death of the Surviving Spouse, or

3. the death of another Dependent.

vi. The termination of the HRA provisions of the Plan by the Board of Trustees.

Claims Applications, Limits and Appeals

Applying for Benefits

When you use your benefits, a claim must be filed before payment can be made. Most providers will submit claims to the Fund for payment for the Fund's share of any covered benefits you receive from them. However, if for some reason a provider does not do so, contact the Fund Office for assistance in filing such claims.

Filing a Claim

For all claims, other than medical and prescription benefits, you must submit a claim form to the Fund Office. Claim forms can be found in the Forms page of the Participant Web Portal or by calling the Fund Office.

All medical service providers, BCBS PPO Network or non-BCBS PPO Network, must bill the local BCBS Plan. If an Out-of-Network provider does not accept an assignment of your benefits and you pay directly for services, you may submit the paid receipt to the Fund with a claim form for appropriate reimbursement. All claims and supporting documentation must be submitted to the Fund Office by you. All prescription service providers must bill Blue Cross Blue Shield of Michigan – Pharmacy Benefit Manager for payment of the Fund's share of any covered benefits you receive from them. If you participate in the Golden Dental Managed Care plan; dental service

providers must bill Golden Dental for payment of the Fund's share of any covered benefits you receive from them

If you use Network providers, they will file claims and will be paid pursuant to contract. If your Out-of-Network provider requests a claim form, it is available by calling the Fund Office or from the Forms page of the BCBSM's Participant Web Portal. To check on the status of your claim, you may contact the Office.

If for some reason a provider does not follow the above procedure for a claim, please contact the Fund Office for assistance in filing such claims.

To avoid delays in processing your claims, remember the following:

- Notify the Fund Office of your claim as soon as possible after it is incurred. Be careful not to exceed the time limits set out throughout this Summary.
- Submit a **complete and itemized bill** with "ICD-9" and "CPT" codes. Balance forward statements, cash register receipts and canceled checks are not acceptable.
- Submit accident information as soon as possible.
- File your claims as quickly as possible.
- If the Fund Office requests additional information from you, please respond promptly.
- If you have already paid your physician for services, indicate on your claim that payment has been made and send the Fund Office a copy of a complete and itemized bill with "ICD-9" and "CPT" codes and evidence that the bill has been paid.
- Notify the Fund Office of any change of address.

Time Limits for Filing Claims

The Fund requires that all claims for medical, hospital, surgical and prescription drug benefits must be submitted for reimbursement within **12 months** from the date of service for facility claims and **6 months** from the date of service for professional claims. All claims for vision and dental benefits must be submitted for reimbursement within **90 days** from the date of service. All claims for Death Benefits and Accidental Death and Dismemberment Benefits must be filed within **one year** from the date of the death or accidental dismemberment. All claims for Weekly Disability Benefits must be filed within **180 days** from the onset of disability. Applications for Loss-of-Time Credit must be filed within **180 days** of the accident or onset of the sickness. After these time limits have passed, the Fund is no longer obligated to pay or reimburse the amount of the claim.

If you fail to provide the Fund Office with notice or proof of claim by the applicable deadline, the claim may still be paid if your failure was because of reasons beyond your control, or if you provided such notice or proof as soon as reasonably possible and no later than one (l) year from the time notice or proof was otherwise required (except if you were legally incapacitated). The Fund Office will process all claims for benefits made by Covered Persons.

Circumstances That Can Result in Denial of Claims or Loss of Benefits

The Board of Trustees or its representatives have the authority to deny payment for claims, and the reasons for denial may include, but are not limited to, one or more of the following:

- The person receiving the services or seeking the benefit was not eligible for the specific benefit sought and/or any benefit under the Plan when the expense was incurred.

- The claim was not received by the Fund within the applicable time limit.

- The expense was for services not covered by the Fund or the expense was not actually incurred.

- The person for whom the claim was filed already received the maximum benefit for the type of benefit.

- The person for whom the claim was filed had not yet satisfied all required deductibles and percent co-payment requirements imposed by the Fund.

- The person for whom the claim was filed (or another person on their behalf) failed to sign the Fund's subrogation agreement, failed to cooperate with the Fund's right of reimbursement, or failed to remit the Fund's reimbursable amount from a recovery, including a partial recovery (in which case, future claims will be denied up to the amount of the Fund's reimbursable amount).

- Another entity was primarily responsible for paying benefits (see the Fund's rules on coordination of benefits, below).

- Eligibility rules were changed, coverage was eliminated, or the benefit was reduced or discontinued by action of the Board of Trustees before the services were received.

- The Fund was terminated.

The above list does not list every reason a claim may be denied. It is only representative of the types of circumstances that might lead to a denial of a claim. If you have questions about a claim

denial, contact the Fund Office, and be certain to review the section below regarding Appeals to avoid loss of rights.

If your claim is denied by the Fund Office, you will be notified with the specific reason for denial within 30 days. In unusual circumstances, additional time will be required to process your claim. You will be notified when additional time is needed.

If your claim is denied by any of the Fund's service providers, you will be informed of the reason for the denial on the "Explanation of Benefits" ("EOB") you receive. If the denial is due to missing information or a missing signature, you should supply the information directly to the service provider. If the denial is due to any other reason and you believe that the claim should have been covered, you should follow the procedure set out below and in the EOB for appealing a denial of your benefit claim.

Appeals

Every effort is made to process your claims promptly and correctly. If your claim for benefits or eligibility is denied in whole or in part, the Fund Office or a Fund Service Provider will notify you of the denial in writing. To appeal the denial or payment, you must follow those steps.

A. Appeals procedures for Active Participants, Non-Medicare Eligible Participants and their beneficiaries and Eligibility Appeals for all Participants

If you need help understanding your EOB that you receive or the Fund's decision to deny you eligibility, a service or coverage, contact the Fund office at (248) 828-6000 or 800-435-4080 Any such denial is called 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, including any such denial based on your eligibility to participate in the Fund. If you don't agree with this decision you have a right to appeal it by filing an appeal. The appeal procedures will depend on whether you claim is an Eligibility claim, Pre-Service claim, Urgent Care Claim or Post-Service Claim.

"Eligibility claim" means a claim requesting coverage as participant and/or dependent in the plan of the BAC of Michigan Health and Welfare Fund.

"Pre-service claim" means a claim for a benefit where the Plan conditions receipt of the benefit, completely or in part, on obtaining approval in advance of receiving medical care.

"Urgent care claim" means a claim for medical care or treatment where applying the time periods for non-urgent determinations could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician who knows your

medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

A claim will be found to be one involving urgent care in one of two ways. If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, the Fund will treat it as such. Absent a determination by your physician, whether a claim is one involving urgent care will be determined by using the judgment of a prudent layperson with average knowledge of health and medicine.

"Post-service claim" means all other claims that are not "eligibility claims", "pre-service claims" or "urgent care claims."

To obtain review of an adverse benefit determination, you must follow the review procedures below.

You must submit the appeal in writing within 180 Days after you receive a denial of benefits to the Board of Trustees, BAC of Michigan Health and Welfare Fund, P.O. Box 99490, Troy, Michigan 48099-9490. The appeal should be in writing, but an appeal of the denial of an urgent care claim may be requested by telephone. No special form is required. Just be sure that the appeal explains your position as clearly as possible. You have the right to appoint someone else (such as a lawyer) to prepare and submit the appeal to the Fund. Make sure your name, Subscriber ID number, trade and name of the claimant (such as your spouse) are included to avoid delays in processing your appeal.

You, or your representative, will have the opportunity to review pertinent documents and other information relevant to the claim free of charge upon submission of a written request. Reasonable access to, and copies of, relevant information will be provided upon request. Whether information or a document is "relevant" is determined in accordance with ERISA Regulation §2560.503-1(m)(8), 29 CFR 2560.503-1(m)(8).

You or your representative, may submit issues, comments, additional legal arguments, and new information in writing to the Board of Trustees for its consideration in the appeal. The Board's review of the appeal will take into account all materials and information received before the review, whether or not that information was previously submitted or considered in the initial determination on the claim.

The Board of Trustees reviews the claim on appeal de novo (which means "anew" and without deference to the original determination) and it will review the additional materials and information submitted, if any.

The Board of Trustees will respond to appeals of denials of claims no later than 72 hours after receiving an appeal of a denial of an **urgent care claim**, no later than 30 days after receiving an appeal of a **pre-service non-urgent care claim**, and no later than 5 days after

the Board of Trustees' first regularly scheduled meeting after receiving an appeal of a claim for **post-service care** or **eligibility claims**, unless the appeal is filed less than 30 days prior to such meeting, in which case it will be reviewed at the subsequent Board of Trustees' meeting.

If, due to special circumstances, the Board of Trustees requires additional time to review the appeal of a claim for post-service care, the claimant will be notified in writing of the special circumstances and when a determination will be made. The Board of Trustees will communicate its decision and the reasons therefor in writing within 5 days after it makes its decision on the appeal.

You will be notified, in writing, of the Board of Trustees' decision with respect to your appeal, including (if your appeal is denied) the reasons and specific references to Plan documents upon which the Board's decision was based.

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

- No fees or costs may be imposed as a condition to requesting review.
- You may submit written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination.
- If your 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, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.
- Upon request, the medical experts whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be advised and provided an explanation of the scientific or clinical judgment free of charge upon request.

The Board of Trustees has the sole and exclusive discretion to interpret and to apply the rules of the Plan, the Trust, and other rules and regulations.

Please note that under the law, no action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of these under or relating to the Plan is barred unless it is brought within ***three years*** after the first date the participant or beneficiary receives a determination of his rights and/or benefits under the terms of the Fund's Plan, unless a shorter period is established by applicable statute, regulation or case law. Also, any action in law or equity brought by a participant or beneficiary against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to this Plan ***must be brought in the United States District Court where the Plan is administered.***

You should seek legal advice with respect to these requirements.

B. Appeals procedures for Medicare Eligible Participants and their beneficiaries

Benefits to the Medicare Eligible Participants and their beneficiaries are provided through an insurance contract(s) with Blue Cross Blue Shield of Michigan Medicare Advantage Part D (MAPD) plan. You will receive an Explanation of Benefits from BCBSM for any service covered under that contract. If you do not agree with any parts of that EOB, please follow the appeal procedures detailed on the EOB. The Fund will only hear appeals related to eligibility to participate in the Plan. Those procedures are detailed above.

Additional Administrative Matters

Facility of Payment

In the event of your death or mental incompetence at a time when benefits remain unpaid, such benefits will be paid to the person or institution who incurred the Covered Charges if the charges have not otherwise been paid.

Examinations

The Board of Trustees has the right to ask a doctor of its choice to examine a person for whom benefits are being claimed. It also has the right to examine any and all hospital or medical records relating to a claim.

Trustee Interpretation and Authority

Under the terms of the Plan and the Trust establishing the Fund, the Board of Trustees has the sole authority to interpret and apply the rules of the Plan, the Trust and any other rules and regulations,

procedures or administrative rules adopted by the Board of Trustees. Decisions of the Board of Trustees or, where Trustee responsibility has been delegated to others, its delegates, will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Board of Trustees or its authorized delegates is challenged in court, the Trust Agreement provides that such decision is to be upheld unless a court with proper jurisdiction finds and issues a decision that it was arbitrary and capricious.

All benefits under the Plan are subject to the Board of Trustees' authority under the Trust Agreement to change them. The Board of Trustees has the authority to increase, decrease, change, amend and terminate benefits, eligibility rules or other provisions of the Plan as it may determine to be in the best interests of the Plan participants and beneficiaries.

The Plan is maintained for the exclusive benefit of the Plan's participants and their eligible dependents. All rights and benefits granted to a participant under the Plan are legally enforceable.

The right to change or eliminate any and all aspects of benefits provided for retirees and their dependents is a right specifically reserved to the Board of Trustees, since coverage for retirees and their dependents, like all of the benefits from the Fund, is not an accrued or vested benefit. The Board of Trustees has the authority to amend or terminate such benefits and to modify or increase the self-payment amount for coverage at any time. Any such change shall be effective even though an employee has already become a retiree, or has met the eligibility requirements to retire now or in the future.

Workers' Compensation Not Affected

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

Plan Discontinuation or Termination

The Fund and its Plan may be discontinued or terminated under certain circumstances - for example, if future collective bargaining agreements and participation agreements do not require contributions to the Plan. In such event, benefits for covered expenses incurred by the termination date will be paid on behalf of eligible participants and their dependents as long as the Fund's assets are more than its liabilities. Full benefits may not be paid if the Fund's liabilities are more than its assets, and benefit payments will be limited to the funds available. The Board of Trustees will not be liable for the adequacy or inadequacy of such funds. If there are any assets remaining after payment of Fund liabilities, those assets will be used for purposes determined by the Board of Trustees according to the Trust Agreement.

Right of Offset

If any payment is made by the Fund to or on behalf of a person who is not entitled to the payment or to the full amount of such payment, the Fund has the right to reduce future payments to that person or to the person responsible for the erroneous payment by the amount of the erroneous payment. This right of offset will not limit the right of the Fund to recover such erroneous payments in any other manner.

Legal Actions – Time Limits for Filing and Jurisdiction

You may not file legal action against the Fund or its Trustees until you have followed all of the proper claim and claim appeal procedures. Under the terms of the Plan, any lawsuit brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of these under or relating to the Plan is barred unless it is brought within three years after the first date the participant or beneficiary receives a determination of his rights and/or benefits under the terms of the Fund's Plan, unless a shorter period is established by applicable statute, regulation or case law. Also, any action in law or equity brought by a participant or beneficiary against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to this Plan must be brought in the United States District Court where the Plan is administered.

Altered or Forged Claims

Any claim form or other materials submitted by or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Board of Trustees reserves the right to forward such matters to appropriate law enforcement agencies for whatever action deemed appropriate. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any manner.

Notice of Hours Worked

Each month the Fund Office will mail you a statement listing a summary of hours worked during the previous contribution month so that you may compare the Fund's records to your pay stubs and information about the balance in your hour bank.

You must report any discrepancy to the Fund Office or BAC Local #2 immediately. The Fund, through its collections committees, and/or BAC Local #2 will investigate the issue and pursue collection of unpaid contributions on the Fund's behalf.

If your Employer fails to remit contributions based on your work, the Fund will pursue collection, but you are responsible for maintaining your coverage by self-payment. If the Fund recovers some or all of the unpaid contributions, your self-payment amounts will be refunded to you based on the extent of the recovery.

Right to Obtain, Require and Rely on Information

The Board of Trustees shall have the right to require, as a condition precedent to the payment of any benefit under the Plan, all information which they reasonably deem necessary, including records of employment, proof of dates of birth and death, marital status, independent medical examinations of any person for whom benefits are being claimed, any and all medical records relating to a claim, etc., and no benefit dependent in any way upon such information shall be payable unless and until such information so required is furnished. Such evidence shall be furnished by the Unions, the Associations, Employers, Employees, participants, Dependents, beneficiaries, alternate recipients or the representative of any of them.

The Board of Trustees shall, in the absence of contrary evidence presented to them, have the right in administering the plan to rely upon information provided to them by the Unions, the Associations, Employers, Employees, participants, Dependents, beneficiaries, alternate recipients or the representatives of any of them. Neither they nor the Fund shall be held liable for good faith reliance thereon.

Medicare

Eligibility for Medicare

You and any of your covered dependents are eligible for Medicare, the health program provided under Social Security for people 65 and older, if:

- You (or any of your covered dependents) are age 65 or older;
- You (or any of your covered dependents who have received Social Security Disability benefits for 24 months or longer) are under age 65; or
- You (or any of your covered dependents) qualify as an eligible person who needs hemodialysis treatment or a kidney transplant because of chronic kidney disease.

Contact your Social Security Administration office three (3) months prior to your 65th birthday, or, if you are otherwise eligible, to find out the enrollment requirements.

Medicare has two kinds of health insurance available to you and your covered dependents.

- Part A, the hospital insurance, helps with the cost of hospitalization and related care. Part A Medicare is automatic for those 65 and over and for disabled persons under 65. Hemodialysis patients must apply for Part A through a Social Security Administration Office.

- Part B, the medical insurance, helps pay doctor bills and other medical expenses. Part B Medicare is voluntary. All persons entitled to coverage under Part A can enroll in Part B.

When you are eligible for Medicare, you and your spouse must enroll for Part B Medicare in order to enroll in the Fund's Plan.

If you have any questions about your Medicare benefits or Medicare's enrollment requirements, consult a Medicare office.

Medicare also has prescription drug insurance available to you and your covered dependents through Medicare Part D programs. **Medicare-eligible participants and retirees receive IMPORTANT additional information regarding Medicare Part D annually. Please contact the Fund Office if you have not received that information or if you would like another copy.**

Coordination with Medicare

Medicare is generally primary if:

- You or any of your covered dependents is over age 65 and not actively working;
- You or any of your covered dependents is under age 65 and have received Social Security Disability benefits for 24 months or longer;
- You or any of your covered dependents is under age 65 and qualifies for Medicare because he needs hemodialysis treatment or a kidney transplant because of chronic kidney disease.

When Medicare is primary, you must file any medical claims with Medicare first. The BCBSM MAPD policy available to Medicare-eligible Retirees under this Fund will adjust its benefit payment taking into account the amount approved and paid by Medicare.

The BAC of Michigan Health and Welfare Fund is considered primary if:

- You are over age 65 and still actively working;
- You are under age 65 and

  - have received Social Security Disability Benefits for less than 24 months;
  - need hemodialysis treatment or a kidney transplant because of chronic kidney disease, but you have not met Medicare's eligibility requirements;
  - have been an end stage renal disease (ESRD) patient for less than 30 months during a period in which you have retained coverage under the Fund as an active Employee.

When the Fund is primary, claims must be filed with the Fund first. The Fund will pay its regular benefit in full. Any claim amounts not paid by the Fund may be filed with Medicare. Medicare will review the claim to determine if it will pay any benefits in addition to the benefits paid by the Fund.

It is intended that the participant and his/her eligible dependents be fully reimbursed for Covered Charges under this Fund and Parts A and B Medicare, to the extent that the combined benefits do not exceed 100% of the total covered charges. Covered Charges are those for which payments may be made under the Fund and are subject to the general benefit limitations and maximums described elsewhere in this booklet.

If an individual is eligible to enroll for Medicare benefits, the Fund will not pay a provider in excess of the amount the Fund would pay if the provider bills and is paid through Medicare.

You should contact the Fund Office if you have any questions concerning the effect Medicare will have on your coverage.

Dependents on Medicare

If you are eligible by way of hours worked in covered employment, the Fund will be the primary payer of benefits to your dependent who is on Medicare because of age or disability. In addition, special rules apply to a person with end-stage renal disease under Medicare. Check with the Fund Office or your local Social Security office for additional information on this.

Medicaid

For participants and dependents eligible for Medicaid benefits, the Fund will reimburse Medicaid payments made to participants and dependents as required under state Medicaid laws, the Fund will ignore Medicaid eligibility when enrolling a participant or dependent or making any benefit payment determination, and the Fund will comply with any subrogation rights required under state Medicaid laws.

Coordination with Medicaid: If you or your dependents are entitled to Medicaid at the same time you are eligible for benefits from the Fund, the Fund will be the primary payer of benefits.

Coordination of Benefits/Non-Duplication of Benefits

Benefits from the Plan are subject to, and limited to, amounts payable in accordance with these COORDINATION OF BENEFITS (COB) Rules. The purpose of these Rules is to avoid duplicate or overlapping payments of benefits resulting in unjust overpayments. The COB Rules apply

generally to all benefits payable from the Plan other than Death, and Accidental Death and Dismemberment. COB Rules come into play whenever any individual has coverage under the Plan and any other group insurance program, health and welfare fund, BCBSM MAPD Plan, Medicare, or other health care plan.

This Plan excludes coverage and will pay no benefits for treatment of injuries resulting from an automobile or motor vehicle accident. Therefore, coordination of benefits is unnecessary with respect to no-fault automobile insurance coverage because there are no benefits for motor vehicle related injuries provided from this Fund. You should carefully review this with your automobile or other motor vehicle insurance carrier to make certain that your own insurance is adequate in this regard.

Generally speaking, the following rules are applied to determine whether the BAC of Michigan Health and Welfare Fund or the other health care plan, fund, policy, contract, program, or statutory payer pays first in accordance with its Schedule of Benefits.

If the Employee terminates his employment and becomes employed by another employer that provides a health insurance program other than the BAC of Michigan Health and Welfare Fund, then that Employer's health insurance program is primary for the coverage. **The BAC of Michigan Health and Welfare Fund will be secondary only.**

(1) If the other plan, fund, policy, contract, program, or statutory payer has not adopted a coordination of benefits provision, it shall be required to pay first.

(2) If both have coordination of benefits provisions, then

a. the plan in which the covered person is covered as an "employee" shall pay in accordance with its Schedule of Benefits as primary and the one in which the covered person is covered as a "dependent" shall pay any remaining balance up to its maximum Schedule of Benefits.

b. the plan that covers the covered person as an active employee or dependent of an active employee shall pay in accordance with its Schedule of Benefits as primary and the plan that covers the individual as a COBRA participant shall pay any remaining balance up to its maximum Schedule of Benefits.

c. where the claim is for an eligible dependent child, the following order of priority shall be followed in determining which plan, fund, policy, contract, program or statutory payer shall pay first:

1. the plan covering the child's parent who has the earlier birthdate anniversary in the calendar year shall be primary;

2. if both parents have the same birthdate, the plan that covered the child for the longer period of time shall be primary;

3. if the child's biological parents are divorced, or legally separated, the plan covering the biological parent who has the earlier birthdate anniversary in the calendar year shall be primary. If both biological parents have the same birthdate, the plan that covered the child for longer period of time shall be primary. If the biological parent with the earlier birthday anniversary in the calendar year is remarried, the plan covering his or her spouse is primary over that which covers the other biological parent, irrespective of the birthday anniversary in the calendar year of the spouse of the biological parent who has the earlier birthday anniversary in the calendar year;

d. where the claim is for an individual who is both a dependent child under this Plan and a dependent spouse under the plan of his or her spouse, the following order of priority shall be followed in determining which health and welfare plan, fund, policy, contract or program shall pay as primary:

1. the plan covering the covered parent or the covered spouse who has the earlier birthdate anniversary in the calendar year shall be primary;

2. if both the covered parent and the covered spouse have the same birthdate, the plan that covered the child/spouse for the longer period of time shall be primary.

Subrogation and Reimbursement

In the event of any payments of services to or on behalf of any person under this Plan, the Fund shall, to the extent of such payments, be subrogated to all rights of recovery of that person (or his representative(s)) arising out of any claim or cause of action which may accrue against a third party, including any occupationally related claim or cause of action covered by the Michigan Workers' Disability Compensation Act or Occupational Disease Act or similar federal or state statutes. That person (or his representative(s)), by acceptance of benefits provided by this Fund, hereby agrees to reimburse the Fund for any benefits so paid hereunder out of monies recovered, fully or partially, from such third party as the result of judgment, settlement or otherwise, irrespective of how differentiated, without any offset for expenses, including legal fees, that person (or his representative(s)) may owe, and before that person (or his representative(s)) pays any other individual, organization or entity out of that full or partial recovery. That person (or his representative(s)) may take no action which would prejudice the Fund and/or any of the Fund's designees' rights, and that person (or his representative(s)) hereby agrees to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Trustees may require to facilitate the enforcement of the Fund's rights. The Fund and/or any of the Fund's designees will not be responsible for attorney's fees or costs incurred and/or paid by

or on behalf of that person (or his representative(s)) unless the Fund and/or any of the Fund's designees has agreed in writing to pay such fees or costs or some portion thereof.

If the Fund and/or any of the Fund's designees pays benefits on behalf of any person and that person (or his representative(s)) receives a settlement, that person (or his representative(s)) must repay the Fund and/or any of the Fund's designees up to the amount of benefits it/they have paid. If that person (or his representative(s)) does not do so, the Fund and/or any of the Fund's designees has the right to treat the amount of benefits paid as a debt of that person (or his representative(s)) to the Fund and/or any of the Fund's designees and may pursue recovery of said amount from that person (or his representative(s)) and/or reduce any future benefits payable on behalf of that person (or his representative(s)) in this amount until this debt has been cancelled.

Restitution where Benefits Improperly Received

The Fund and its Board of Trustees shall have the right to pursue restitution from any person who receives benefits of any description from the Fund to which such person was not entitled, whether by virtue of the ineligibility of such person at the time services were rendered, by virtue of receipt of excluded benefits or otherwise.

Exclusions and Limitations (Applicable to all Benefits)

Exclusion of Coverage for Auto-Vehicular Accidents

The Fund ***excludes*** coverage for any claim arising out of an auto or other vehicular accident. "Vehicle" includes all usual forms of transportation designed primarily for use on public highways, including autos, motorcycles, vans, pick-up trucks, etc. Consequently, all Eligible Persons are expected to cover themselves for auto and other vehicular-related accident claims under their individual insurance policies.

It is important that eligible persons check with their respective insurance agent and/or their insurance carrier to make certain they are completely covered under their policy for any claims arising out of a vehicular accident. They should make it perfectly clear to their agent or carrier that the Fund completely excludes coverage for vehicular-related accidents. Therefore, no one covered by this Plan should buy a coordinated automobile policy.

However, Death Benefits and Accidental Death and Dismemberment Benefits continue to be payable for any loss resulting from automobile or vehicular accidents.

Other Exclusions

Except as may be provided for under the terms of the Plan, the Plan shall not provide benefits for the following:

The Fund will **NOT** provide for care and services not covered as medically necessary or appropriate under Blue Cross Blue Shield of Michigan Medical Policy.

The Fund will **NOT** provide for treatment of injuries sustained in a motor vehicle accident or other motor vehicle licensed to be on the road or complications resulting from such injuries or accident, except Death Benefits and Accidental Death and Dismemberment Benefits. The term "vehicle" includes all usual forms of transportation designed primarily for use on public highways, including autos, motorcycles, vans, pick-up trucks, etc.

The Fund will **NOT** provide for loss or expense from sickness, or disease that entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law, or as a result of any accidental bodily injury, which arises out of or in the course of employment for pay or profit.

The Fund will **NOT** provide for care and services available at no cost in veteran's, marine or other hospital, facility, or institution owned or operated by or on behalf of any national government, its agencies or a political subdivision thereof, unless a charge is imposed and an itemized bill for services is submitted, or for care obtainable without cost from governmental agencies.

The Fund will **NOT** provide for treatment of a condition caused by military action or war or determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

The Fund will **NOT** provide for care and services payable by government-sponsored health care programs such as Medicare or TRICARE, except as provided under the Plan's contract with BCBSM Medicare Advantage Plan.

The Fund will **NOT** provide for payment to the extent that such payment is prohibited by any law of the jurisdiction where the covered person resides at the time the expenses are incurred.

The Fund will **NOT** provide for services that the covered person is not legally required to pay, that would not be charged if no coverage existed, for which a charge is not customarily made, for services available without cost, or for any nonresident tax levied by a community hospital.

The Fund will **NOT** provide for any procedure, care or treatment for which the medical necessity cannot be proven to the satisfaction of the Plan, except allergy treatments and reconstruction after mastectomy.

The Fund will **NOT** provide for services outside the scope of the license of the institution or practitioner rendering the services.

The Fund will **NOT** provide for custodial care, rest therapy, education, training, or bed and board while confined to an institution that is primarily a school or other institution for training, a place of rest, or a place for the aged.

The Fund will **NOT** provide for services for treatment of an illness or injury due to declared or undeclared war or any act thereof, active participation in a riot, the commission of or attempted commission of an assault or felony, or engagement in any unlawful act.

The Fund will **NOT** pay for office visits to Out-of-Network providers.

The Fund will **NOT** provide for services and supplies that are not medically necessary according to accepted standards of medical practice, including cosmetic surgery solely for improving appearance, except that coverage will be provided for 1) reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast for symmetrical appearance and prostheses and physical complications in all stages of mastectomy; 2) to correct a condition resulting from a congenital anomaly; or 3) to correct a condition resulting from an accident (excluding auto/vehicular accidents).

The Fund will **NOT** provide for drugs, devices, medical treatments or procedures that are experimental or investigative, including organ transplants, except as required by section 2709 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act. The terms "experimental" or "investigative" mean medical practices, procedures, treatment, services, drugs, or supplies that are considered experimental or investigational by, or not approved by, the Food and Drug Administration or the Department of Health and Human Services.

The Fund will **NOT** provide for expense incurred for in-vitro fertilization or artificial insemination.

The Fund will **NOT** provide for reversing sterilization.

The Fund will **NOT** provide for pre-employment, pre-marital, school or sports examination provided by non-network providers.

The Fund will **NOT** provide for routine treatment or services primarily for weight loss or control, unless necessitated as the direct result of a specifically identifiable and diagnosed condition or disease etiology, except bariatric surgery, which is covered as set forth in the attached Exhibits.

The Fund will **NOT** provide for acupuncture, hypnotism or any goal-oriented behavior modification type therapy.

The Fund will **NOT** provide for air conditioners, purifiers, humidifiers, dehumidifiers, whirlpool, heating pads, hot water bottles, waterbeds, bandages and support garments, rubber gloves,

treadmills, exercise equipment, lift chairs, and other equipment that does not constitute medically necessary durable medical equipment, even if prescribed by a physician.

The Fund will **NOT** provide for expenses incurred or resulting from self-inflicted injuries, unless the injuries resulted from a medical condition such as depression.

The Fund will **NOT** provide for travel or transportation by other than professional ground ambulance.

The Fund will **NOT** provide for services in connection with speech therapy, unless the speech therapy 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).

The Fund will **NOT** provide for care or treatment rendered by a member of the covered person's family or by a person normally residing in the covered person's home.

The Fund will **NOT** provide for hospital admissions, medical services and supplies provided **prior** to the effective date of coverage or **after** the coverage termination date.

The Fund will **NOT** provide for treatment of temporal mandibular jaw disorders ("TMJ"), however, diagnosis of TMJ may be covered through the Dental Benefit.

The Fund will **NOT** provide for the use of a private room. If used, the average semi-private room rate of that hospital will be paid, except private room accommodations required by the hospital for treatment in quarantine purposes and not for the comfort of the patient.

The Fund will **NOT** provide for charges for hospital rooms in excess of the hospital's regular charges.

The Fund will **NOT** provide for services and/or supplies for personal comfort items such as, television, telephones, lotion, powder, transportation within hospital, guest trays or other non-essential personal items and services, including take-home prescription drugs and supplies, etc.

The Fund will **NOT** provide for services and/or supplies for recreational or educational therapy, massage therapy, or some forms of non-medical self-care or self-help training.

The Fund will **NOT** provide for nutritional and dietary supplements

The Fund will **NOT** provide for psychiatric services after determination that a condition will not respond to treatment.

The Fund will **NOT** provide for psychological tests for guidance or counseling for vocational purposes.

The Fund will **NOT** provide for drugs that require a prescription by state law, but not Federal law.

The Fund will **NOT** provide for administration of drugs or any drug consumed at the time and place of the prescription order.

The Fund will **NOT** provide for refills not authorized by a physician.

The Fund will **NOT** provide for more than a one-month supply of prescription drugs (except for specified maintenance drugs that are covered for 90 days).

The Fund will **NOT** provide for refills dispensed after one year from the date of the original order.

The Fund will **NOT** provide for drugs dispensed for cosmetic purposes.

The Fund will **NOT** provide for hospital confinement or other medical expenses due to a child of a dependent child, unless that grandchild is also a dependent of the participant subject to the requirements for Coverage for Dependents. The Plan will not provide for hospital confinement and other medical expenses due to a second or subsequent pregnancy of a dependent child.

The Fund will **NOT** provide for voluntary termination of pregnancy (abortions) for dependent children, unless medically necessary.

The Fund will **NOT** provide for non-prescription (over-the-counter) drugs.

Note: The above list is not a complete list of items not covered by the Plan. An item that does not appear as an exclusion is not automatically covered as a benefit.

LEGAL NOTICES

ERISA Rights

As a participant in the BAC of Michigan Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and the union hall, all Plan documents including collective bargaining agreements and copies of all documents filed by the Fund with the United States Department of Labor, such as detailed annual reports and Plan descriptions;

- Obtain copies of all Plan documents and other Plan information upon written request to the Board of Trustees, the Plan Administrator. The Fund will, however, make a reasonable charge established by the Board of Trustees for furnishing the copies;

- Receive a summary of the Plan's annual financial report. The Board of Trustees is required by law to furnish each participant with a copy of this summary annual report;

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. See page 28 of this summary plan description on the rules governing your COBRA continuation coverage rights; and

- Reduction or elimination of the exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage for another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, who are 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, the union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you may be entitled 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 a right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay 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, for example, if it finds your claim to be frivolous.

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, located at Cincinnati Regional Office 1885 Dixie Hwy, Ste 210, Ft. Wright, KY 41011-2664, Tel (859) 578-4680 Fax (859) 578-4688, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You can read the materials listed above by making an appointment at the Fund Office during normal business hours. In addition, copies of the materials will be mailed to you if you send a written request to the Fund Office. There will be a per-page charge for copying some of the materials. Before requesting materials, call the Fund Office and find out the cost. If a charge is made, your check must be attached to your request for the material.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). "Loss of eligibility" includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It does not include a loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim. However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at BAC of Michigan Health and Welfare Fund, P.O. Box 99490, Troy, MI 48099-9490, (248) 828-6000.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending provider and the patient.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, contact the Fund Office at BAC of Michigan Health and Welfare Fund, P.O. Box 99490, Troy, MI 48099-9490, (248) 828-6000.

The Fund has provided coverage for mastectomies for a number of years. As part of this coverage, the Plan also covered the procedures necessary to effect reconstruction of the breast on which the mastectomy was performed, as well as the cost of prostheses and physical complications of all stages of mastectomy, including lymph edemas, as recommended by the attending physician of any patient receiving Plan benefits in connection with the mastectomy and in consultation with the patient. The Plan also covers any surgery and reconstruction of the other breast to achieve a symmetrical appearance.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally 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 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 earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal

law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of the Privacy Practices of the BAC of Michigan Health and Welfare Fund

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND CONTACT THE FUND'S PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS.

The BAC of Michigan Health and Welfare Fund ("Plan") is required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) to make sure that health information that identifies you is kept private to the extent required by law.

The Plan is also required to give you this Notice regarding

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

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic) and, when applicable, includes "genetic information." De-identified information, which does not identify an individual and that cannot reasonably be expected to be used to identify an individual, is not PHI.

This Notice and its contents are intended to conform to the requirements of HIPAA. Please be advised that other entities that provide services to you related to your participation in the Plan have issued or may issue separate notices regarding disclosure of PHI that is maintained on the Plan's behalf by those entities.

Section 1 How the Plan May Use and Disclose PHI About You

The following categories describe different ways that the Plan uses and discloses PHI. Not every use or disclosure in each category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories. Except for the purposes described in the categories below, we will use and disclose PHI only with your written authorization. You may revoke such authorization at any time by writing to the Plan's Privacy Officer.

Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

For Payment. The Plan may use and disclose PHI about you for payment purposes such as to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. The Plan may also share PHI with a utilization review or precertification service provider. Likewise, the Plan may share PHI with another entity to assist with the coordination of benefit payments.

For Health Care Operations. The Plan may use and disclose PHI about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use PHI in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Plan administrative activities. The disclosure of PHI that is genetic information for underwriting purposes is prohibited and the Plan will not disclose any of your genetic information for such purposes.

To Inform You About Treatment, Treatment Alternatives or Other Health Related Benefits. The Plan may use your PHI for treatment purposes and other related benefits. The Plan may use your PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination, or (4) recommended alternative treatments, therapies, health care providers, or settings of care. For instance, the Plan may forward a communication to a participant who is a smoker regarding a smoking-cessation program.

For Disclosure to the Fund's Board of Trustees. The Plan may disclose your PHI to the Plan's Board of Trustees (Plan Sponsor) for plan administration functions performed by the Plan Sponsor on behalf of the Plan including, but not limited to, reviewing appeals. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or for modifying, amending or terminating the group health plan. "Summary health information" is information that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with federal regulations.

Business Associates. The Plan may disclose PHI to its business associates that perform functions on the Plan's behalf or provide the Plan with services if the information is necessary for such functions or services. For example, the Plan may use another company to perform billing services on its behalf. All of the Plan's business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in their agreement with the Plan.

Section 2 Other Uses and Disclosures for Which Consent, Authorization or Opportunity to Agree or Object is Not Required

When Legally Required. The Plan will disclose your PHI when it is required to do so by any federal, state or local law.

For Public Health Activities. The Plan may disclose your PHI for public health activities such as the reporting of vital events such as birth or death or the tracking of products regulated by the Food and Drug Administration.

For Reporting Abuse, Neglect or Domestic Violence. The Plan may disclose your PHI when required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

To Conduct Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, the Plan may not disclose your PHI if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, the Plan may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to you of the request or, if such assurance is not forthcoming, if the Plan has made a reasonable effort to notify you about the request or to obtain an order protecting your PHI.

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your PHI to a law enforcement official for certain law enforcement purposes, including the reporting of certain types of wounds, upon the request of a law enforcement official for locating a suspect, fugitive, material witness, missing person, or crime victim, to report a death, to report a crime on the premises and to report a crime in a medical emergency. A disclosure of information about an individual who is or is suspected to be a crime victim may be made only if a) the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement

because of emergency circumstances, b) the law enforcement official represents that the information is not intended to be used against the individual and the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and c) the Plan determines disclosure is in the best interest of the individual as determined by the exercise of its best judgment.

To Coroners, Medical Examiners and Funeral Directors. The Plan may release PHI to coroners or medical examiners for duties authorized by law or to funeral directors consistent with applicable law.

Organ and Tissue Donation. If you are an organ donor, the Plan may release PHI to organizations that handle organ procurement or transplantation.

For Research. The Plan may disclose your PHI for research subject to certain conditions regarding the manner in which the research is conducted.

In the Event of a Serious Threat to Health or Safety. The Plan may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person when consistent with applicable law and standards of ethical conduct and the Plan in good faith believes such use or disclosure is necessary.

For Specified Government Functions. In certain circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans affairs, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Workers' Compensation. The Plan may release your PHI to the extent necessary to comply with laws related to workers' compensation or similar programs.

Other Uses and Disclosures

The Plan will not (1) supply confidential information to another entity for its marketing purposes in violation of the privacy regulations, or (2) sell your confidential information in violation of the privacy regulations.

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to the Plan will be made only if you provide a written authorization.

The Plan asks you to complete an authorization form if you would like someone, such as a spouse, to be able to have access to your PHI.

If you provide the Plan with written authorization to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use

or disclose PHI about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures that the Plan has already made with your permission.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

You have the following rights:

The right to request restrictions or limitations on the PHI the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. The Plan is not, however, required to agree to your request with the exception of a request for a restriction of a disclosure of PHI pertaining solely to a health care item or service for which the health care provider involved has been paid out of pocket that is for purposes of carrying out payment or health care operations (and not for the purposes of carrying out treatment).

To request restrictions, you must make your request in writing to the Plan's Privacy Officer. In your request, you must tell the Plan (1) what information you want to limit, (2) whether you want to limit the Plan's use, disclosure or both; and (3) to whom the limits apply.

The right to request to receive confidential communication of your PHI by an alternative means or at an alternative location if a disclosure of your PHI could endanger you. The request must be made in writing to the Plan's Privacy Officer and must specify the alternative location or other method of communication that you prefer (for example, using an alternate address). Your request must include a statement that the restriction is necessary to prevent a disclosure that could endanger you. The Plan does not refuse to accommodate such a request unless the request imposes an unreasonable administrative burden. If the request is granted, the documentation of your request will be placed in your record.

The right to access documents regarding your eligibility, payment of claims, appeals or other similar documents in your Designated Record Set for inspection and/or copying. If the information you request is in an electronic health record, you may request that these records be transmitted electronically. Your request for access to documents with your PHI must be in writing to the Plan's Privacy Officer. When a request for access is accepted (in whole or in part), you will be notified of the decisions and you may then inspect the PHI, copy it, or both, in the form or format requested at a time and place convenient to you and the Plan. If you would like, you may receive a summary of the requested PHI instead of your entire record, for a reasonable fee. You may also receive a copy of your PHI by mail if you prefer. (The Plan charges a reasonable, cost-based fee for copying, including labor and supplies [for instance, paper, computer disks] and for postage if you request that the information be mailed. No fee is charged for retrieving or handling the PHI or for

processing the participant's request for access.)

If a request for access is denied (in whole or in part), the Plan will grant access to PHI for which there are no grounds to deny access. The Plan will also inform you why your request for access was denied, how to appeal the denial (if the denial is reviewable), and how to file complaints with the Plan and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, the Plan will designate a licensed health care professional, not involved in the original denial decision, to serve as a reviewing official, and will notify you in writing of the reviewing official's determination.

The right to request to amend your PHI if it is inaccurate or incomplete. You may request that your PHI be amended. That request must be in writing to the Fund's Privacy Officer and include a reason why your PHI should be amended. If you do not include a reason, the Plan will not act on the request. When a request for amendment is accepted (in whole or in part), the Plan will inform you that your request for amendment has been accepted. The Plan will request from you permission to contact other individuals or health care entities that you identify that need to be informed of the amendment(s), and will inform them and other entities with whom the Plan does business who may rely on the disputed PHI to your detriment. The Plan will identify the record(s) that are the subject of the amendment request and will append the amendment to the record.

If a request for amendment is denied, you will be notified why the request was denied (e.g., the information requested was not created by the Plan, is accurate and complete, is not part of the record, or may not legally be changed such as information compiled in anticipation of a civil, criminal or administrative proceeding), how to file a statement of disagreement or a request that the Plan provide the request for amendment and the denial in any future release of the disputed PHI, and how to file a complaint with the Plan or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, the Plan may write a rebuttal statement and will provide a copy to the participant, and the Plan will include the request for amendment, denial letter, statement of disagreement, and rebuttal (if any), with any future disclosures of the disputed PHI. If you do not choose to write a statement of disagreement with the denial decision, the Plan is not required to include the request for amendment and denial decision letter with future disclosures of the disputed PHI unless you request the Plan to do so. When the Plan receives notification that your PHI has been amended, the Plan will ensure that the amendment is appended to your records, and will inform entities with whom it does business that may use or rely on your PHI of the amendment and require them to make the necessary corrections.

The right to obtain an accounting of disclosures of your PHI. The right to an accounting extends to disclosures, other than disclosures made (1) for the purposes of treatment, payment or health care operations, including those made to business associates (vendors), (2) to an individual (or personal representative) about his or her own PHI, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for national security or intelligence purposes and (8) to correctional institutions or law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to the Plan's Privacy Officer. Your request must specify a time period, which may not be longer than six (6) years. You may request and receive an accounting of disclosures once during any twelve (12) month period for no charge. If you request more than one accounting within the same twelve (12) month period, a reasonable, cost-based fee may be charged. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You also have the right to an accounting of disclosures of electronic health records for purposes of payment, treatment and health care operations. The right to such an accounting depends on whether the Plan maintains such electronic health records and, if so, when the electronic health records were acquired by the Plan and when the disclosure occurred.

The right to receive a paper copy of this Notice and any revisions to this Notice. You may request a copy of this Notice is writing to the Plan's Privacy Officer at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

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

- a power of attorney for health care purposes;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- a birth certificate identifying the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

LEGAL DUTIES OF THE BAC OF MICHIGAN HEALTH AND WELFARE FUND REGARDING YOUR HEALTH INFORMATION

The Plan is required by law to maintain the privacy of your PHI as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. If your PHI is improperly accessed, acquired, used, or disclosed, the Plan will notify you, as required by law. That notification may include a description of what happened, the information involved, and the steps you can take to protect yourself.

The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice

provisions effective for all PHI the Plan has about you as well as any information the Plan receives in the future. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

Section 3 Minimum Necessary Standard

When using, disclosing or requesting PHI, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual or pursuant to an authorization;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

YOUR RIGHT TO FILE A COMPLAINT

You have the right to express complaints to the BAC of Michigan Health and Welfare Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the BAC of Michigan Health and Welfare Fund should be made in writing to the Fund's Privacy Officer. The BAC of Michigan Health and Welfare Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

FOR MORE INFORMATION CONTACT THE PRIVACY OFFICER

For questions about this Notice, to exercise your privacy rights, or to file a complaint, contact the Plan's Privacy Officer, BAC of Michigan Health and Welfare Fund, P.O. Box 99490, Troy, MI 48099-9490, (248) 828-6000.

BAC of Michigan Health and Welfare Fund - Social Security Number Privacy Policy

The BAC of Michigan Health and Welfare Fund is required by Michigan law to make sure that your Social Security number and the Social Security numbers of your family members are kept private as set forth in that law.

The law permits the Fund to use Social Security numbers to verify your identity and the identities of your family members and to perform other functions related to providing health and welfare benefits under the Fund's Plan. Therefore, the Fund will continue to require Social Security numbers on application and enrollment forms. When your employer pays contributions on your behalf, the law permits your employer to provide the Fund with your Social Security number so that the Fund may determine your eligibility status. The law also permits the Fund to use Social Security numbers when authorized or required to do so by state or federal statute, by court order, or pursuant to legal discovery or process. The Fund will ensure to the extent practicable the confidentiality of those Social Security numbers.

In order to protect your privacy and in compliance with the law, the Fund will use alternate identification numbers wherever feasible, including on benefits cards and explanations of benefits. The Fund does not print Social Security numbers on the exterior of any envelope or package sent through the mail or in a manner that can be seen from the exterior of such envelope or package. The Fund's website is secure and permits participants to access information through use of a password other than your Social Security number.

Only Fund employees and Fund service providers may access the Social Security numbers of Fund participants and family members and only as necessary to provide services to the Fund. The Fund uses practical means to limit access to written and electronic records in its possession that contain Social Security numbers to those Fund employees and service providers whose job duties require such access, such as securing areas where Social Security number information is located when not in use and requiring the use of passwords for access to electronic files containing Social Security numbers. The Fund disposes of documents that contain Social Security numbers that the Fund is not actively using or is not otherwise obligated to retain by shredding and other processes that protect the confidentiality of the Social Security numbers. Fund employees must not disclose Social Security numbers by publicly displaying more than four sequential digits of a Social Security number or in any other manner prohibited by law.

The Fund notifies all service providers that they must ensure, to the extent practicable, the Confidentiality of all Social Security numbers related to Fund participants and their families as required by law. The Fund may take action regarding service providers who fail to protect adequately the confidentiality of those Social Security numbers, including the termination of contracts.

The Fund disciplines its employees who violate this Policy, up to and including termination.

BAC of Michigan Health and Welfare Fund - Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by a nonparticipating provider at a participating hospital or ambulatory surgical center, you are protected from balance or surprise billing.

What is balance billing?

Balance billing – sometimes called surprise billing – is when you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that doesn't participate with your health plan.

"Nonparticipating" describes providers and facilities that haven't signed a contract with your health plan. Nonparticipating providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care — such as when you have an emergency or schedule a visit at a participating facility but are unexpectedly treated by a nonparticipating provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from a nonparticipating provider or facility, the most the provider or facility may bill you is your plan's in-network out-of-pocket amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Depending on your plan, you may have additional protections under Michigan law if you receive post-stabilization services from a nonparticipating provider when you're in a participating facility. If your plan is governed by Michigan law, those providers can't balance bill you even if you give written consent.

Certain services at a participating hospital or ambulatory surgical center

When you get services from a participating hospital or ambulatory surgical center, certain providers there may be nonparticipating. In these cases, the most those providers may bill you is your plan's in-network out-of-pocket amount. This applies to emergency medicine, anesthesia, pathology, radiology,

laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these participating facilities, nonparticipating providers **can't** balance bill you unless you give written consent and give up your protections. **You're never required to give up your protections from balance billing. You also aren't required to get care from a nonparticipating provider. You can choose a provider or facility in your plan's network.**

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (such as copayments, coinsurance and deductibles that you would pay if the provider or facility was in network). Your health plan will pay nonparticipating providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization)
    - Cover emergency services by nonparticipating providers
    - Base what you owe the provider or facility (out-of-pocket costs) on what it would pay an in-network provider or facility and show that amount in your explanation of benefit
    - Count any amount you pay for emergency services or services rendered by nonparticipating providers in the circumstances outlined above toward your deductible and out-of-pocket limit

If you believe you've been incorrectly billed, contact the No Surprises Help Desk at 1-800-985-3059. Visit http://michigan.gov/difs for more information about your rights under Michigan law.

NOTES

PLAN OF THE

BAC OF MICHIGAN HEALTH AND WELFARE FUND

Plan in effect as of January 1, 2022

PLAN OF THE
BAC OF MICHIGAN
HEALTH AND WELFARE FUND

(Plan in effect as of January 1, 2022)

Pursuant to the authority granted to it by the Agreement and Declaration of Trust, the Board of Trustees of the BAC of Michigan Health and Welfare Fund hereby adopts and continues this Plan, effective May 1, 2014. Since that date, the 2014 Plan has been amended eight times and what follows is the Plan in effect as of January 1, 2022.

ARTICLE I: DEFINITION OF TERMS

The following words and phrases shall have the following meanings when used in the Plan, unless a different meaning is plainly required by the context.

Section 1: Active Participant

The term "Active Participant" means a Participant who is eligible pursuant to Article II, Section 1, or Article II, Section 2.

Section 2: Associations

The term "Associations" shall mean the Associated Concrete Contractors of Michigan, the AGC of Michigan, and the Mason Contractors Association, Inc.

Section 3: Benefit Year

The term "Benefit Year" means the 12-month accounting period of the Plan for purposes of benefits and claims processing, which begins on January 1 and ends on December 31 of each calendar year.

Section 4: Board of Trustees

The term "Board of Trustees" or "Board" means the Board of Trustees of the BAC of Michigan Health and Welfare Fund, as set forth in the Fund's Agreement and Declaration of Trust, as it may be amended from time to time.

Section 5: Dependent

The term "Dependent" means:

a. The current lawful spouse of a Participant.

   A spouse's dependent coverage ends immediately upon divorce from the Participant. By seeking spousal coverage, each Participant agrees that he shall be personally liable to the

Fund for any amounts the Fund pays in benefits for services rendered to or on behalf of the former spouse after the date of the entry of the judgment or decree of divorce but prior to notification to the Fund of the divorce, irrespective of whether such Participant continues to be eligible for benefits at the time of the Fund's discovery of the divorce, demand for repayment or at any time of reference.

b. A child or a Participant, as defined immediately below, at the Participant's election, regardless of the child's marital status. A Participant's election to disenroll a child who was previously covered as a Dependent hereunder must be in writing and on a form satisfactory to the Board filed with the Fund administrative office. Such election shall be effective as soon as administratively feasible, but not before the first day of the month following the month within which notice is received by the Fund.

"Child" is defined herein as the Participant's biological sons and daughters, adopted children (including children placed for adoption) and stepchildren, prior to the last day of the calendar month in which such child reaches age twenty-six (26) years.

c. No child shall be considered a Dependent under this Plan after the end of the calendar month in which the child attains the age of twenty-six (26) years, except that any child who becomes totally and permanently disabled from either a physical or mental condition prior to the end of the calendar month in which he attains the age of twenty-six (26) shall continue as a Dependent for as long as the disability exists and he is chiefly dependent upon the Participant for support and maintenance, at the Participant's election in accordance with the procedure set forth in Article I, Section 6(b) above.

d. At the Participant's election in accordance with the procedure set forth in Article I, Section 6(b) above, a person who has not yet attained age eighteen (18) years of whom a Participant or spouse is named full legal guardian (other than a limited or temporary guardian). Notwithstanding the preceding sentence, a person who is not the child of a Participant or spouse shall not be a "Dependent" under this subsection unless (1) the parents of such child do not claim the child as a dependent; and (2) the Participant or spouse's adjusted gross income is higher than the highest adjusted gross income of any of the person's parents. The Fund shall require proof that this requirement is satisfied prior to any individual being considered a Dependent hereunder.

Status as a Dependent shall require such documentation as the Board may require from time to time, including, but not limited to, Federal income tax records, adoption records, physician's statements, birth certificates, marriage certificates, qualified medical child support orders, and judgments of divorce.

Section 6: Eligible Person

The term "Eligible Person" means an eligible Participant, an eligible Dependent or an eligible Retiree.

Section 7: Employee

The term "Employee" means:

a. Any person who is or has been employed by one or more Employers to perform tasks coming within the trade jurisdiction of the Union, and

b. Any person who is employed by the Union, a board of trustees, committee or other agency established through collective bargaining between the Union and one or more of the Associations to administer or be responsible for fringe benefit funds, educational or other programs, on whose behalf the Employer is obligated, pursuant to a Health Agreement, to make Employer contributions to the Fund in an amount determined by the Board, and

c. Any person who is employed by an Employer that is bound to a collective bargaining agreement with the Union, but who performs any work under any terms which are not in accordance with the collective bargaining agreement negotiated by the Union, and whose Employer elects to contribute to the Fund based on behalf of such employee pursuant to a Health Agreement under such other terms and conditions as the Board may prescribe, and to make Employer contributions to the Fund in an amount determined by the Board.

Section 8: Employer

The term "Employer" means:

a. Any member of one or more of the Associations and any other individual, partnership, corporation or other business entity which uses or employs the services of individuals performing tasks coming within the work jurisdiction of the Union and who is obligated, pursuant to a Health Agreement, to make Employer contributions to the Fund at the rate established through collective bargaining between the Union and one or more of the Associations, and

b. The Union, or any board of trustees, committee or other agency established to administer or be responsible for fringe benefit funds, educational or other programs established through collective bargaining by the Union and one or more of the Associations, to the extent, and solely to the extent, that it acts as an Employer of its Employees in whose behalf it is obligated, pursuant to a Health Agreement, to make Employer contributions to the Fund in an amount determined by the Board, and

c. Any member of one or more of the Associations and any other individual, partnership, corporation or other business entity which uses or employs the services of individuals performing tasks coming within the work jurisdiction of the Union with respect to employees not included in the bargaining unit represented by the Union, who elects to contribute on such non-bargaining unit personnel pursuant to a Health Agreement under such other terms and conditions as the Board may prescribe, and to make Employer contributions to the Fund in an amount determined by the Board.

Section 9: Fund

The term "Fund" means the BAC of Michigan Health and Welfare Fund and all assets of the Fund.

Section 10: Health Agreement

The term "Health Agreement" shall mean any collective bargaining agreement or article thereof or other agreement which provides for Employer contributions to the Fund (or adopts, expressly or implicitly, a written agreement which so provides) and details the basis upon which such contributions are to be made.

Section 11: Hourly Reserve Bank

The term "Hourly Reserve Bank" means a record maintained by the Fund for each Employee defined in Article I, Section 8(a) and Working Owner defined in Article I, Section 17(b) of any hours of covered employment and Employer contributions which the Fund has received in excess of those hours of covered employment and Employer contributions required to maintain eligibility, less any hours of covered employment and Employer contributions subtracted for such Employee to maintain his continuing eligibility pursuant to the provisions of the Plan for time periods in which the Fund has received less than the number of hours of covered employment and Employer contributions required for his continued eligibility. An Hourly Reserve Bank shall not be established for any Non-Working Owner or Sole Proprietor.

In no event shall the number of hours maintained in any Employee's hour bank exceed 520[1].

A Participant shall retain credit for any hours of covered employment and Employer contributions remaining in his Hourly Reserve Bank for a period of 12 consecutive months after the termination of his eligibility, after which his Hourly Reserve Bank will be terminated.

Section 12: Hours of Work

Hours of Work shall be the units by which each Employee's eligibility for participation and benefits in the Fund is determined. For all Employees except Fund Employees, Hours of Work shall be determined based on the work hours received at the contribution rate required for journeymen in the Agreement Between Bricklayers' and Allied Craftworkers Local No. 2 of Michigan, Bricklayers and Allied Craftworkers International Union Of North America, AFL-CIO And Labor-Management Cooperation Committee ("Bricklayers Agreement"). If contributions are received at a lower rate than the one specified in the Bricklayers Agreement, Hours of Work shall be pro-rated accordingly.

Section 13: Illness

[1] Employees whose hourly reserve bank as of June 1, 2019 was above 480 because they were grandfathered at a higher reserve bank pursuant to the Plan changes made effective March 1, 2004 (where the hour bank was lowered from 720 hours to 480) will be allowed to add additional hours to their maximum hourly reserve bank, so the hour bank covers the same number of months of eligibility as prior to June 1, 2019.

The term "Illness" means any kind of bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage or complications of pregnancy. An Illness includes injuries that a person sustains in an accident, other than a vehicular accident.

Section 14: Non-Bargaining Unit Employee

The term "Non-Bargaining Unit Employee" or "NBUE" means any Employee employed by an Employer to perform tasks outside the work jurisdiction of the Union who is classified as one of the following:

a. The "Non-Working Owner" classification includes the following Employees who do not perform any work within the work jurisdiction of the Union: shareholders of incorporated Employers, estimators, general superintendents, designated managing partners of partnership Employer, and non-owner non-bargaining unit Employees, including, but not limited to, those who perform only clerical work for the Employer.

b. The "Working Owner" classification includes shareholders of incorporated Employers and non-managing partners of partnership Employer who are performing work within the work jurisdiction of the Union.

c. The "Sole Proprietor" classification includes the sole proprietors of Employers.

d. The "Fund Employee" classification includes Employees of the Fund.

e. The "Union Employee" classification includes Employees of the Union.

Section 15: Participant

The term "Participant" means any Employee or former Employee of a contributing Employer or a Retiree who has met and continues to meet the eligibility requirements of the Plan and any rules and regulations established by the Board.

Section 16: Plan Year

The term "Plan Year" means the 12-month fiscal accounting period of the Plan, which begins on May 1 of each year and ends on April 30 of the following year.

Section 17: Qualified Medical Child Support Order

The term "Qualified Medical Child Support Order" means a medical support order that creates or recognizes the existence of an alternate recipient's right to receive benefits as a Dependent under this Plan.

Section 18: Retired Participant or Eligible Retiree

The term "Retired Participant" or "Eligible Retiree" means a person who is eligible for benefits pursuant to Article II, Section 8 of this Plan either as an Early Retiree or as a Medicare-Eligible Retiree.

Section 19: Spouse

The term "Spouse" means an individual who is legally married to a Participant. The designation of a Spouse as a Dependent or beneficiary of a Participant shall terminate immediately upon the entry of a judgment or decree of divorce between a Participant and his Spouse.

Each Participant who enrolls his spouse for coverage agrees to be personally liable to the Fund for any amounts the Fund pays in benefits for services rendered to or on behalf of such individual after the date of the entry of the judgment or decree of divorce between the Participant and such individual, but prior to notification to the Fund of the divorce, irrespective of whether such Participant continues to be eligible for benefits at the time of the Fund's discovery of the divorce, demand for repayment or at any time of reference.

A former spouse shall be recognized as a beneficiary for any purpose following the entry of such judgment or decree only if designated by the Participant as beneficiary after the entry of the judgment or decree on a form prescribed and furnished by the Board.

Section 20: Union

The term "Union" shall mean Bricklayers' and Allied Craftworkers' Local Union No. 2 of Michigan, Bricklayers and Allied Craftworkers International Union of North America, AFL-CIO.

Section 21: Rule of Construction

Wherever used herein, masculine pronouns shall be deemed to include the feminine and vice versa and singular pronouns shall be deemed to include the plural wherever appropriate.

ARTICLE II: ELIGIBILITY AND COVERAGE

Section 1: Initial Eligibility

a. Bargaining Unit Employees

An Employee shall establish initial eligibility for this Plan on the first day of the month in which the Fund Office receives all contributions required based on at least 390 Hours of Work performed within six (6) consecutive months or less, and such eligibility shall continue until the last day of the third month after such requirements were met, unless subsection (b) of this Article II, Section 1 is applicable.

b. Employees Covered by an Employer-Provided Health Plan.

If an Employee was covered under an Employer-provided health care plan based on that Employee's employment on the date on which his Employer first became bound to a Health Agreement requiring Employer contributions to the Fund on his behalf (i.e., a newly-organized Employer), and he presents proof of such coverage to the Fund, the Employee shall become a Participant on the first day of the first full month for which the Employer is obligated to contribute to the Fund, provided that the Employer posts a bond with the Fund (in either cash or by surety bond in a form and from an insurer acceptable to the Fund). The amount of the bond shall be equal to the product of the then-current hourly contribution rate set forth in the Bricklayers Agreement, multiplied by 390 (Hours of Work) and multiplied by the number of employees on whose behalf the Employer is making contributions to the Fund based on the Health Agreement and the number of owners and/or other Non-Bargaining Unit Employees who will be covered under a Health Agreement, if any.

The full amount of the bond shall be returned to the Employer one (1) year after the date of its posting, if the Employer has complied with its obligations to the Fund during that year.

c. Non-Bargaining Unit Employees

i. For all Employees except Fund Employees: An Employer may elect, by entering into a Health Agreement on such terms and conditions as the Board may require, to contribute to the Fund on behalf of its Non-Bargaining Unit Employees (NBUEs) defined in Article I, Section 14, under the following conditions:

A. An Employer must contribute on all NBUEs it employs, with the exception of the following, for whom coverage is optional:

1. NBUEs participating in another collectively bargained health care plan;

2. NBUEs with health care coverage through another employer-sponsored health care plan;

3. NBUEs who perform only clerical work for the Employer; and

4. NBUEs who are receiving a pension benefit.

B. All NBUEs to be covered by the Fund must be listed on the Health Agreement at the time it is signed, and the Employer must notify the Fund of any change in NBUEs upon whom the Employer is contributing.

C. If an Employer contributes on NBUEs who are either Non-Working Owners or Working Owners, and such Owners are husband and wife, the Employer is required to contribute with respect to only one of the spouses. In the event

that one of the Owner-spouses is a tradesperson, such contributions must be made with respect to the Owner-spouse who is a tradesperson.

D. In no event will contributions or self-payments on behalf of a NBUE be accepted if the Employer is delinquent in paying contributions on bargaining unit employees, unless there is a payment schedule in effect that has been approved by the Fund or ordered by a court.

An NBUE shall become a Participant on the first day of the first month following a period of three (3) consecutive months or less in which he is credited with at least 480 Hours of Work and Employer contributions, unless subsection (b) of this Article II, Section 1 is applicable.

ii. For NBUEs who are Fund Employees: The Fund shall extend coverage as defined herein to each Fund Employee effective as of the first day of the month following the completion of the Fund Employee's probationary period, as that period is defined under the terms of the Fund's collective bargaining agreement with the Fund Employees or any contract of employment into which the Fund may enter.

Section 2: Continuing Eligibility

a. Continuing Eligibility by Working or Drawing on Hourly Reserve Bank

i. Bargaining Unit Employees and Non-Bargaining Unit Employees who are Union Employees:

Once a Participant who is a Bargaining Unit Employee or a Non-Bargaining Unit Employee who is a Union Employee has established initial eligibility, he shall continue to be eligible for benefits if he meets one of the following requirements:

A. he is credited with 130 Hours of Work and Employer contributions for work performed during the third month preceding such month, or

B. If the number of Hours of Work and Employer contributions received for a month is less than 130, the number of hours/contributions needed to equal 130 Hours of Work is withdrawn from the Participant's Hourly Reserve Bank, provided that he is available for work and the Fund does not receive information that the Participant is working in non-covered employment. If a Bargaining Unit Participant has fewer than 130 hours in his Hourly Reserve Bank, and if this amount, together with the number of Hours of Work and Employer contributions received, is insufficient to continue his coverage, the Participant may continue coverage for one month only by remitting a self-payment equal to the current hourly contribution rate multiplied by the number of hours needed to reach a total of 130 Hours of Work provided that he is available for work and the Fund does not receive information that the Participant is working in non-covered employment.

ii. Non-Bargaining Unit Employees except Union Employees:

A. Non-Working Owners and Sole Proprietors:

A Non-Working Owner or a Sole Proprietor shall continue to be eligible for benefits for a month if he is credited with 160 Hours of Work and Employer contributions for work performed during the third month preceding such month. The Fund will not accept less than 160 Hours of Work and Employer contributions for work performed by a Non-Working Owner or a Sole Proprietor in any month. No Hourly Reserve Bank shall be established for a Non-Working Owner or a Sole Proprietor.

B. Working Owners:

A Working Owner shall continue to be eligible for benefits for a month if he is credited with 160 Hours of Work and Employer contributions for work performed during the third month preceding such month.

If the number of Hours of Work and Employer contributions received for a month is less than 160, the number of hours/contributions needed to equal 160 Hours of Work shall be withdrawn from the Working Owner's Hourly Reserve Bank.

If a Working Owner has fewer than 160 hours in his Hourly Reserve Bank, and if this amount, together with the number of Hours of Work and Employer contributions received, is insufficient to continue his coverage, the Participant may continue coverage for one month only by remitting a self-payment equal to the current hourly contribution rate multiplied by the number of hours needed to reach a total of 160 Hours of Work.

C. Fund Employees:

A Fund Employee shall continue to be eligible for benefits for each month in which such Employee continues to work on a full-time basis for the Fund. No Hourly Reserve Bank shall be established for a Fund Employee.

b. Continuing Eligibility Through Self-Payment:

i. Bargaining Unit Employees:

A Participant who is a bargaining unit employee who does not meet the continuing eligibility requirements of Section 2(a)(i) of this Article II for a month because of a lack of sufficient hours of employment may elect to continue eligibility for that month by making a monthly self-payment at a rate determined by the Board, up to a maximum of 12 consecutive months, provided that he submits a written statement

from the Union every 3 months that he is available for work and not working in non-covered employment.

A Retired Participant may not continue eligibility by self-payment unless he has returned to work in covered employment.

A Participant whose eligibility is terminated because he fails to make a self-payment may elect continuation coverage under Section 10 of this Article II (COBRA), subject to all requirements thereof.

If a Participant who is a bargaining unit employee makes a self-payment and the Fund thereafter receives Employer contributions on his behalf sufficient to continue his eligibility, the Fund will retain the self-payment as credit on behalf of the Participant only if it is needed to continue the Participant's eligibility for the next month; the Fund shall refund the self-payment to the Participant if it is not needed to continue his eligibility for the next month.

ii. Non-Bargaining Unit Employees:

A Participant who is a NBUE who does not meet the continuing eligibility requirements of Section 2(a)(ii) of this Article II for a month may elect to continue eligibility for that month as follows:

A. Fund Employees may continue coverage by making self-payments for no longer than twelve (12) months.

B. Working Owners and Union Employees may continue coverage through drawing on the Hourly Reserve Bank until the Hourly Reserve Bank is exhausted, and thereafter, by making self-payments for no longer than twelve (12) months.

C. Non-Working Owners and Sole Proprietors may continue coverage under the provisions of COBRA continuation coverage. Under no circumstances may a Non-Working Owner or Sole Proprietor continue coverage by means of self-payment except under the terms of the Permanent and Total Disability Program under Section 3(b) below, under the terms of Section 12 below (Eligibility When Entering Armed Forces or Uniformed Services), or as a Retiree pursuant to Section 8 below.

Under no circumstances shall the Fund accept self-payments for NBUEs if the Employer is delinquent in remitting contributions for bargaining unit employees, unless there is a payment schedule in effect that has been approved by the Fund or ordered by a court.

An NBUE Participant whose eligibility is terminated because he fails to make a self-payment, because the Fund has rejected his self-payment because the

Employer is delinquent in contributions with respect to its bargaining unit employees, or because he has exhausted the three-month period for making such self-payments, he may elect continuation coverage under Section 10 of this Article II (COBRA), subject to all requirements thereof.

If an NBUE Participant makes a self-payment and the Fund thereafter receives Employer contributions on his behalf sufficient to continue his eligibility, the Fund will retain the self-payment as credit on behalf of the Participant only if it is needed to continue the Participant's eligibility for the next month; the Fund shall refund the self-payment to the Participant if it is not needed to continue his eligibility for the next month.

Section 3: Disability Eligibility

a. Loss of Time Credit

i. A bargaining unit Participant or an NBUE Participant classified as a Working Owner, a Sole Proprietor, or a Union Employee, who is eligible to receive Weekly Disability Benefits under Article III, Section 3 of this Plan (or who would be eligible for Weekly Disability Benefits if his injury or Illness had not been work-related, or if his injury had not been suffered in an automobile accident) shall, upon application to the Board in a form acceptable to them no later than one hundred and eighty (180) days after the date of the injury or the onset of Illness, be eligible to receive Loss of Time Credit in the following amount for each week that he is eligible for Weekly Disability Benefits (or would be eligible, as described above):

A. For bargaining unit Participants and Union Employees, thirty-two and one-half (32.5) Hours of Work; and

B. For an NBUE Participant classified as a Working Owner or Sole Proprietor, forty (40) Hours of Work.

ii. A Fund Employee who is eligible to receive Weekly Disability Benefits under Article III, Section 3 of this Plan (or who would be eligible for Weekly Disability Benefits if his injury or Illness had not been work-related, or if his injury had not been suffered in an automobile accident) shall, upon application to the Board in a form acceptable to them no later than one hundred and eighty (180) days after the date of the injury or the onset of Illness, continue to be covered each week that the Participant is eligible for Weekly Disability Benefits (or would be eligible, as described above).

iii. A bargaining unit Participant or an NBUE Participant classified as a Working Owner, a Sole Proprietor, a Union Employee or a Fund Employee who:

A. remains disabled after the end of the period during which he is eligible to receive Weekly Disability Benefits, and

B. continues to be disabled on the date his eligibility to receive those benefits terminates (or would have terminated if he had been eligible for such benefits, as described above)

shall receive six (6) additional months of coverage at no cost to him ("6-month extension").

iv. If the bargaining unit Participant or the NBUE Participant classified as either a Working Owner or a Union Employee remains disabled after the 6-month extension, he may continue his eligibility by use of the credits in his Hourly Reserve Bank, if any.

v. If the bargaining unit Participant or the NBUE Participant classified as a Working Owner or a Union Employee remains disabled after exhausting the credits in his Hourly Reserve Bank and if he meets the requirements for Permanent and Total Disability Coverage under Section 3(b) of this Article II, he may thereafter continue coverage by making self-payments at a rate determined by the Board for disabled Participants, subject to all the requirements thereof.

vi. If the bargaining unit Participant or the NBUE Participant classified as a Working Owner, a Union Employee or a Fund Employee does not meet the requirements for Permanent and Total Disability Coverage, he may continue coverage by making self-payments under Section 2(b) of this Article II (Continuation of Eligibility Through Self-Payment), subject to all requirements and limitations thereof.

vii. If the bargaining unit Participant or the NBUE Participant classified as a Working Owner, a Union Employee or a Fund Employee

A. fails to make a required self-payment;

B. if the Fund rejects a self-payment of a NBUE Participant classified as a Working Owner or a Union Employee because the Employer is delinquent in contributions with respect to its bargaining unit employees; or

C. if he has exhausted the applicable period for making such self-payments,

he may elect continuation coverage under Section 10 of this Article II (COBRA) if he is so entitled, subject to all requirements thereof.

b. Permanent and Total Disability

i. A bargaining unit Participant or an NBUE Participant classified as a Working Owner, a Sole Proprietor, a Union Employee or a Fund Employee is determined to be totally and permanently disabled (as defined under Section 3(b)(ii) of this Article

II) shall continue to be eligible for benefits for a month by making a self-payment for that month at a rate determined by the Board, provided that:

A. such Participant became permanently and totally disabled while covered under the Plan as a member of a bargaining unit represented by the Union or while covered under the Plan as an NBUE Participant classified as a Working Owner, a Sole Proprietor a Union Employee or a Fund Employee; and

B. such Participant is not eligible for coverage as a Retiree; and

C. such Participant did not become permanently and totally disabled as a result of non-covered employment, nor was the injury or Illness contracted, suffered, or incurred while the Participant engaged in a felony; and

D. such Participant applies for continuation of eligibility while permanently and totally disabled in a time and manner prescribed by the Board, and submits with such application all information and documentation required by the Board, including either proof of a Social Security Disability Award or, in the absence of a Social Security Disability Award, a determination by an independent medical examiner that the Participant is permanently and totally disabled, and all IRS Forms W-2, 1099 and 1040 received by or submitted by such Participant from the date of his last covered employment through the date of application; and

E. For a bargaining unit Participant or an NBUE Participant classified as a Working Owner, a Sole Proprietor, or a Union Employee, he either:

   I. has been credited with at least 500 Hours of Work and contributions prior to the date of application and has been eligible for benefits as a Participant for at least one month in prior twenty-four consecutive month period immediately preceding the date of application for continuation of eligibility while permanent and totally disabled; or

   II. has at least 10 years of service or more with the Bricklayers Pension Trust Fund – Metropolitan Area, the Michigan BAC Pension Fund, the Cement Masons Pension Trust Fund – Detroit and Vicinity, or, for tile setters, the Bricklayers and Trowel Trades International Pension Fund, or at least 10,000 hours of work and contributions to the Fund, and has received a Social Security Disability Award within 30 months of his last month of active employment, and maintained coverage with the Fund via self-payments and/or COBRA continuation coverage; and

F. For a Fund Employee, he has been employed by the Fund for at least the twenty-four consecutive month period immediately preceding the date of

application for continuation of eligibility while permanent and totally disabled.

ii. A permanently and totally disabled Participant is one who has a physical or mental condition which, on the basis of satisfactory medical evidence, permanently and totally prevents him from engaging in any regular occupation or employment in his current occupation (that is, the bricklaying, cement mason and/or tile, marble and terrazzo trades for a bargaining unit Participant or an NBUE Participant classified as a Working Owner or a Sole Proprietor, and his employment with the Union or the Fund, respectively, for Union Employees and Fund Employees) for remuneration or profit (except for rehabilitation as approved by the Board) and which is likely to be permanent and continuous during the remainder of the Participant's life. A Participant shall not be deemed permanently and totally disabled if his incapacity was contracted, suffered or incurred while the Participant was engaged in a felony.

iii. The eligibility of a Participant who is determined to be permanently and totally disabled but does not have a Social Security Disability Award is limited to twenty-four (24) months (subject to all other requirements and limitations in this Plan for eligibility). Effective May 1, 2013, Participants covered by virtue of disability on December 31, 2009 who did not have a Social Security Disability Award within twenty-four months of January 1, 2010, may elect to continue or reinstate their eligibility on a one-time basis, as applicable, by remitting a monthly self-payment at the rate applicable for Early Retirees (as the Board may change such rate from time to time).

iv. A Permanently and Totally Disabled Participant who is eligible for Medicare must enroll in Medicare Parts A, B and D, and the Fund will provide coverage that is the same as a Medicare-Eligible Retiree under Article III, Section 6 (but he shall not be entitled to elect the Non-Medical Program under Article III, Section 9).

v. A Participant determined to be permanently and totally disabled may exhaust the credits in his Hourly Reserve Bank, if any, including any contributions received for the month in which the disability commences, prior to commencing self-payments. This period of coverage shall not count toward the twenty-four (24) month limitation of subsection iii above.

vi. A Participant will not be permitted to continue to be eligible for benefits by making self-payments as a permanently and totally disabled Participant as of the earliest date any of the following occur:

A. The Participant engages in any occupation or employment (except for rehabilitation as determined by the Board) which is inconsistent with the finding of total and permanent disability, or

B. The Participant refuses or fails to submit, upon request from the Board which it shall make no more frequently than annually, proof of continuing receipt of Social Security Disability Benefits, and copies of all IRS Forms W-2, 1099 and 1040 received by or submitted by him, as applicable, from the date of commencement of his eligibility for permanent and total disability coverage through the date of the request, or

C. The Participant becomes employed in an effort at rehabilitation as allowed under paragraph A, above, but fails to provide satisfactory evidence of income when requested by the Board, or

D. The Participant does not timely remit his monthly payment for coverage in the amount required; or

E. The Participant becomes eligible for coverage as a Retiree; or

F. The Fund no longer provides permanent and total disability coverage.

Section 4: Termination of Eligibility

a. A Participant's eligibility for benefits shall immediately terminate on the earliest of the following dates:

i. the date he is no longer meets or fulfills the requirements for coverage under the applicable terms of the Plan; or

ii. the effective date of a Plan amendment which results in his no longer meeting or fulfilling the requirements for coverage under the applicable terms of the Plan as amended; or

iii. the effective date of a Plan amendment which eliminates coverage for that classification of Employee, or eliminates that classification of Employee entirely; or

iv. the date the Plan terminates;

v. the date he is inducted into the Armed Forces, unless he elects to make self-payments in accordance with the provisions of Section 12 of this Article II (Eligibility When Entering Armed Forces or Uniformed Services); or

vi. for NBUEs, the date the NBUE or his Employer violates the Health Agreement that provides for contributions on behalf of the NBUE.

b. As applicable, unless coverage is continued pursuant to and in accordance with all of the provisions of Section 10 of this Article II (COBRA), a Dependent's coverage will terminate upon the earliest of:

i. the date of termination of a Participant's coverage; or

ii. the date on which a Dependent ceases to meet the requirements for Dependent coverage or fails to establish that those requirements are met upon request of the Board; or

iii. with regard to a Dependent Spouse or any stepchildren, the date of entry of a judgment or decree of divorce by the Court between the Participant and his Dependent Spouse; or

iv. with regard to a Dependent child who becomes eligible for coverage under the Plan as a Participant, the date of that eligibility. However, such child may be again be covered as a Dependent if that child loses his/her own eligibility as a Participant, subject to all requirements for the coverage of a Dependent child; or

vi. the date on which a Participant or a Retired Participant continuing coverage under Section 10 of this Article II (COBRA) elects not to cover his Dependent and the Dependent does not pay for individual COBRA continuation coverage; or

vii. the date on which the Dependent enters the Armed Forces of any country; or

viii. the date on which Dependent coverage is no longer provided by the Fund to all similarly situated persons by action of the Board.

Section 5: Reinstatement of Eligibility

a. If a Bargaining Unit Employee has not been eligible under the terms of Section 2(a) of this Article II for a period of twelve (12) consecutive months or longer, he must again satisfy the Initial Eligibility Requirements of Section 1 of this Article II.

b. If a Bargaining Unit Employee has not been eligible under the terms of Section 2(a) of this Article II for a period of less than twelve (12) consecutive months, he will again become eligible on the corresponding eligibility month following three (3) or fewer consecutive months during which he is credited with 130 Hours of Work and contributions.

c. If a NBUE Employee loses coverage for any period, he must again satisfy the Initial Eligibility Requirements of Section 1 of this Article II.

Section 6: Reciprocity

a. The Board of Trustees has entered into reciprocity agreements with other insurance/health and welfare funds covering bricklayer, cement mason and/or tile, marble and terrazzo trades throughout the Country. Pursuant to these reciprocity agreements, employer contributions submitted on behalf of an Employee to one fund may be transferred to another fund upon the Employee's written request and authorization and may be credited toward meeting the continuing eligibility requirements of the recipient fund.

b. Employer contributions received by this Fund from other funds pursuant to the terms of a reciprocity agreement shall be credited by this Fund toward hours for purposes of an Employee's eligibility on a pro-rata basis; that is, the hours credited based on the receipt of employer contributions shall be reduced as necessary to reflect a lower hourly contribution rate in the area in which the work was performed than that which would be applicable were the work performed at the time within the geographic jurisdiction of this Fund.

c. If, after a reduction in the credited hours due to a difference in the employer contribution rates between funds, the hours and employer contributions thus credited do not meet the continuing eligibility requirements of this Fund, an employee will be permitted to remit a self-payment to the Fund in the amount of the short-fall to continue his eligibility in this Fund.

Section 7: Dependent Eligibility

a. Effective Date of Dependent Coverage

i. Benefits (excluding Accidental Death and Dismemberment Benefits, Weekly Disability Benefits and Loss-of-Time Credits under the provisions for Continuation of Eligibility During Short-Term Disability) are generally available to a Participant's Dependents whenever the Participant is eligible for benefits.

ii. If a Participant acquires a new Dependent, the new Dependent will be eligible for benefits retroactive to the date such person became the Participant's Dependent, provided the required enrollment notice, including birth certificates for children, Social Security numbers for adults, marriage certificates for spouses or a copy of the Judgment of Divorce establishing responsibility for health care for stepchildren, is given to the Fund within thirty (30) days of the acquisition of the new Dependent. If the Fund does not receive such notice with all required documentation within thirty (30) days of such person becoming a Dependent, the Dependent will be enrolled for coverage under the Plan on a prospective basis only, with coverage to begin no earlier than the date on which the Fund receives the notice and can administratively implement such request for coverage.

iii. If a Participant does not enroll one or more of his Dependents for coverage at the time of the Participant's initial eligibility, or the acquisition of the Dependent if later, due to such Dependent's coverage under another health plan, the Participant may enroll such eligible Dependent upon the subsequent loss of such other coverage retroactive to the date that person lost such other coverage, provided that the enrollment is made within thirty (30) days of the loss of the other coverage.

iv. If a Participant seeks to re-enroll a Dependent child whom the Participant previously disenrolled, then the Dependent child shall be eligible for coverage as

soon as administratively feasible, but not before the first day of the month following the month within which the re-enrollment is received by the Fund Office.

v. If a Dependent is eligible for Medicare, the Dependent must enroll in Medicare, and the Fund will provide secondary and supplemental coverage to Medicare.

b. Qualified Medical Child Support Orders

The Fund shall provide benefits in accordance with any valid order of a court determined by the Fund to be a Qualified Medical Child Support Order under applicable federal law which creates or recognizes the right of an alternate recipient to benefits as a Dependent under the Plan, but only to the extent provided in such order and allowed by federal law.

c. Special Rule for Former Spouses and Stepchildren Following a Divorce

Coverage for a Dependent Spouse and any Dependent stepchildren ends immediately upon divorce from the Participant. If the Fund is not notified of the judgment or decree of divorce, and the Fund pays benefits to or on behalf of the former spouse or any former Dependent stepchildren for services rendered after the divorce, both the Participant and the former Spouse shall be personally jointly and severally liable to the Fund for any amounts the Fund pays on behalf of the former Spouse or any Dependent stepchildren after the date of the entry of the judgment or decree of divorce but prior to the written notification to the Fund of the divorce, irrespective of whether such Participant continues to be eligible for benefits at the time of the Fund's discovery of the divorce, demand for repayment or at any time of reference. The Fund reserves the right to recover the amounts owed from the Participant, the former Spouse, the former Dependent stepchildren, and/or any combination thereof. The Board may, in its discretion, pursue direct collection of such amounts by any legal means, including litigation, by termination of the Participant's participation in the Fund and/or by offsetting such amounts owed to the Fund by the Participant against future benefits for which such Participant may become eligible.

Section 8: Retired Participant Eligibility

When a Participant retires, he may continue eligibility by drawing on his Hourly Reserve Bank, if any, until the hours in his Hourly Reserve Bank fall below 130 Hours of Work. Thereafter, the Participant and his Dependents may remain eligible for benefits for a month by making a monthly self-payment at a rate to be established by the Board of Trustees from time to time, provided the Participant meets the requirements as an Early Retiree or as a Medicare-Eligible Retiree set forth in this Section 8.

a. Early Retiree Coverage Eligibility.

A Participant is eligible for Early Retiree coverage if:

i. the Participant applies for coverage as an Early Retiree in a form acceptable to the Board of Trustees;

ii. the Participant (except for Fund Employee Participants) is receiving or will receive an early retirement benefit from the Bricklayers Pension Trust Fund – Metropolitan Area, the Michigan BAC Pension Fund, the Cement Masons Pension Trust Fund – Detroit and Vicinity, or, for tile setters, the Bricklayers and Trowel Trades International Pension Fund (in the case of Fund Employee Participants, the Participant has ten or more years of employment with the Fund and is employed by the Fund on the date of retirement); and

iii. the Participant (except Union Employee Participants) has been eligible for benefits from the Fund based upon work hours or self-payments at least once in each of the four (4) rolling years immediately preceding the date of the application (for Union Participants, the Participant is eligible for benefits on the date of the application).

Coverage as an Early Retiree will commence when the Participant begins receiving an early retirement benefit from the Bricklayers Pension Trust Fund – Metropolitan Area, the Michigan BAC Pension Fund, the Cement Masons Pension Trust Fund – Detroit and Vicinity, or, for tile setters, the Bricklayers and Trowel Trades International Pension Fund so long as he pays the applicable self-payment amount, provided the Participant will be permitted to continue his active coverage through his Hourly Reserve Bank until it is exhausted. Coverage as an Early Retiree will terminate when the Participant becomes eligible for Medicare-Eligible coverage. When an Early Retiree becomes eligible for Medicare, he must elect such coverage, and the Fund will provide coverage as a Medicare-Eligible Retiree, subject to the provisions of this Plan controlling such coverage.

A Participant who is covered as an Early Retiree must notify the Fund Office upon returning to covered employment. Such Participant will retain Early Retiree coverage unless he satisfies the Initial Eligibility requirements in Article II, at which time he will be an Active Participant. If an Early Retiree returns to covered employment but does not satisfy the Initial Eligibility requirements in Article II, his Early Retiree monthly self-payment will be credited with the Employer contributions the Fund receives on his behalf.

Non-Working Owners are not eligible for Early Retiree coverage.

b. Medicare-Eligible Retiree Coverage Eligibility.

A Participant is eligible for Medicare-Eligible Retiree coverage if:

i. the Participant is eligible for Medicare and has enrolled in Medicare Parts A, B, and D;

ii. the Participant has applied for Medicare-Eligible Retiree coverage in a form acceptable to the Board, or the Participant is currently eligible for Early Retiree coverage;

iii. the Participant has been credited with 500 hours of Employer contributions in each of the five rolling years before turning age 65 (not applicable to a Participant currently eligible for Early Retiree coverage); and

iv. for Participants (except Union Employee Participants), the Participant has been eligible based upon work hours or self-payments or as an Early Retiree in each of the two (2) rolling calendar months immediately preceding the month in which he applies for Normal Retiree eligibility (not applicable to a Participant currently eligible for Early Retiree coverage) (for Union Employee Participants, the Participant is eligible for benefits on the date of the application (not applicable to a Participant currently eligible for Early Retiree coverage)).

A Participant or Dependent continuing coverage hereunder must pay the applicable self-payment amount. A Participant who is covered as a Medicare-Eligible Retiree must notify the Fund Office upon returning to covered employment. Such Participant will retain Medicare–Eligible Retiree coverage, but will not be required to make a self-payment if the Fund receives Hours of Work with Employer contributions sufficient to meet the requirements of initial or continuing eligibility.

A Participant who is a Non-Working Owner and is otherwise eligible for Medicare-Eligible Retiree coverage may have coverage for the Participant only and not Dependents.

c. Benefits.

Early Retirees and their non-Medicare-Eligible Dependents and the non-Medicare-Eligible Dependents of Medicare-Eligible Retirees shall be eligible to receive medical, hospital, and surgical benefits as set forth in Article III, section 5, below, but such coverage does not include Prescription Drug Benefits, Accidental Death and Dismemberment Benefits (Article III, Section 2 of this Plan), Weekly Disability Benefits (Article III, Section 3 of this Plan), or loss-of-time credits under the provisions for Continuation of Eligibility During Short Term Disability (Article II, Section 3(a) of this Plan).

Should such individuals become eligible for Medicare, they shall, upon election and proper self-payment, receive medical, hospital, surgical and prescription drug benefits as a Medicare-Eligible Retiree as provided below.

Medicare-Eligible Retirees and their Medicare-Eligible Dependents and the Medicare-Eligible Dependents of Early Retirees shall be eligible to receive medical, hospital, surgical and prescription drug benefits as set forth in Article III, section 6, below, but such coverage does not include Accidental Death and Dismemberment Benefits (Article III, Section 2 of this Plan), Weekly Disability Benefits (Article III, Section 3 of this Plan), or loss-of-time credits under the provisions for Continuation of Eligibility During Short Term Disability (Article II, Section 3(a) of this Plan).

Each Medicare-Eligible Retiree and Medicare-Eligible Dependent covered under this Plan must elect, participate in and pay all premiums associated with Medicare Parts A, B and D.

d. Retiree Special Delayed Enrollment.

If, at the time of his retirement, an individual has health care coverage through his Spouse's employer and, although he meets the eligibility requirements for Early Retiree or Medicare-Eligible Retiree coverage as set out in this Section 8, he elects not to initiate such coverage on the effective date of his retirement due to his coverage under his Spouse's employer, he will be permitted to return to coverage at any time after the date of his retirement, on the following conditions:

i. his request to return to coverage is made no more than 30 days after the date on which his coverage under his Spouse's employer terminates; and

ii. he provides proof that he maintained health care coverage through his Spouse's employer continuously from the date he first became eligible for coverage as a Retiree through the date he elects to return to Early Retiree or Medicare-Eligible Retiree coverage, as applicable.

e. Spouse Special Delayed Enrollment.

A permanently and totally disabled Participant who is eligible pursuant to Article II, Section 3.b and ,upon retirement, a Participant eligible for either Early Retiree Coverage or Medicare-Eligible Coverage may choose either to cover himself only or to cover Dependents also. This choice, once made, cannot be changed with the following exception: if a permanently and totally disabled Participant or a Retired Participant's Spouse has health care coverage through such Spouse's employer plan at time of the commencement of Permanent and Total Disability coverage or at the time of the Retired Participant's retirement, the Participant may elect to continue coverage for only himself at the time of disability or retirement, and will be permitted to subsequently elect to enroll his Spouse for coverage at any time thereafter provided:

i. such election is made within 30 days of the date on which the Spouse's coverage under the employer-provided group health care plan terminates;

ii. the Participant continues to be covered by this Plan at the time of such enrollment; and

iii. the Participant provides proof that his Spouse maintained health care coverage through his Spouse's employer continuously from the date the Participant first became eligible for coverage as a permanently and totally disabled Participant or Retiree through the date his Spouse elects to return to coverage under the Plan.

f. Post-Retirement Marriage

If the Retired Participant marries after retirement, the Retired Participant may elect to provide coverage for his new Spouse by applying to the Fund Office and providing satisfactory proof of that marriage within 30 days after the marriage.

Section 9: Surviving Spouse and Surviving Dependent Eligibility

a. Eligibility

i. Upon the death of a Participant, a surviving Spouse and surviving Dependents may elect to continue coverage under this Plan for the surviving Spouse and the deceased Participant's eligible Dependents (including children born to the surviving Spouse of a male deceased Participant within nine (9) months after his death), if any, subject to the provisions of this Section 9 of Article II.

ii. Such surviving Spouse and Dependents are entitled to coverage under this Plan at no cost to them until the Participant's Hourly Reserve Bank, if any, falls below 130 Hours of Work.

iii. Thereafter, such surviving Spouse and Dependents may continue coverage under this Plan by making monthly self-payments at a rate determined by the Board of Trustees, which may change from time to time.

b. COBRA

Surviving Spouse and surviving Dependent coverage described in this Article II, Section 9 is offered as an alternative to the continuation coverage under Section 10 of this Article II (COBRA). An eligible surviving Spouse and surviving Dependents may instead elect continuation coverage under Section 10 of this Article II (COBRA).

c. Benefits

The coverage provided to eligible surviving Spouses and surviving Dependents is the same as the coverage provided to Early Retirees and Permanently and Totally Disabled Participants and their Dependents.

d. Limitations

i. The surviving Spouse must not be eligible for Medicare at the time of the surviving Spouse continuation coverage is to begin.

ii. The surviving Spouse must elect to continue coverage under this Section 9 of Article II within sixty (60) days from the date of the Participant's death.

iii. The Dependents must continue to meet the Plan definition of Dependent.

e. Termination of Eligibility

Eligibility for surviving Spouse benefits hereunder shall immediately terminate upon the earliest of the following:

i. the date the Fund no longer continues to offer this coverage; or

ii. the date the monthly self-payment is not received in a timely manner; or

iii. the date the surviving Spouse or the deceased Participant's Dependents become eligible for coverage under another health plan; or

iv. For each Dependents, the date on which such Dependent no longer meets the Plan definition of Dependent; or

v. the date the Fund terminates.

Section 10: COBRA Continuation Coverage Eligibility

a. Qualifying Event

As used herein, the term "qualifying event" means certain specified events that can cause the termination of coverage under this Plan. The following are the qualifying events applicable to this Plan:

1. for an Employee, the termination of his covered employment or the reduction of covered hours with contributions below the requirements for coverage for any reason other than the Employee's gross misconduct.

2. for a Dependent Spouse, the death of the Employee, the termination of his covered employment or the reduction of covered hours with contributions below the requirements for coverage for any reason other than the Employee's gross misconduct, or a divorce from the Employee.

3. for a Dependent child, the death of the Employee, the termination of his covered employment or the reduction of covered hours with contributions below the requirements for coverage for any reason other than the Employee's gross misconduct, the divorce of the Dependent child's parents (one of whom is the Employee), or the Dependent child no longer meeting the Plan's definition of Dependent child.

b. Rights of Participant to Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), when a Participant's coverage hereunder terminates because of a qualifying event, he may elect to continue his eligibility in accordance with the provisions of COBRA

for all benefits, except Death Benefits, Accidental Death and Dismemberment Benefits, and Weekly Disability Benefits (and he will not be eligible for loss-of-time credits under the provisions for Continuation of Eligibility During Short Term Disability) by making monthly self-payments to the Fund for a maximum period of eighteen (18) consecutive months. However, if the participant is disabled at the time his eligibility terminates because of a qualifying event, or within sixty (60) days of that date and is determined to be eligible to receive Social Security Disability benefits, he may elect to make payments for a maximum period of twenty-nine (29) consecutive months. The Participant must notify the Fund of Social Security's determination within sixty (60) days of its issuance **and** within the eighteen (18) month COBRA period.

If at any time during this period, the Participant elects not to make payments and, as a result, his eligibility is terminated, he shall not be eligible again until he has met the requirements for re-establishment of eligibility.

Dependents who lose coverage because of death, divorce or failure to qualify as Dependents also have the right to continue coverage as set out above. If a second event occurs which would qualify a Dependent for COBRA coverage during the first eighteen (18) month period of COBRA coverage, the COBRA participant is eligible to continue coverage for up to thirty-six (36) months.

c. Rights of Dependents to Continuation Coverage

Under COBRA, when an eligible Dependent's coverage terminates because of a qualifying event, such Dependent shall have the right to continue coverage.

Notwithstanding the foregoing, a Dependent's right to elect continuation coverage in the event of divorce of the Participant shall terminate unless the Fund receives a copy of the judgment or decree of divorce within sixty (60) days after the date of its entry by a Court. In addition, a Dependent's right to elect continuation coverage in the event of death of the Participant shall terminate unless the Fund receives notice of the death of the Participant within sixty (60) days of that death. Children born to, adopted by or placed for adoption with a Participant during his COBRA continuation period have the same right to elect continuation coverage as other Dependent children who no longer qualify as eligible Dependents, so long as the Fund receives notice within thirty (30) days of that birth, adoption or placement for adoption.

Dependents who lose coverage because of the termination of the Participant's covered employment or the reduction of covered hours with contributions below the requirements for coverage for any reason other than his gross misconduct may continue coverage hereunder for up to eighteen (18) consecutive months by payment of a monthly self-payment. However, if the Participant became entitled to Medicare before the termination of the Participant's covered employment or the reduction of covered hours with contributions below the requirements for coverage for any reason other than his gross misconduct, Dependents may continue coverage hereunder for the greater of either (a) thirty-six (36) months from the date of the Participant's Medicare entitlement, or (b)

eighteen (18) months from the date of the termination of the Participant's covered employment or the reduction of covered hours with contributions below the requirements for coverage for any reason other than his gross misconduct. If a second event occurs which would qualify a Dependent for COBRA coverage during this eighteen (18) month period of COBRA coverage, the Dependent may continue coverage for up to thirty-six (36) months from the date of the initial loss of coverage. (The Participant's entitlement to Medicare after the termination of the Participant's covered employment or the reduction of covered hours with contributions below the requirements for coverage for any reason other than his gross misconduct is a second qualifying event for Dependents.) If the Participant or any of his Dependents is determined to be eligible to receive Social Security Disability benefits at the time the Participant's eligibility terminates or within sixty (60) days of that date, the Dependent may elect to continue coverage by making monthly self-payments for up to twenty-nine (29) consecutive months from the date of the initial loss of coverage.

A Dependent who loses coverage because of the death or divorce of the Employee or the Dependent no longer meeting the definition of Dependent under the Plan may continue coverage for up to thirty-six (36) consecutive months by payment of a monthly self-payment.

d. Election Notice

The Fund Office will provide a COBRA election notice within 30 days after receiving timely notice of a qualifying event.

e. Self-Payment Amount

The self-payment amount shall be set by the Board of Trustees, may be adjusted from time to time, and shall not exceed 102% of the Fund's actual cost for coverage, except that for coverage from the 19th through the 29th month based on the Participant or any of his Dependents determination to be eligible to receive Social Security Disability benefits, the monthly self-payment amount shall not exceed 150% of the Fund's actual cost for coverage. Payment must be made by check or money order payable to the "BAC of Michigan Health and Welfare Fund" and sent to the Fund Office. Failure to submit payment in full and on time will result in loss of coverage.

f. Termination of COBRA Coverage

COBRA continuation coverage will terminate at the earliest of the date on which:

i. the Fund no longer provides coverage for similarly situated persons; or

ii. full payment for continuation coverage is not received by the Fund in a timely fashion; or

iii. the Participant or the Dependent becomes covered under another group health plan that does not include a preexisting conditions clause that applies to the Participant or Dependent; or

iv. the Participant or the Dependent is receiving COBRA continuation coverage because either the Participant or Dependent are disabled as defined under the Social Security Act and Social Security determines that this person is no longer disabled; or

v. the Participant becomes entitled to Medicare benefits. However, a Participant's entitlement to Medicare is a second event which would qualify a Dependent for COBRA coverage for up to thirty-six (36) months from the date of the initial loss of coverage; or

vi. written notice is received that the Participant or Dependent wishes to discontinue COBRA continuation coverage; or

vii. the end of the 18-, 29- or 36-month COBRA period, as set out above, ends.

Section 11: Family and Medical Leave Act Eligibility

A contributing Employer that is a "covered employer" as that term is defined by the Family and Medical Leave Act of 1993 ("FMLA") shall, in order to provide or continue coverage for an Employee participating or eligible to participate in this Plan, be required to notify the Fund when an "eligible employee" has been granted family or medical leave in accordance with the terms and conditions established by the Board of Trustees. Both the Employer and the Employee shall be required to provide such notices, information and documentation as may be required by the Board of Trustees. The Fund will continue coverage during the period of any leave for which an Employee is eligible under the provisions of the FMLA, provided the Employer makes contributions to the Plan at the same rate and in the same amount as if the Employee were continuously employed during the period of the leave and provided further that the Employer complies fully with all requirements established by the Board of Trustees.

Section 12: Eligibility When Entering Armed Forces or Uniformed Services

If a Participant leaves covered employment to enter service in the Armed Forces or other Uniformed Services of the United States (hereinafter "Services"), he may elect to continue coverage for all benefits for which he is eligible under the Plan except Death Benefits, Accidental Death and Dismemberment Benefits, and Weekly Disability Benefits (and will not be eligible for Loss of Time Credits under the provisions for Continuation of Eligibility During Short Term Disability), for a period which is the lesser of

a. the twenty-four (24) month period beginning the last day of covered employment, or

b. the period of his service in the Services plus ninety (90) days.

It is the Participant's responsibility under Federal law to notify the Fund Office when he is called to Service.

If the Participant's period of service is less than 31 days, he will receive coverage at no cost to him. If the Participant's period of service is 31 or more days, continuation of coverage hereunder requires that he make a monthly payment, unless he elects to use his Hourly Reserve Bank, if any, first.

If the Participant elects to maintain coverage during his period of service by making monthly self-payments, the amount of his monthly payment will equal the reduced, active rate for a maximum of twelve (12) months. If the Participant was eligible by self-payment immediately before his period of service, those months will be included in this twelve (12) month maximum. After the Participant has made a maximum of twelve (12) monthly self-payments at the reduced, active rate, he may continue coverage by self-payment in an amount equal to the Fund's current COBRA premium rate, until the end of the lesser of either the twenty-four (24) month period beginning on the last day of covered employment or the period of his service plus ninety (90) days.

The Participant may elect to use his Hourly Reserve Bank, if any, first when he enters the Service to maintain coverage. When his Hourly Reserve Bank, if any, becomes depleted, the Participant may continue coverage by making self-payment at the reduced, active rate for a maximum of twelve (12) months and, thereafter, by making self-payment in an amount equal to the Fund's current COBRA premium rate, until the end of the lesser of either the twenty-four (24) month period beginning on the last day of covered employment or the period of his service plus ninety (90) days. The Fund shall not use the hours in a Participant's Hourly Reserve Bank, if any, to maintain his coverage without his written consent. The Participant may discontinue his coverage upon entry into the Services and elect to freeze his Hourly Reserve Bank for use upon discharge (unless the period of his service exceeds five (5) years).

No initial eligibility requirement shall be imposed on a Participant who returns to covered employment or registers on the Union's Out-of-Work list within ninety (90) days of his discharge under honorable conditions from the Services (or within 24 months if he is recovering from an illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, his service in the Services), regardless of whether the Participant continued coverage during his service as provided hereunder. However, if the period of service exceeds five (5) years, initial eligibility requirements must be satisfied before benefits begin again irrespective of when the Participant returns to work.

Section 13: Additional Special Eligibility Provisions

A Participant or Dependent, who is eligible but not enrolled for coverage under this Plan, may enroll for coverage under the Plan if either:

a. the Participant or Dependent is covered under a Medicaid plan or State CHIP; coverage of the Participant or Dependent under such Medicaid plan or State CHIP is terminated as a result of loss of eligibility for the Medicaid plan or State CHIP; and the Participant or

Dependent requests coverage under this Plan no later than sixty (60) days after the date the Participant's or Dependent's coverage under such Medicaid or State CHIP terminates; or

b. the Participant or Dependent becomes eligible for assistance under a Medicaid plan or State CHIP (including under any waiver or demonstration project conducted under or in relation to those plans), and the Participant requests coverage under this Plan no later than sixty (60) days after the date the Participant or Dependent is determined to be eligible for such assistance.

Section 14: Creditable Coverage for Pre-Existing Conditions Exclusions

The Plan shall provide written certification to any Participant or Dependent whose coverage under this Plan terminates for any reason stating the period of time during which such individual was continuously covered under the Plan, including COBRA continuation coverage, if any, and any pre-existing condition exclusions that were imposed by the Plan with respect to such individual, pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and any regulations promulgated thereunder. The Plan will also honor any certification of creditable coverage that is presented by a Participant or Dependent at the time of initial eligibility to the extent so required by HIPAA and any regulations promulgated thereunder.

ARTICLE III: SCHEDULE OF BENEFITS

Section 1: Death Benefit

a. Payment and Amount of Death Benefit

Upon receipt of an application provided by the Fund in a form acceptable to the Fund and accompanied by such documentation, identification and proofs as the Fund may require, a Death Benefit shall be payable in the amount set forth below, provided that written notice of the death is received by the Fund Office within one (1) year of the date of death.

Description of Deceased	Benefit
Active Participants (Including those whose coverage is continuing through the hour bank, self-payments or during short-term disability and NBUEs)	$10,000
Dependents (Spouse and Dependent Children) of Active Participants	$1,000
Retiree (Early Retiree or Medicare-Eligible Retiree)	$1,000
Permanently and Totally Disabled Participants	$1,000
Surviving Spouse	$500

b. Dependent Coverage

Benefits are payable upon the death of a Participant's Dependent only if the Participant is an Active Participant on the date of the Dependent's death. The Death Benefit for

Dependents ends when the Dependent loses dependent status under the Plan. However, if a Participant's coverage terminates due to his death and his Dependents are otherwise eligible for coverage, the Dependents will continue to have Death Benefit coverage until the Participant's Hourly Reserve Bank falls below 130 hours/contributions.

c. Beneficiary Designation

i. Upon the death of an Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse, the benefit will be paid to the designated beneficiary.

ii. An Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse may designate anyone of his/her choosing as beneficiary for purposes of a Death Benefit by filing a written designation with the Fund Office. If more than one (1) beneficiary is designated, the beneficiaries will share equally.

iii. An Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse may change the designated beneficiary at any time by submitting a new designation form. The change will become effective on the date of receipt by the Fund Office, except that the Fund will not honor any beneficiary designation received by the Fund Office after the date of death of the Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse.

iv. The designation of a spouse as a beneficiary (even if such designation was made prior to their marriage) automatically terminates and is canceled upon entry of a judgment or decree of divorce between the Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse and his/her spouse, although an Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse may designate a former spouse as beneficiary by completing another beneficiary card <u>after</u> the parties' divorce. If an Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse dies and his/her former spouse is the only beneficiary designated by the Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse (and it was completed prior to the parties' divorce), any Death Benefit payable on behalf of that Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse will be paid as though he had no valid designation on file with the Fund, or if more than one (1) beneficiary is designated, the benefit will be paid excluding the former spouse.

v. If, upon the death of an Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse, there is no valid beneficiary designation because:

a. no beneficiary has been designated, or

b. the designated beneficiary has predeceased the deceased person, or

c. the designation made has terminated by operation of this Plan due to divorce between the deceased and his/her former spouse,

any Death Benefit payable will be paid to the first of the following:

A. wife or husband, but if none living, then

B. all children then living in equal shares, but if none living, then

C. parents in equal shares, but if none living, then

D. all brothers and sisters then living in equal shares, but if none living, then

E. any individual(s) that is a beneficiary of the deceased person's estate in equal shares, but if there is no estate,

F. the individual(s) identified as entitled to a share of the deceased person's property in a sworn Affidavit of Decedent's Successor for Delivery of Certain Assets Owned by Decedent with respect to the covered person, in accordance with MCL §§ 700.3983-700.3984, in proportion to the shares identified on the form.

If there are none of the foregoing, then no Death Benefit is payable on behalf of the covered person.

vi. Dependents are not permitted to designate a beneficiary. The Death Benefit payable on behalf of a Dependent shall be payable to the first of the following:

A. the Participant, but if not living, then

B. the Participant's Spouse, but if not living, then

C. the Dependent's siblings in equal shares, but if none living, then

D. the administrator or executor of the estate of the covered person.

If there are none of the foregoing, then no Death Benefit is payable on behalf of the Dependent.

d. Burial Expenses

The Plan may pay a benefit to any individual who submits an application in a form acceptable to the Board of Trustees accompanied by proof that the individual incurred the expenses in connection with the covered person's burial, which are unreimbursed from any other source. The amount to be paid hereunder shall be equal to the lesser of $500 or the unreimbursed amount and shall be subtracted from the full Death Benefit payable.

Any payment made according to this provision regarding the designation of beneficiaries will be made in good faith and will fully release the Plan, the Fund and its Board of any further responsibility for such payment.

e. Termination of Eligibility for Death Benefit

No Death Benefit will be paid after earliest of the following dates:

i. The date the Participant's eligibility for benefits under the Plan terminates;

ii. The date the Participant enters the Armed Forces or other uniformed services of any Country or at any time during the period of his service;

iii. The date the participant elects COBRA continuation coverage, or

iv. The date the Plan no longer provides this benefit.

Section 2: Accidental Death and Dismemberment Benefit

a. Payment of Accidental Death and Dismemberment Benefit

Upon receipt of an application in a form acceptable to the Fund, accompanied by such documentation, identification and proofs as the Fund may require, including, but not limited to, proof that bodily injuries were sustained which were caused directly and exclusively by purely accidental means, an Accidental Death and Dismemberment Benefit shall be payable in the amount set forth below, subject to the limitations and provisions of the Plan. For purposes of this benefit, unless information is received indicating otherwise, a drug overdose is presumed to be accidental.

b. Amounts Payable

i. The amount of the benefit payable for accidental death is $10,000. The Accidental Death Benefit is in addition to the Death Benefit.

ii. The amount of the benefit payable for accidental dismemberment is as follows:

A. Loss of both hands or both feet: $2,000;

B. Loss of entire sight of both eyes: $2,000;

C. Loss of one hand and one foot: $2,000;

D. Loss of one hand or one foot and entire sight of one eye: $2,000;

E. Loss of one hand or one foot: $1,000;

F. Loss of entire sight of one eye: $1,000.

"Loss" when used in describing dismemberment benefits with reference to hand or foot means complete severance through or above the wrist or ankle joint and with reference to eye means the irrevocable loss of the entire sight thereof.

c. Eligibility

The Accidental Death and Dismemberment Benefit is payable only when the loss is sustained by an Active Participant who is eligible under Article II, Section 2(a). Participants maintaining eligibility by self-payment or through loss-of-time credits, Retired Participants, Totally and Permanently Disabled Participants, Surviving Spouses, and those covered pursuant to the provisions on COBRA continuation coverage and Dependents are not eligible for the Accidental Death and Dismemberment Benefit.

d. Beneficiary Designation

A benefit hereunder shall be paid directly to the Participant if still living; if he is not living, the benefit will be paid to the individual identified as the Beneficiary in Section 1(c) of this Article III. If no individual is so identified, then no Accidental Death and Dismemberment Benefit is payable.

e. Termination

Irrespective of the date of loss, no Accidental Death and Dismemberment Benefit will be issued after the earliest of the following dates:

i. The date the Participant is no longer eligible under the Plan pursuant to Article II, Section 2(a); or

ii. The date the Participant enters the Armed Forces or other uniformed services of any Country or at any time during the period of his service; or

iii. The date the Plan no longer provides this benefit.

f. Limitations and Exclusions

i. Written notice of the death or dismemberment must be received by the Fund Office within one (1) year of the date of death or dismemberment. If written notice is not timely received by the Fund Office, no benefit will be paid for accidental death or dismemberment.

ii. If an eligible Participant shall sustain more than one (1) of the aforesaid losses as a result of any one (1) accident, payment shall be made only for that loss for which the largest amount is payable.

iii. An Accidental Death and Dismemberment Benefits shall not be paid for losses caused by:

A. War or act of war, whether war is declared or undeclared; or

B. Disease or infection, except pyogenic or septic infection of visible wound that resulted because of an accident; or

C. Participation in or as the result of the commission of a criminal act.

Section 3: Weekly Disability Benefits

a. Weekly Disability Benefits are payable only on behalf of a disabled bargaining unit Participant, a Union Employee, a Fund Employee or a disabled NBUE Participant classified as a Working Owner or a Sole Proprietor, and who is either maintaining eligibility under Article II, Section 2(a) or during the first 4 months of maintaining eligibility under Article II, Section 2(b). No Participant who is a Non-Working Owner, is eligible for Weekly Disability Benefits.

b. The term "disability" or "disabled" for purposes of this Section 3 means a temporary disability which renders the Participant unemployable and which results from an Illness or injury that is not the result of an on-the-job injury or an automobile accident.

c. An application for Weekly Disability Benefits in a form acceptable to the Board of Trustees, accompanied by such documentation, identification and proofs as the Fund may require, must be filed with the Fund Office within one hundred and eighty (180) days of the onset of the Illness or injury.

d. A Participant must be under the care of a physician or surgeon in order to receive Weekly Disability Benefits.

e. A Participant is not eligible for Weekly Disability Benefits for any week for which the Participant receives State unemployment benefits.

f. The Weekly Disability Benefit is $200 per week for a period of twenty-six (26) continuous weeks or the period of his disability, whichever is shorter.

g. Payment for any one (1) payable day of disability benefits is one-seventh (1/7) of the weekly benefit amount.

h. Benefits shall commence on the first (1st) day of disability due to an injury and on the eighth (8th) day of disability due to an Illness, including pregnancy and substance abuse.

i. A Participant will not be eligible for a new period for Weekly Disability Benefits until the Participant has been reemployed in covered employment on a full-time basis for a minimum of one (1) day (eight (8) hours of work). Under no circumstances may a Participant be eligible for more than three (3) disability periods because of a disability due to the same Illness or injury.

j. Disability due to pregnancy is deemed to be for the period six (6) weeks prior to the due date through the six (6) to eight (8) weeks following the delivery date. If more extended maternity leave is claimed to be necessary (up to the twenty-six (26) continuous week maximum), the Participant shall provide medical documentation deemed sufficient by the Fund.

k. The Fund is the Employer's agent for purposes of the payment of employment taxes on Weekly Disability benefits as set forth in Treasury Regulation §31.6051-3.

Section 4: Medical, Hospital, Surgical and Prescription Drug Benefits for Active Participants and their Dependents

Medical, hospital, surgical and prescription drug benefits provided by the Fund to Active Participants and their Dependents shall be set forth in the schedules of benefits in the Fund's policies of insurance, Group Enrollments, Coverage Agreements and/or Administrative Services Agreements with the Blue Cross Blue Shield of Michigan (BCBSM) PPO Network, which are incorporated by reference as if printed verbatim herein.

Section 5: Medical Benefits for Early Retirees and their non-Medicare-Eligible Dependents, and the non-Medicare-Eligible Dependents of Medicare-Eligible Retirees

Medical, hospital, and surgical and benefits provided by the Fund to Early Retirees and their non-Medicare-Eligible Dependents, and the non-Medicare-Eligible Dependents of Medicare-Eligible Retirees shall be set forth in the schedules of benefits in the Fund's policies of insurance, Group Enrollments, Coverage Agreements and/or Administrative Services Agreements with the BCBSM PPO Network, which are incorporated by reference as if printed verbatim herein. Participants covered under this Section do not receive prescription drug benefits from the Fund.

Section 6: Medical and Prescription Drug Benefits for Medicare-Eligible Retirees and their Medicare-Eligible Dependents and the Medicare-Eligible Dependents of Early Retirees

The Fund provides Medicare-Eligible Retirees and their Medicare-Eligible Dependent**s** and the Medicare-Eligible Dependents of Early Retirees with medical, hospital, surgical and prescription drug benefits through an insurance contract(s) with Blue Cross Blue Shield of Michigan Medicare

Advantage Part D (MAPD) plan, the terms of which are incorporated by reference as if printed verbatim herein. The full cost of the MAPD plan shall be paid by the Medicare-Eligible Retiree and/or Medicare-Eligible Dependents.

Section 7: Vision Benefits

a. Vision Care Providers

The Board of Trustees may enter into agreements on behalf of the Fund with vision care providers that agree to charge reduced fees to Eligible Persons. The Board of Trustees may also terminate such agreements at any time for any reason. Eligible Persons may choose any licensed vision professional from whom to receive services, whether or not connected with a vision care provider with which the Fund has an agreement. By entering into an agreement with a vision care provider, neither the Fund nor the Board of Trustees is endorsing or recommending any particular professional. A current list of the vision care providers with which the Fund has an agreement, if any, can be obtained from the Fund Office. Vision benefits are payable as set forth in this Section, subject to all applicable copayments and limitations. Vision benefits, together with all other benefits and eligibility rules under this Plan, are subject to change by the Board of Trustees at its sole discretion.

b. Amounts Payable

The Fund will pay 100% of covered expenses actually incurred up to the following calendar-year annual benefit limits per Eligible Person for Active Participants, COBRA Participants, NBUE Participants, and their Dependents or once every two calendar years for Retired Participants, Permanently and Totally Disabled Participants, Surviving Spouses, and their Dependents:

	Maximum Payable ($)
Examination Fee	50.00
Single Lenses (Pair)	75.00
Bifocal Lenses (Pair)	90.00
Trifocal Lenses (Pair)	100.00
Frames	100.00
Contact Lenses (in lieu of frames and lenses)	140.00

The covered person is responsible to pay any amounts charged which are in excess of the applicable maximum amount payable by the Fund.

c. Limitations

Vision benefits are **not** provided for the following services:

i. Sunglasses, unless they are prescribed to be worn at substantially all times.

ii. Glasses with tinted lenses, scratch coat, UV protection, and other specialty items.

iii. Routine yearly examinations required by an employer in connection with the occupation of the individual.

iv. Vision expense for covered services resulting from occupational bodily injury or disease.

v. Vision expense for covered services in a hospital owned or operated by the Federal Government or for which the Employee is not required to pay.

vi. Any vision care to the extent that benefits for the service or supply are payable under any other insurance or group policy.

vii. A service or supply not furnished by a licensed physician, optometrist or ophthalmologist.

viii. Service or supplies in connection with occupationally related conditions.

Section 8: Dental Benefits

a. Coverage

Active Participants, COBRA Participants, NBUE Participants, Retired Participants, Permanently and Totally Disabled Participants, Surviving Spouses and their Dependents may choose between Traditional Benefits and Golden Dental Managed Care Program options.

b. Traditional Benefits

i. The Fund will pay 100% of the reasonable and customary amounts of expenses for dental treatment received by an Eligible Person from any licensed dentist, oral surgeon or hygienist (with respect to prophylaxis), up to $400 per Benefit Year for each Eligible Person.

ii. All types of dental services, surgical and non-surgical, are covered under this benefit, including periodontal work, extractions (impacted and non-impacted), radiographs, consultations, orthodontics, exams and cleanings.

iii. Orthodontic treatment is included in the annual maximum for each Eligible Person.

iv. Benefits will be paid directly to the dentist or other professional unless the covered person submits a paid, itemized bill for services rendered. Charges in excess of the amount allowed by the Fund's schedule of benefits are the responsibility of the covered person.

v. The Board of Trustees may enter into agreements on behalf of the Fund with dental preferred provider organizations that agree to charge reduced fees to Eligible Persons. The Board of Trustees may also terminate such agreements at any time for any reason. Eligible Persons may choose any licensed dentist from whom to receive services, whether or not connected with a preferred provider organization with which the Fund has an agreement. By entering into an agreement with a preferred provider organization, neither the Fund nor the Board of Trustees is endorsing or recommending any particular professional. A current list of the dental preferred provider organizations, if any, can be obtained from the Fund Office. Dental benefits, together with all other benefits and eligibility rules of this Plan, are subject to change by the Board of Trustees at its sole discretion.

c. Golden Dental Managed Care Program

i. Participants may elect, on an annual basis, to participate in the Golden Dental Managed Care Program instead of the Traditional Benefits described in Section 8(b) of this Article III. Once enrolled, the Participant and his Dependents must remain in the Golden Dental Managed Care Program for the entire year. Under the Golden Dental Managed Care Program, all dental services are exclusively provided by Golden Dental providers. By entering into an agreement with Golden Dental, neither the Fund nor the Board of Trustees is endorsing or recommending any particular professional.

ii. Except for orthodontic treatment, the Fund will pay up to $1,500 per calendar year per Eligible Person under the Fund's agreement with Golden Dental Managed Care Program, which is incorporated by reference as if printed verbatim herein, subject to the following limits:

Class I - Diagnostic and Preventative Services	100%
Class II - Restorative	75%
Class III - Prosthetics	75%
Class IV - Specialty Care	50%

iii. For orthodontic treatment, under the Fund's agreement with Golden Dental Managed Care Program, which is incorporated by reference as if printed verbatim herein, the Fund will pay 50% up to a lifetime maximum of $1,800 per Eligible Person.

Section 9: Non-Medical Program for Retirees

Instead of the regular retiree program, Retired Participants may elect to receive the following coverage only for a special reduced monthly self-payment rate to be established by the Board of Trustees, which rate may change from time to time at the discretion of the Board of Trustees:

Dental: Either $400 per calendar year for Traditional Benefits **or** $1,500 per calendar year for Golden Dental Managed Care Program coverage, if elected.

Vision: Vision Benefits in accordance with Article III, Section 7.b.

Death Benefit: $1,000 for Retired Participant only.

Section 10: Telemedicine Benefits

The Fund provides all Eligible Persons except Medicare-Eligible Retirees with telemedicine benefits through a service agreement with CADRPLUS, the terms of which are incorporated by reference as if printed verbatim herein.

As a condition to receive telemedicine benefits, an Eligible Person must provide all required information and documentation requested by CADR.

Telemedicine consultations are generally not subject to any of the deductible, coinsurance or copayment requirements described above, provided however, that (1) if a licensed physician issues a prescription as a result of a telemedicine consultation, the applicable Prescription Drug Benefit copayment set forth in Article III, Section 5 of the Plan applies when that prescription is filled; and (2) any follow up service, care or treatment received as a result of a telemedicine consultation is subject to the applicable deductible, coinsurance or copayment requirements described above.

Section 11: Health Reimbursement Account for Marble Shop Employees

a. Background

Effective January 1, 2017, the Tile, Marble & Terrazzo Insurance Trust Fund ("TMT Fund") merged into this Fund. At the time of the merger, the TMT Fund had established Health/Medical Reimbursement Accounts ("HRAs") on behalf of certain participants who had contributions remitted to the TMT Fund under an agreement between the Union and Michigan Marble Fabricators ("Marble Shop Employees"). As part of the merger, the Fund agreed to recognize the HRA balances of the Marble Shop Employees that existed as of January 1, 2017, but will not permit the addition of funds to the HRAs beyond the funds required to be credited from Marble Shop Employees' work hours for December 2016.

Accordingly, the Marble Shop Employees who had HRAs in the TMT Fund as described above shall be permitted to use those HRAs until they are exhausted as provided in this Section.

The HRA account is a bookkeeping account only – it cannot be cashed out at any time and it does not vest. The Board of Trustees may terminate the account at any time. The HRA can only be used for such purposes as are set forth in subsection b. and is subject to cancellation pursuant to subsection c.

b. Permitted Uses

Marble Shop Employees may use the HRAs to reimburse amounts incurred for qualified medical, dental, vision or prescription drug expenses, as defined in Section 213(d) of the Internal Revenue Code, on behalf of the Marble Shop Employee or his Spouse and Dependents, which are not covered by the Fund due to co-payments, maximum allowable benefits, or services that are not payable under the Plan, and to pay self-payment amounts which may be due to continue coverage. The HRA may be used only up to the balance that was transferred in accordance with the Merger Agreement.

A Marble Shop Employee and/or his Spouse and Dependents, as applicable, shall complete and submit an HRA Claim Form accompanied by all written proofs that the Fund administrative office shall request in order to apply for HRA benefits.

Upon use of the HRA for the purposes described above, an equal amount will be cancelled from the available account balance in accordance with subsection d.

c. Excluded Uses

The HRA may not be used to cover over-the-counter vitamins, holistic medicines or treatments, over-the-counter drugs which are not prescribed by a physician, or which are otherwise excluded by IRS guidelines or plan provisions.

d. Cancellation of HRA Balance

The account balance shall be reduced or cancelled, as applicable, upon the earliest of the following to occur:

i. Use of the HRA as set out in subsection b. Once the HRA balance is reduced to zero, it shall no longer be available for use.

ii. Twenty-four (24) months after the termination of the Marble Shop Employee's coverage.

iii. Immediately upon a Marble Shop Employee's written election to waive future use of the HRA, which shall be permitted each January 1.

iv. Immediately upon a former Marble Shop Employee's written election to waive future use of the HRA.

v. The latest of:

1. the death of the Marble Shop Employee, or

2. the death of the Surviving Spouse, or

3. the death of another Dependent.

vi. The termination of the HRA provisions of the Plan by the Board of Trustees.

ARTICLE IV: CLAIMS PROCESSING

Section 1: Eligibility Determinations

Participant eligibility is determined by the Fund Office based on receipt of hours and contributions, self-payments and all other relevant factors as set forth in Article II of this Plan. Dependent eligibility is determined by the Fund Office based on information provided on forms available from the Fund Office and supporting documentation. All materials related to requests for eligibility must be submitted within the time periods required by Part II of this Plan.

Section 2: Claims for Benefits

a. Time Limits for Claims

i. All claims for medical, hospital, surgical and prescription drug benefits must be submitted for reimbursement within 12 months from the date of service for facility claims and 6 months from the date of service for professional claims.

ii. All claims for vision and dental benefits must be submitted for reimbursement within 90 days from the date of service.

iii. All claims for Death Benefits, and Accidental Death and Dismemberment Claims, must be submitted within one (1) year from the date of the death or accident.

iv. All claims for Weekly Disability Benefits (and eligibility for loss-of-time credits under the provisions for Continuation of Eligibility During Short Term Disability) must be submitted within one hundred eighty (180) days of the onset of disability.

At the Board of Trustees' sole and exclusive discretion, if the notice or proof of claim is not received by the applicable deadline, the claim may still be paid if the claimant's failure was because of extenuating reasons beyond the claimant's control, or if the claimant provided such notice or proof as soon as reasonably possible and no later than one (l) year from the time notice or proof was otherwise required.

b. If processing of a claim cannot be completed because of missing information, the Fund Office will notify the claimant and advise of the specific reason why the processing of the claim cannot be completed and what information is necessary to permit the processing of the claim to continue. It is at all times the claimant's responsibility to provide all information required by the Fund Office within the required time period set out above or elsewhere in this Plan or in a document incorporated herein by reference. Failure to remit adequate information to the Fund or to a Fund service provider neither tolls those time periods nor restarts them.

c. After the applicable time limit has passed, the Fund is no longer obligated to pay or reimburse the amount of the claim. However, the Fund may still pay the claim at its discretion if the failure to submit the claim was due to reasons determined by the Fund to be beyond the control of the claimant, or if the claimant provided such notice or proof as soon as the Fund determines to have been reasonably possible but no more than one (1) year from the date notice or proof was otherwise required (except where the individual was legally incapacitated).

d. Any claim form or other material submitted by or on behalf of any claimant that contains a material alteration or forged or false information, including signatures, will be rejected. The Board of Trustees reserves the right to forward such matters to appropriate law enforcement agencies for whatever action deemed appropriate. This will not limit the right of the Fund to offset or recover any losses it suffers as a result of such material in any manner, including civil litigation, and/or to exclude permanently the claimant and any persons claiming benefit through the claimant from some or all benefits from the Fund.

Section 3: Denial of Claims

a. If a claim is denied by the Fund Office, the claimant will be notified with the specific reason for denial within the time periods required by applicable regulations, unless additional time is required to process the claim, in which case the claimant will be notified of the delay.

b. If a claim is denied by a Fund service provider, the claimant will be informed of the reason for the denial by the service provider, and claimants must comply with the requirements of the service provider with respect to any missing information needed to process the claim.

Section 4: Appealing a Denial of a Claim

a. A claimant (or his appointed representative) may appeal a denial of any claim for benefits by writing out the reasons for disagreement and the facts on which the claimant relies for the claim to benefits and mailing the appeal to the Board of Trustees, BAC of Michigan Health and Welfare Fund, within 180 days from the date of the notice of denial. No special form is required. An appeal of a denial of a pre-service claim for urgent care may be requested by telephone.

b. Appeals are considered by the Board of Trustees within the time periods set forth in the applicable regulations. The Board of Trustees will review the appeal in accordance with the requirements of the applicable regulations.

c. Claimants are notified, in writing, of the Board of Trustees' decision with respect to appeals, including (if the appeal is denied) the reasons and specific references to Plan documents upon which the Board of Trustees' decision was based.

Section 5: Requirement of Exhaustion of Administrative Remedies

No lawsuit can be filed against the Fund in connection with any claim until the claimant has exhausted all administrative appeals.

ARTICLE V: EXCEPTIONS AND LIMITATIONS

Except as may be provided for under the terms of the Plan or the Fund's agreements with service providers, the Plan shall not provide benefits for the following:

1. The Fund will **NOT** provide for care and services not covered as medically necessary or appropriate under Blue Cross Blue Shield of Michigan Medical Policy.

2. The Fund will **NOT** provide for treatment of injuries sustained in a motor vehicle accident or other motor vehicle licensed to be on the road or complications resulting from such injuries or accident, except Death Benefits and Accidental Death and Dismemberment Benefits. The term "vehicle" includes all usual forms of transportation designed primarily for use on public highways, including autos, motorcycles, vans, pick-up trucks, etc.

3. The Fund will **NOT** provide for loss or expense from sickness, or disease that entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law, or because of any accidental bodily injury, which arises out of or in the course of employment for pay or profit.

4. The Fund will **NOT** provide for care and services available at no cost in veteran's, marine or other hospital, facility, or institution owned or operated by or on behalf of any national government, its agencies or a political subdivision thereof, unless a charge is imposed and an itemized bill for services is submitted, or for care obtainable without cost from governmental agencies.

5. The Fund will **NOT** provide for treatment of a condition caused by military action or war or determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

6. The Fund will **NOT** provide for care and services payable by government-sponsored health care programs such as Medicare or TRICARE, except as provided under the Plan's contract with BCBSM Medicare Advantage Plan.

7. The Fund will **NOT** provide for payment to the extent that such payment is prohibited by any law of the jurisdiction where the covered person resides at the time the expenses are incurred.

8. The Fund will **NOT** provide for services that the covered person is not legally required to pay, that would not be charged if no coverage existed, for which a charge is not customarily made, for services available without cost, or for any nonresident tax levied by a community hospital.

9. The Fund will **NOT** provide for any procedure, care or treatment for which the medical

necessity cannot be proven to the satisfaction of the Plan, except allergy treatments and reconstruction after mastectomy.

10. The Fund will **NOT** provide for services outside the scope of the license of the institution or practitioner rendering the services.

11. The Fund will **NOT** provide for custodial care, rest therapy, education, training, or bed and board while confined to an institution that is primarily a school or other institution for training, a place of rest, or a place for the aged.

12. The Fund will **NOT** provide for services for treatment of an illness or injury due to declared or undeclared war or any act thereof, active participation in a riot, the commission or attempted commission of an assault or felony, or the engagement by the covered person in any unlawful act.

13. The Fund will **NOT** pay for office visits to Out-of-Network providers.

14. The Fund will **NOT** provide for services and supplies that are not medically necessary according to accepted standards of medical practice, including cosmetic surgery solely for improving appearance, except that coverage will be provided for 1) reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast for symmetrical appearance and prostheses and physical complications in all stages of mastectomy; 2) to correct a condition resulting from a congenital anomaly; or 3) to correct a condition resulting from an accident (excluding auto/vehicular accidents).

15. The Fund will **NOT** provide for drugs, devices, medical treatments or procedures that are experimental or investigative, including organ transplants, except as required by section 2709 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act. The terms "experimental" or "investigative" mean medical practices, procedures, treatment, services, drugs, or supplies that are considered experimental or investigational by, or not approved by, the Food and Drug Administration or the Department of Health and Human Services.

16. The Fund will **NOT** provide for expense incurred for in-vitro fertilization or artificial insemination.

17. The Fund will **NOT** provide for reversing sterilization.

18. The Fund will **NOT** provide for pre-employment, pre-marital, school or sports examination provided by non-network providers.

19. The Fund will **NOT** provide for routine treatment or services primarily for weight loss or control, unless necessitated as the direct result of a specifically identifiable and diagnosed condition or disease etiology, except bariatric surgery, which is covered as set forth in Article III, Section 4.o of this Plan.

20. The Fund will **NOT** provide for acupuncture, hypnotism or any goal-oriented/behavior modification-type therapy.

21. The Fund will **NOT** provide for air conditioners, purifiers, humidifiers, dehumidifiers, whirlpool, heating pads, hot water bottles, waterbeds, bandages and support garments, rubber gloves, treadmills, exercise equipment, lift chairs, and other equipment that does not constitute medically necessary durable medical equipment, even if prescribed by a physician.

22. The Fund will **NOT** provide for expenses incurred or resulting from self-inflicted injuries, unless the injuries resulted from a medical condition such as depression.

23. The Fund will **NOT** provide for travel or transportation by other than professional ground ambulance.

24. The Fund will **NOT** provide services in connection with speech therapy, unless the speech therapy 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).

25. The Fund will **NOT** provide for care or treatment rendered by a member of the covered person's family or by a person normally residing in the covered person's home.

26. The Fund will **NOT** provide for hospital admissions, medical services and supplies provided **prior** to the effective date of coverage or **after** the coverage termination date.

27. The Fund will **NOT** provide for treatment of temporal mandibular jaw disorders ("TMJ"), however, diagnosis of TMJ may be covered through the Dental Benefit.

28. The Fund will **NOT** provide for the use of a private room. If used, the average semi-private room rate of that hospital will be paid, except private room accommodations required by the hospital for treatment in quarantine purposes and not for the comfort of the patient.

29. The Fund will **NOT** provide for charges for hospital rooms in excess of the hospital's regular charges.

30. The Fund will **NOT** provide for services and/or supplies for personal comfort items such as, television, telephones, lotion, powder, transportation within hospital, guest trays or other non-essential personal items and services, including take-home prescription drugs and supplies, etc.

31. The Fund will **NOT** provide for services and/or supplies for recreational or educational therapy, massage therapy, or non-medical self-care or self-help training.

32. The Fund will **NOT** provide for nutritional and dietary supplements.

33. The Fund will **NOT** provide for psychiatric services after determination that a condition will not respond to treatment.

34. The Fund will **NOT** provide for psychological tests for guidance or counseling for vocational purposes.

35. The Fund will **NOT** provide for drugs that require a prescription by state law, but not Federal law.

36. The Fund will **NOT** provide for administration of drugs or any drug consumed at the time and place of the prescription order.

37. The Fund will **NOT** provide for refills not authorized by a physician.

38. The Fund will **NOT** provide for more than a one-month supply of prescription drugs (except for specified maintenance drugs that are covered for 90 days).

39. The Fund will **NOT** provide for refills dispensed after one year from the date of the original order.

40. The Fund will **NOT** provide for drugs dispensed or any other product for cosmetic purposes.

41. The Fund will **NOT** provide for hospital confinement or other medical expenses due to a child of a dependent child, unless that grandchild is also a dependent of the participant subject to the requirements for Coverage for Dependents. The Plan will not provide for hospital confinement and other medical expenses due to a second or subsequent pregnancy of a dependent child.

42. The Fund will **NOT** provide for voluntary termination of pregnancy (abortions) for dependent children.

43. The Fund will **NOT** provide for non-prescription (over-the-counter) drugs.

An item that does not appear as an exclusion is not automatically covered as a benefit.

ARTICLE VI: ADMINISTRATION OF THE PLAN

Section 1: Trustee Authority

a. The Board of Trustees has the sole and exclusive authority to interpret and apply the rules of this Plan, the Trust and any other rules and regulations, procedures or administrative rules adopted by the Board of Trustees. Decisions by the Board of Trustees or, where Board of Trustee responsibility has been delegated to others, its delegatees, will be final and binding on all persons dealing with this Plan or claiming a benefit under this Plan. If

a decision of the Board of Trustees or its authorized delegates is challenged in court, the Trust Agreement provides, and it is hereby stated as the express intent of this Plan, that such decision is to be upheld unless a court of competent jurisdiction finds and issues a decision that such decision of the Board of Trustees was arbitrary and capricious.

b. All benefits under the Plan are subject to the Board of Trustees' authority under the Trust Agreement to change them. The Board of Trustees has the sole and exclusive discretion and authority to increase, decrease, change, amend and terminate benefits, eligibility rules or any other provisions of the Plan as it may determine to be in the best interests of the Plan participants and beneficiaries.

c. The right to change or eliminate any and all aspects of benefits provided for Retired Participants and their Dependents is a right specifically reserved to the Board of Trustees. The Board of Trustees has the authority to amend or terminate such benefits and/or to modify or increase self-payment amounts for coverage at any time.

d. Any Plan changes shall be effective even though an individual has already become a Participant, Dependent or Retiree, or has met the eligibility requirements to retire now or in the future. Under no circumstances do any benefits under this Plan or otherwise provided by the Fund "vest."

Section 2: Right to Benefits

No Employee, Employer, Participant, former Participant, Dependent, former Dependent, claimant, beneficiary or any other person claiming by or through any such person, shall have any right, interest or title to any benefits under the Trust Agreement, the Plan, or the Fund, except as such right, interest or title shall have been specifically granted pursuant to the terms of the Plan.

Section 3: Right to Information

The Board of Trustees shall have the right to require, as a condition precedent to the payment of any benefit under the Plan, all information which it reasonably deems necessary, including records of employment, tax records, proof of dates of birth and death, marital status, independent medical examinations of any person for whom benefits are being claimed, any and all medical records relating to a claim, etc., and no benefit dependent in any way upon such information shall be payable unless and until such information so required is furnished. Such evidence may be furnished by the Union, the Associations, Employers, Employees, Participants, Dependents, claimants, beneficiaries, alternate recipients or the representative of any of them.

Section 4: Right to Rely on Information

The Board of Trustees shall, in the absence of contrary evidence presented to them, have the right in administering the Plan to rely upon information provided to it by the Union, the Associations, Employers, Employees, Participants, Dependents, claimants, beneficiaries, alternate recipients or the representatives of any of them. Neither the Board of Trustees nor the Fund shall be held liable for good faith reliance thereon.

Section 5: Non-Reversion to Employers

No Employer shall have any right, title or interest in the contributions made to the Fund and no part of the Fund shall revert to the Employers or any of them.

Section 6: Compliance with Applicable Law

The Board of Trustees shall exercise such authority and responsibility as it deems appropriate in order to comply with the Internal Revenue Code, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Patient Protection and Affordable Care Act of 2010 ("PPACA") and such other statutes or valid governmental regulations issued thereunder as may apply to this Fund.

Section 7: Determination of Benefits

The Fund Office shall make all initial determinations as to the right of any person to any benefit under this Plan. Any denial by the Fund Office of any claim for benefits under the Plan shall be stated in writing and delivered or mailed to the claimant, and such statement shall set forth the specific reasons for the denial, explained in language calculated to be understood by the claimant. In addition, the Board of Trustees shall afford any claimant a reasonable opportunity for an appeal/review of the Fund Office's decision denying the claim and shall so inform the claimant.

Section 8: Medicare Secondary Payer Rules

a. If a Participant continues to work beyond the date he becomes eligible for Medicare, he and his Dependents, if any, shall be entitled to the same benefits offered to all other Participants and their Dependents. Medicare shall be the secondary payer, paying benefits only with respect to charges not covered by the Fund. However, when he ceases active employment, Medicare shall automatically become the primary payer when he is no longer eligible based on Employer contributions.

b. If a Dependent of a Participant who is eligible based on Employer contributions is on Medicare, the Fund will be the primary payer of benefits and Medicare will be secondary.

c. If a Retired Participant eligible for Medicare returns to covered employment, he shall be an Active Participant, and during such period of coverage as an Active Participant, the Fund will be the primary payer of benefits and Medicare will be secondary. When the Active Participant ceases working, his coverage as an Active Participant ceases and becomes covered as a Retired Participant, Medicare will be the primary payer of benefits and the Fund will be secondary.

Section 9: Medicaid and TRICARE

The eligibility and benefit rights of an Eligible Person shall be determined under this Plan without regard to that person's eligibility for or entitlement to Medicaid or TRICARE and this Plan shall, subject to other relevant provisions hereof, be the primary payer of benefits to such person.

The Plan will comply with any assignment of rights made by or on behalf of a Participant or his Dependents required by a State's Medicaid program and, further, will honor any subrogation rights a State may have as the result of having paid benefits on behalf of a Participant or his Dependents for which this Plan, as primary payer, was liable.

Section 10: Coordination of Benefits

a. All benefits from the Fund, except Accidental Death and Dismemberment Benefits and Death Benefits, are subject to and limited to benefits payable in accordance with coordination of benefits provisions, the purpose of which is to avoid duplicate or overlapping payout of benefits. Coordination of benefits provisions apply whenever a person covered hereunder has coverage under another health plan, fund, policy, contract or program ("covered person").

b. Under the following provisions, the Fund will pay benefits if it is determined to be primary. If it is not, the other health plan, fund, policy, contract or program ("health plan") will be required to pay the benefits up to the maximum amount payable in accordance with its Schedule of Benefits and this Fund will then pay any remaining amounts not covered by such other health plan in accordance with this Fund's Schedule of Benefits, if any, so that in the aggregate, no more than 100% of the incurred covered expenses are paid.

   The determination as to when this Fund is primary shall generally be determined as follows:

   i. If the covered person terminates his employment and becomes employed by another employer that provides a health plan other than through this Fund, then that employer's health plan shall be required to pay as primary.

   ii. If the other health plan has not adopted a coordination of benefits provision, it shall be required to pay as primary.

   iii. If the other health plan has adopted a coordination of benefits provision, then:

      A. The health plan in which the covered person is covered as an employee shall pay as primary and the health plan in which the covered person is covered a dependent shall pay as secondary.

      B. The health plan in which the covered person is covered as an active employee or dependent of an active employee (not as a laid-off employee or retiree) shall pay as primary and the health plan in which the covered person is covered as a laid-off employee or retiree or dependent of a laid-off employee or retiree shall pay as secondary.

C. If a covered person is covered by more than one health plan but one of the health plans covers the person pursuant to COBRA, then the COBRA coverage is secondary to the other health plan.

D. When the covered person is a Dependent child, the following order of priority shall be followed in determining which health plan shall pay as primary:

I. For children of parents not separated, or children or legally separated, divorced or never married parents with joint physical custody:

(a) The health plan covering the parent who has the earlier birth date anniversary in the calendar year.

(b) If both parents have the same birth date anniversary in the calendar year, the one health plan that covered the child for the longer period of time.

II. For children of legally separated, divorced or never married parents without joint physical custody:

(a) The health plan covering the parent with physical custody of the child.

(b) Then the health plan covering the parent without physical custody of the child.

However, if a court decree, such as a judgment of divorce, states that **one** parent is responsible for the health care expenses of the child, and the health plan has been advised of that legal responsibility, then that health plan shall pay as primary for the child and the other health plan would be secondary. If a court decree states that **both** parents are responsible for providing health coverage, then the two health plans would be of the same priority level and the rules of subparagraph I., above, would apply.

E. Where the covered person is covered as a Dependent child under this Fund and a Dependent spouse under the health plan of his or her spouse, the following order of priority shall be followed in determining which health plan shall pay as primary:

I. The health plan covering the parent or spouse who has the earlier birth date anniversary in the calendar year.

II. If both the parent and spouse have the same birth date anniversary, the plan that covered the child/spouse for the longer period of time.

Section 11: Facility of Payment

In the event of an Eligible Person's death or mental incompetence at a time when benefits remain unpaid, such benefits will be paid to the person or institution who incurred the charges if the charges have not otherwise been paid.

Whenever payments which should have been made under this Plan have been made under any other plans, the Fund shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted, and amounts so paid shall be deemed to be benefits paid under this Plan, and, to the extent of such payments, the Fund shall be fully discharged from liability under this Plan.

Section 12: Right of Recovery

Whenever payments have been made by the Fund to or on behalf of any individual in excess of the maximum amount of payment, the Fund shall have the right to recover such payments to the extent of such excess, from among one or more of the following, as the Fund shall determine: any persons to, for or with respect to whom or whose dependents such payments were made, any provider, any other insurance companies, and/or any other organization(s). The Fund may pursue such remedies, legal and/or equitable, as the Board of Trustees, in its sole and exclusive discretion, may elect.

Section 13: Restitution Where Benefits Improperly Received

The Fund and the Board of Trustees shall have the right to pursue restitution from any person or entity who receives benefits of any description from the Fund to which such person/entity was not entitled, whether by virtue of the ineligibility of such person at the time services were rendered, by virtue of receipt of excluded benefits or otherwise.

Section 14: Subrogation and Reimbursement

In the event of any payments of services to or on behalf of any person under this Plan, the Fund shall, to the extent of such payments, be subrogated to all rights of recovery of that person (or his representative(s)) arising out of any claim or cause of action which may accrue against a third party, including any occupationally related claim or cause of action covered by the Michigan Workers' Disability Compensation Act or Occupational Disease Act or similar federal or state statutes. That person (or his representative(s)), by acceptance of benefits provided by this Fund, hereby agrees to reimburse the Fund for any benefits so paid hereunder out of monies recovered, fully or partially, from such third party as the result of judgment, settlement or otherwise, irrespective of how differentiated, without any offset for expenses, including legal fees, that person (or his representative(s)) may owe, and before that person (or his representative(s)) pays any other individual, organization or entity out of that full or partial recovery. That person (or his representative(s)) may take no action which would prejudice the Fund and/or any of the Fund's

designees' rights, and that person (or his representative(s)) hereby agrees to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Board may require to facilitate the enforcement of the Fund's rights. The Fund and/or any of the Fund's designees will not be responsible for attorneys' fees or costs incurred and/or paid by or on behalf of that person (or his representative(s)) unless the Fund and/or any of the Fund's designees has agreed in writing to pay such fees or costs or some portion thereof.

If the Fund and/or any of the Fund's designees pays benefits on behalf of any person, and that person (or his representative(s)) receives a settlement, that person (or his representative(s)) must repay the Fund and/or any of the Fund's designees up to the amount of benefits it/they have paid. If that person (or his representative(s)) does not do so, the Fund and/or any of the Fund's designees has the right to treat the amount of benefits paid as a debt of that person (or his representative(s)) to the Fund and/or any of the Fund's designees and may pursue recovery of said amount from that person (or his representative(s)) and/or reduce any future benefits payable on behalf of that person (or his representative(s)) in this amount until this debt has been cancelled.

Section 15: Title and Rights to Fund

No Employee, Employer, Participant, former Participant, Dependent, former Dependent, claimant, beneficiary or any other person claiming by or through any such person, shall have any right, interest or title to any benefits under the Trust Agreement, the Plan, or the Fund, except as such right, interest or title shall have been specifically granted pursuant to the terms of the Plan. No Employer shall have any right, title or interest in the contributions made to the Fund and no part of the Fund shall revert to the Employers or any of them.

Section 16: Workers' Compensation Not Affected

This Plan is not in place of and does not affect any requirement for coverage under any Workers' Compensation law, occupational diseases law or similar law. Benefits which would otherwise be payable under provisions of these laws will not be paid by the Fund merely because the Employee fails or neglects to file a claim for benefits under the rules of these laws.

Section 17: Altered or Forged Claims

Any claim form or other material submitted by or on behalf of any person that contains a material alteration or forged, false or omitted information, including signatures, will be rejected. The Fund and its Board reserve the right to forward such matters to appropriate law enforcement agencies for whatever action deemed appropriate. This will not limit the right of the Fund to recover any loses it suffers because of such material in any manner, including civil litigation.

Section 18: Right of Offset

If any payment is made by the Fund to or on behalf of a person who is not entitled to the payment or the full amount of such payment, the Fund has the right to reduce future payments to that person or to the person responsible for the erroneous payment by the amount of the erroneous payment.

This right of offset will not limit the right of the Fund to recover such erroneous payments in any other manner, including civil litigation.

Section 19: Legal Actions – Limitations Period

An individual may not file legal action against the Fund or its Board of Trustees until that individual has followed all of the proper claim and claim appeal procedures. In addition, no action may be brought more than three (3) years after the time written proof of loss or claim is to be furnished to the Fund.

Section 20: Examinations

The Board of Trustees has the right to ask a doctor or other health professional of its choice to examine a person for whom benefits are being claimed, and to examine any and all Hospital or medical records relating to a claim, subject to this Plan provisions regarding Health Privacy.

Section 21: Unclaimed Benefits

Any benefit payment under the terms of the Plan that is unclaimed or uncashed for a period of two (2) years shall revert to and become part of the Fund.

Section 22: Health Privacy

The Fund (through the Fund Office) and the Board of Trustees (which is the Plan Sponsor as that term is defined in ERISA) use and disclose health information that is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder, for purposes of treatment, payment and/or health care operations as permitted by the Standards for Privacy of Individually Identifiable Health Information promulgated by the United States Department of Health and Human Services and codified at 45 C.F.R. §160 and §164 ("Standards").

The Fund Office may use and disclose protected health information to the Fund's Trustees, who may use and disclose that protected health information and protected health information that they receive from any other source to any person, including the Fund's service providers or prospective service providers, only to the extent necessary for the Board to perform administrative functions including, but not limited to, those functions related to coordination of treatment, facilitation of payment and health care operations; activities designed to improve health or reduce health care costs; accreditation, certification, licensing or credentialing activities; underwriting premium rating, bid solicitation or related functions to create, renew or replace service providers, health insurance or health benefits; review and auditing, including compliance reviews, medical reviews, legal services and compliance programs; business planning and development including cost management and planning-related analyses and formulary development; business management and general administrative activities of the Fund, including customer service and resolution of internal grievances; providing information to Participants and other covered persons on benefits and services; and reviewing appeals. The Trustees may have access to summary health information so that it may solicit premium bids from health insurers and health maintenance organizations, or

to modify or amend the Plan or to terminate the Fund. The Trustees may also have access to protected health information on whether a person is eligible for benefits under the terms of this Plan.

The Plan will disclose protected health information to the Trustees only upon receipt of a certificate, in accordance with 45 C.F.R. §164.504(f)(2)(ii), that this provision regarding Health Privacy has been adopted and that the Trustees agree to abide by its terms. The Trustees are subject to the following:

a. The Trustees will not use or further disclose protected health information other than as permitted or required by this Plan document or as required by law.

b. The Trustees will require that each of the agents, including subcontractors, to whom they provide protected health information agree to written contractual provisions that impose the same restrictions and conditions that apply to the Trustees with respect to such information.

c. The Trustees will not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit administered by the Trustees.

d. The Trustees will report to the Fund Office any use or disclosure of the protected health information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

e. The Trustees will provide Participants and other covered persons with protected health information in accordance with the rights accorded to them under the Standards, including the right to access protected health information, the right to an opportunity to amend protected health information and the right to an accounting of disclosures of protected health information.

f. The Trustees will make the Fund Office's internal practices, books, and records relating to the use and disclosure of protected health information available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with the Standards.

g. The Trustees will, as is administratively feasible, return or destroy all protected health information received from the Fund office that the Trustees maintain in any form, and will not retain copies of such information when it is no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Trustees will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

h. The Trustees will use their best efforts to request only the minimum necessary type and amount of protected health information to carry out the functions for which the information is requested.

i. The Trustees will ensure that adequate separation occurs between the Fund Office, which has been provided with access to the protected health information, and the Trustees. The Trustees have obtained an agreement from the Fund Office to restrict access and use of such information to the administrative functions that the Trustees have authorized the Fund Office to perform. The Trustees certify that employees of the Fund Office are the only employees to access and use protected health information as set forth above.

Anyone who suspects an improper use or disclosure of protected health information may report the occurrence to the Fund's Privacy Officer as designated by the Fund's Privacy Policy.

Section 23: Health Information Security

The Fund (through the Fund Office) and the Board of Trustees (which is the Plan Sponsor as that term is defined by ERISA) will comply with the security regulations issued pursuant to HIPAA, codified at 45 C.F.R. §§ 160, 162 and 164 ("Security Rule"), with regard to Electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Trustees on behalf of the Fund, except for the following types of ePHI:

(1) ePHI that it receives pursuant to an appropriate authorization (as described in 45 C.F.R. § 164.508), and

(2) ePHI that qualifies as Summary Health Information that it receives for the purpose of:

(i) obtaining premium bids for providing health insurance coverage under the Fund (as set forth in 45 C.F.R. § 164.504(f)(1)(ii)(A)), or

(ii) modifying, amending or terminating the Fund (as set forth in 45 C.F.R. § 164.504(f)(1)(ii)(B)), and

(3) ePHI that is information on whether an individual is participating in the Plan , or is enrolled or has disenrolled from the Plan, or is enrolled or has disenrolled from a health insurance issuer or HMO offered by the Plan (as set forth in 45 C.F.R. § 164.504(f)(1)(iii)).

The Trustees shall, in accordance with the Security Rule:

(1) Reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Trustees on behalf of the Fund,

(2) Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI they create, receive, maintain or transmit on behalf of the Fund,

(3) Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Trustees will use ePHI only for Fund administration activities and not for employment-related actions or for any purpose unrelated to Fund administration,

(4) Ensure that any agent, including a subcontractor, to whom the Trustees provide such information agrees to implement reasonable and appropriate security measures to protect the information, and

(5) Report to the Fund any Security Incident of which the Trustee(s) become(s) aware.

If other terms of the Plan conflict with the provisions of this Section, this Section shall control. The Security Rule is incorporated herein by reference. Unless defined in the Plan, all capitalized terms herein have the definition given to them by the Security Rule.

ARTICLE VII: AMENDMENT, TERMINATION AND MERGER

Section 1: Termination of Fund

Pursuant to the Agreement and Declaration of Trust, the Fund shall remain in full force and effect unless and until it is terminated by action of the Union and the Associations, until the Board of Trustees merges or consolidates the Fund with or into and/or transfers the assets of the Fund to another tax exempt trust fund or funds, until no funds are left for administration of the Fund, or until no individuals remain alive who can qualify for benefit hereunder.

If the Fund terminates, the Fund will pay benefits for covered expenses on behalf of Eligible Persons incurred on or before the termination date as long as the Fund's assets exceed its liabilities. Full benefits may not be paid if the Fund's liabilities exceed its assets, and benefit payments will be limited to the funds available, if any. The Board of Trustees shall not be liable for the adequacy or inadequacy of such funds. Any assets remaining after payment of Fund liabilities, if any, will be used for purposes determined by the Board of Trustees according to the Trust Agreement.

Section 2: Amendment

This Plan may be amended in any respect by a majority vote of the Board of Trustees pursuant to the voting rules set forth in the Fund's Agreement and Declaration of Trust, except that no amendment that conflicts with the terms of the Agreement and Declaration of Trust shall be valid.

NOTES

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

BAC of Michigan Health and Welfare Fund
Group Number: 71784 Package Code(s): 010
Section Code(s): 1000
PPO - PPO Plan, Rx, Hearing
Effective Date: 01/01/2022
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$250 per member $750 per family	$250 per member $750 per family
Copays • Fixed Dollar Copays	$25 copay for: • Office visits $50 copay for: • Urgent care services $250 copay for: • Facility medical emergency	$50 copay for: • Urgent care services $250 copay for: • Facility medical emergency
Coinsurance • Percent Coinsurance	20%	40% **Note:** Services without a network are covered at the in-network level.
Annual coinsurance maximums – applies to coinsurance amounts for all covered services **–** but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$1,000 per member $2,000 per family	$3,000 per member $6,000 per family
Annual out-of-pocket maximums – applies to deductibles, flat dollar copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable	$7,900 per member $15,800 per family	$15,800 per member $31,600 per family
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per benefit period, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Not Covered
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Not Covered
Well Child Care No frequency restrictions	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $25 copay	Not Covered
Online Visits	Covered - 100%	Not Covered
Office Consultations	Covered - 100% after $25 copay	Not Covered
Pre-Surgical Consultations	Covered - 100% after $25 copay	Not Covered

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - $250 copay then 80% after deductible; copay waived if admitted or accidental injury	Covered - $250 copay then 60% after deductible; copay waived if admitted or accidental injury
Non-Emergency use of the Emergency Room	Covered - $250 copay then 80% after deductible	Covered - 60% after deductible
Urgent Care Services	Covered - $50 copay then 80% after deductible	Covered - $50 copay then 60% after deductible
Ambulance Services - Medically Necessary Ground Transport Only	Covered - 80% after deductible	Covered - 80%

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 80% after deductible	Covered - 60% after deductible
Home Health Care	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing	Covered - 80% after deductible	Covered - 60% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered – 60% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80% after deductible	Covered - 60% after deductible
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral/Mental Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) - Pre-authorization required - **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy**	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Not Covered	Not Covered

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Physical therapy is limited to 25 visits	Covered - 80% after deductible	Covered - 60% after deductible

** Occupational and/or Speech Therapy is covered when services are necessary following hospitalization for an accident (except accidents that are work or auto related), stroke, cancer or heart -related problems.

BAC of Michigan Health and Welfare Fund
Group Number: 71784 Package Code(s): 010
Section Code(s): 1000
Hearing Care Coverage
Effective Date: 01/01/2022
Benefits-at-a-glance

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BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed for Active members only

Benefits	Coverage
Frequency Limitation	Once every 12 months
Audiometric Exam	Covered - 100% after deductible and coinsurance
Hearing Aid Evaluation	Covered - 100% after deductible and coinsurance
Hearing Aid	Covered - $500 Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.
Hearing Aid Conformity Test	Covered - 100%

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BAC of Michigan Health and Welfare Fund
Group Number: 71784 Package Code(s): 010
Section Code(s): 1000
Prescription Drugs
Effective Date: 01/01/2022
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30-day supply	$5 copay - Generic drugs 30% coinsurance - Brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90-day supply Effective July 1, 2019, your coverage only covers a 90-day supply of maintenance medications obtained using mail order or our exclusive Smart90 retail pharmacy. If you obtain your 90-day supply of maintenance medications from any other provider, you may be responsible for the total cost. Contact Customer Service for a Smart90 retail pharmacy location nearest you.	$0 copay – Generic drugs 30% coinsurance - Brand drugs
Specialty Drugs – 30-day supply Retail and Mail Order Your coverage only covers specialty drugs obtained from our exclusive pharmacy network for specialty drugs, subject to your cost share requirements. If you obtain your specialty drugs from any other provider, you may be responsible for the total cost. Contact Customer Service for the location nearest you.	Retail: $5 copay - Generic drugs 30% coinsurance - Brand drugs Mail Order: $0 copay - Generic drugs 30% coinsurance - Brand drugs Members are restricted to a 30-day supply at both retail and mail order and certain specialty drugs are limited to only a 15-day supply for each fill.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	

Benefits	Coverage
Smoking Cessation Drugs	100%
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Not Covered
Diabetic Supplies	Includes: Needles/Syringes - Covered at 100% if an injectable prescription drug was filled within the last 120 days under the BCBSM Rx benefit Retail Test Strips and Lancets: $5 copay - Generic drugs 30% coinsurance - Brand drugs Mail Order Test Strips and Lancets: 30% coinsurance - Brand drugs

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

BAC of Michigan Health and Welfare Fund
Group Number: 71784 Package Code(s): 010
Section Code(s): 1000
PPO - PPO Plan
Effective Date: 01/01/2022
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$250 per member $750 per family	$250 per member $750 per family
Copays • Fixed Dollar Copays	$25 copay for: • Office visits $50 copay for: • Urgent care services $250 copay for: • Facility medical emergency	$50 copay for: • Urgent care services $250 copay for: • Facility medical emergency
Coinsurance • Percent Coinsurance	20%	40% **Note:** Services without a network are covered at the in-network level.
Annual coinsurance maximums – applies to coinsurance amounts for all covered services **–** but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$1,000 per member $2,000 per family	$3,000 per member $6,000 per family
Annual out-of-pocket maximums – applies to deductibles, flat dollar copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable	$7,900 per member $15,800 per family	$15,800 per member $31,600 per family
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per benefit period, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Not Covered
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Not Covered
Well Child Care No frequency restrictions	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $25 copay	Not Covered
Online Visits	Covered - 100%	Not Covered
Office Consultations	Covered - 100% after $25 copay	Not Covered
Pre-Surgical Consultations	Covered - 100% after $25 copay	Not Covered

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - $250 copay then 80% after deductible; copay waived if admitted or accidental injury	Covered - $250 copay then 60% after deductible; copay waived if admitted or accidental injury
Non-Emergency use of the Emergency Room	Covered - $250 copay then 80% after deductible	Covered - 60% after deductible
Urgent Care Services	Covered - $50 copay then 80% after deductible	Covered - $50 copay then 60% after deductible
Ambulance Services - Medically Necessary Ground Transport Only	Covered - 80% after deductible	Covered - 80%

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 80% after deductible	Covered - 60% after deductible
Home Health Care	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing	Covered - 80% after deductible	Covered - 60% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered – 60% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80% after deductible	Covered - 60% after deductible
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral/Mental Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) - Pre-authorization required - **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy**	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Not Covered	Not Covered

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Physical therapy is limited to 25 visits	Covered - 80% after deductible	Covered - 60% after deductible

** Occupational and/or Speech Therapy is covered when services are necessary following hospitalization for an accident (except accidents that are work or auto related), stroke, cancer or heart -related problems.

2022

Medicare Plus Blue℠ Group PPO

Medical Benefits with Prescription Drugs

BAC of Michigan Health and Welfare Fund – Option 1

Benefits-at-a-Glance

January 1, 2022 - December 31, 2022

The benefit information provided is a summary of what we cover and what you pay. A complete list of services is found in the *Evidence of Coverage* and *Medical Benefits Chart*. If you have any questions about this plan's benefits or costs, please call Medicare Plus Blue Group PPO Customer Service (phone numbers are on the back cover of this booklet). You can always view the most current *Evidence of Coverage* by requesting it from Customer Service.

To join Medicare Plus Blue Group PPO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area of the United States and its territories.

Comprehensive Formulary
35187600 01/22
Medicare Plus Blue is a PPO plan with a Medicare contract.
Enrollment in Medicare Plus Blue depends on contract renewal.

www.bcbsm.com/medicare H9572_Grp22PassiveBAAG_M FVNR 0821

Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

Medicare Advantage Plans

Benefit	In-network and Out-of-network:
Premium	In addition to the Medicare Part B premium, you may also be required to pay a premium contribution as defined by your employer, union group, or third-party administrator.
Deductible	$0
Out-of-Pocket Maximum	$1,000 All medical and hospital care services below apply to this annual amount.
Note: Services with a [1] may require prior authorization.	
Ambulance services[1] – medically necessary transport; coverage applies to each one-way trip	Covered up to 100% of approved amount
Cardiac rehabilitation services	Covered up to 100% of approved amount
Chiropractic care – covered services include manual manipulation of the spine to correct subluxation	Covered up to 100% of approved amount
Dental services	Original Medicare covers very limited medically necessary dental services. Your Medicare Plus Blue Group PPO plan will cover those same medically necessary services. For cost sharing information for those services (e.g. surgery, office visits, X-rays), contact Customer Service.
Diabetes services and supplies[1] (includes coverage for glucose monitors, test strips, lancets, and self-management training)	Services are covered up to 100% of the approved amount for diabetes-related durable medical equipment or supplies and self-management training.
Diagnostic tests, lab services, and radiology services[1] (costs for these services may vary based on place of service)	Covered up to 100% of approved amount
Durable medical equipment[1]	Covered up to 100% of approved amount

Benefit	In-network and Out-of-network:
Emergency care – worldwide coverage for qualified medical emergencies and first aid services (copay waived if admitted to hospital within 3 days)	Covered up to 100% of approved amount
Hearing services • Diagnostic testing	Covered up to 100% of approved amount
Home health agency care[1]	Covered – 100%
Hospice care	Services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. Member may have to pay part of the costs for respite care and hospice-related outpatient prescription drugs.
Inpatient facility evaluation and management[1]	Covered up to 100% of approved amount
Inpatient hospital care[1]	Covered up to 100% of approved amount
Inpatient mental health care[1]	Covered up to 100% of approved amount
Kidney disease • Dialysis services[1] • Professional charges	 Covered up to 100% of approved amount Covered up to 100% of approved amount
Office visits, including Diagnostic Hearing, Outpatient Substance Abuse, Podiatry, and Vision	Covered up to 100% of approved amount
Outpatient mental health care • Facility and clinic services • Services in an office[1]	 Covered up to 100% of approved amount Covered up to 100% of approved amount
Outpatient physical, speech and occupational therapy[1]	Covered up to 100% of approved amount

Benefit	In-network and Out-of-network:
Outpatient services[1]	Covered up to 100% of approved amount
Outpatient substance abuse services[1] • Facility and clinic services	Covered up to 100% of approved amount
Outpatient surgery[1], including services at hospital outpatient facilities and ambulatory surgery centers	Covered up to 100% of approved amount
Podiatry: • Medically necessary foot care services other than office visits[1]	Covered up to 100% of approved amount
Prosthetic and orthotic devices and supplies[1]	Covered up to 100% of approved amount
Skilled nursing facility[1] – covers up to 100 days per benefit period	Covered up to 100% of approved amount
Supervised exercise therapy	Covered up to 100% of approved amount
Urgent care visits – covered worldwide	Covered up to 100% of approved amount
Vision services • Diagnosis and treatment of diseases and injuries of the eye	Covered up to 100% of approved amount

Preventive Services and Wellness/Education Programs	

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Annual “Wellness” visit
- Bone mass measurement (bone density)
- Breast cancer screening (mammograms)
- Cardiovascular disease screening (behavioral therapy)
- Cervical and vaginal cancer screenings
- Colorectal cancer screenings
  o Screening fecal occult blood test
  o Screening flexible sigmoidoscopy
  o Screening colonoscopy
  o Screening barium enema
  o DNA based colorectal screening every 3 years
- Depression screenings
- Diabetes screening
- Diabetes self-management training
- Flu shots (vaccine)
- Glaucoma screening
- Hepatitis B shots (vaccine)
- Hepatitis C screening test
- HIV screening
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and counseling
- Pneumococcal shot
- Prostate cancer screening
  o Digital rectal exam
  o Prostate specific antigen (PSA) test
- Screening for lung cancer with low dose computed tomography (LDCT)
- Sexually transmitted infections screening and counseling
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Welcome to Medicare prevention visits (initial preventive physical exam)
Any additional preventive services approved by Medicare during the contract year will be covered.
	In-network and Out-of-network:
	
	Covered – 100%

Prescription Drugs

Formulary Type: Comprehensive Formulary

Phase 1: The Deductible Stage

Because there is no deductible for the plan, this payment stage does not apply to you.

Phase 2: The Initial Coverage Stage

You pay the following until your out-of-pocket costs reach $7,050. See Chapter 6 Section 5.6 of the *Evidence of Coverage* for information about how Medicare counts your out-of-pocket costs.

Up to a 31-day supply	Preferred retail and preferred mail-order pharmacies	Standard retail and standard mail-order pharmacies
Tier 1 – Preferred Generic	$3	$10
Tier 2 – Generic	$3	$10
Tier 3 – Preferred Brand	$15	$20
Tier 4 – Non-Preferred Drug	$25	$30
Tier 5 – Specialty Tier	$25	$30

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.

32- to 90-day supply	Preferred retail and preferred mail-order pharmacies	Standard retail and standard mail-order pharmacies
Tier 1 – Preferred Generic	$7.50	$25
Tier 2 – Generic	$7.50	$25
Tier 3 – Preferred Brand	$37.50	$50
Tier 4 – Non-Preferred Drug	$62.50	$75
Tier 5 – Specialty Tier	Not offered	Not offered

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.

Phases 3 & 4: The Coverage Gap & The Catastrophic Stages

Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* by contacting Customer Service. Phone numbers are on the back cover of this booklet.

Medicare Plus Blue Group PPO has a network of doctors, hospitals, pharmacies, and other providers. Using providers that do not accept Medicare may cost you more.

Outside Michigan, your costs are the same as in-network and out-of-network services when you use providers that accept Medicare. Using providers that do not accept Medicare may cost you more. To locate a provider in our network, use the Find a Doctor tool on our website at: **www.bcbsm.com/providersmedicare**.

Non-contracted providers are under no obligation to treat Medicare Plus Blue Group PPO members, except in emergency situations. Please call our customer service number or see the *Evidence of Coverage* for more information.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website (**www.bcbsm.com/pharmaciesmedicare**). Or, call us and we will send you a copy of a *Provider/Pharmacy Directory* or, for members outside of Michigan, a *Provider/Pharmacy Locator* (phone numbers are on the back cover of this booklet).

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **www.bcbsm.com/formularymedicare**.

For more information, please call us at 1-866-684-8216, Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time. From October 1 through March 31, hours are from 8 a.m. to 9 p.m., seven days a week. TTY users should call 711. Or you can visit us at **www.bcbsm.com/medicare**.

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W004703

2022

Medicare Plus Blue℠ Group PPO

Medical Benefits with Prescription Drugs

BAC of Michigan Health and Welfare Fund – Option 2

Benefits-at-a-Glance

January 1, 2022 - December 31, 2022

The benefit information provided is a summary of what we cover and what you pay. A complete list of services is found in the *Evidence of Coverage* and *Medical Benefits Chart*. If you have any questions about this plan's benefits or costs, please call Medicare Plus Blue Group PPO Customer Service (phone numbers are on the back cover of this booklet). You can always view the most current *Evidence of Coverage* by requesting it from Customer Service.

To join Medicare Plus Blue Group PPO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area of the United States and its territories.

Comprehensive Formulary
35187601 01/22
Medicare Plus Blue is a PPO plan with a Medicare contract.
Enrollment in Medicare Plus Blue depends on contract renewal.

www.bcbsm.com/medicare H9572_Grp22PassiveBAAG_M FVNR 0821

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Medicare Advantage Plans

Benefit	In-network and Out-of-network:
Premium	In addition to the Medicare Part B premium, you may also be required to pay a premium contribution as defined by your employer, union group, or third-party administrator.
Deductible	$100
Out-of-Pocket Maximum	$1,000 All medical and hospital care services below apply to this annual amount.
Note: Services with a [1] may require prior authorization.	
Ambulance services[1] – medically necessary transport; coverage applies to each one-way trip	10% of approved amount, after deductible
Cardiac rehabilitation services	10% of approved amount, after deductible
Chiropractic care – covered services include manual manipulation of the spine to correct subluxation	$10
Dental services	Original Medicare covers very limited medically necessary dental services. Your Medicare Plus Blue Group PPO plan will cover those same medically necessary services. For cost sharing information for those services (e.g. surgery, office visits, X-rays), contact Customer Service.
Diabetes services and supplies[1] (includes coverage for glucose monitors, test strips, lancets, and self-management training)	Services are covered up to 100% of the approved amount for diabetes-related durable medical equipment or supplies and self-management training. Diabetic shoes covered up to 100% of approved amount, after deductible
Diagnostic tests, lab services, and radiology services[1] (costs for these services may vary based on place of service)	10% of approved amount, after deductible

Benefit	In-network and Out-of-network:
Durable medical equipment[1]	10% of approved amount, after deductible
Emergency care – worldwide coverage for qualified medical emergencies and first aid services (copay waived if admitted to hospital within 3 days)	$75, not subject to the deductible
Hearing services • Diagnostic testing	10% of approved amount, after deductible
Home health agency care[1]	Covered – 100%
Hospice care	Services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. Member may have to pay part of the costs for respite care and hospice-related outpatient prescription drugs.
Inpatient facility evaluation and management[1]	10% of approved amount, after deductible
Inpatient hospital care[1]	10% of approved amount, after deductible
Inpatient mental health care[1]	10% of approved amount, after deductible
Kidney disease • Dialysis services[1] • Professional charges	 10% of approved amount, after deductible 10% of approved amount, after deductible
Office visits, including Diagnostic Hearing, Outpatient Substance Abuse, Podiatry, and Vision	$10
Outpatient mental health care • Facility and clinic services • Services in an office[1]	 10% of approved amount, after deductible $10

Benefit	In-network and Out-of-network:
Outpatient physical, speech and occupational therapy[1]	10% of approved amount, after deductible
Outpatient services[1]	10% of approved amount, after deductible
Outpatient substance abuse services[1] • Facility and clinic services	10% of approved amount, after deductible
Outpatient surgery[1], including services at hospital outpatient facilities and ambulatory surgery centers	10% of approved amount, after deductible
Podiatry: • Medically necessary foot care services other than office visits[1]	10% of approved amount, after deductible
Prosthetic and orthotic devices and supplies[1]	10% of approved amount, after deductible
Skilled nursing facility[1] – covers up to 100 days per benefit period	10% of approved amount, after deductible
Supervised exercise therapy	10% of approved amount, after deductible
Urgent care visits – covered worldwide	$10, not subject to the deductible
Vision services • Diagnosis and treatment of diseases and injuries of the eye	10% of approved amount, after deductible

Preventive Services and Wellness/Education Programs	

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Annual “Wellness” visit
- Bone mass measurement (bone density)
- Breast cancer screening (mammograms)
- Cardiovascular disease screening (behavioral therapy)
- Cervical and vaginal cancer screenings
- Colorectal cancer screenings
  o Screening fecal occult blood test
  o Screening flexible sigmoidoscopy
  o Screening colonoscopy
  o Screening barium enema
  o DNA based colorectal screening every 3 years
- Depression screenings
- Diabetes screening
- Diabetes self-management training
- Flu shots (vaccine)
- Glaucoma screening
- Hepatitis B shots (vaccine)
- Hepatitis C screening test
- HIV screening
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and counseling
- Pneumococcal shot
- Prostate cancer screening
  o Digital rectal exam
  o Prostate specific antigen (PSA) test
- Screening for lung cancer with low dose computed tomography (LDCT)
- Sexually transmitted infections screening and counseling
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Welcome to Medicare prevention visits (initial preventive physical exam)
Any additional preventive services approved by Medicare during the contract year will be covered.
	In-network and Out-of-network:
	
	Covered – 100%

Prescription Drugs

Formulary Type: Comprehensive Formulary

Phase 1: The Deductible Stage

Because there is no deductible for the plan, this payment stage does not apply to you.

Phase 2: The Initial Coverage Stage

You pay the following until your out-of-pocket costs reach $7,050. See Chapter 6 Section 5.6 of the *Evidence of Coverage* for information about how Medicare counts your out-of-pocket costs.

Up to a 31-day supply	Preferred retail and preferred mail-order pharmacies	Standard retail and standard mail-order pharmacies
Tier 1 – Preferred Generic	$3	$10
Tier 2 – Generic	$3	$10
Tier 3 – Preferred Brand	$15	$20
Tier 4 – Non-Preferred Drug	$25	$30
Tier 5 – Specialty Tier	$25	$30

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.

32- to 90-day supply	Preferred retail and preferred mail-order pharmacies	Standard retail and standard mail-order pharmacies
Tier 1 – Preferred Generic	$7.50	$25
Tier 2 – Generic	$7.50	$25
Tier 3 – Preferred Brand	$37.50	$50
Tier 4 – Non-Preferred Drug	$62.50	$75
Tier 5 – Specialty Tier	Not offered	Not offered

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.

Phases 3 & 4: The Coverage Gap & The Catastrophic Stages

Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* by contacting Customer Service. Phone numbers are on the back cover of this booklet.

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Non-contracted providers are under no obligation to treat Medicare Plus Blue Group PPO members, except in emergency situations. Please call our customer service number or see the *Evidence of Coverage* for more information.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost sharing. You may pay less if you use these pharmacies. You can see our plan's pharmacy directory at our website (**www.bcbsm.com/pharmaciesmedicare**). Or, call us and we will send you a copy of a *Provider/Pharmacy Directory* or, for members outside of Michigan, a *Provider/Pharmacy Locator* (phone numbers are on the back cover of this booklet).

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **www.bcbsm.com/formularymedicare**.

For more information, please call us at 1-866-684-8216, Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time. From October 1 through March 31, hours are from 8 a.m. to 9 p.m., seven days a week. TTY users should call 711. Or you can visit us at **www.bcbsm.com/medicare**.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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2022

Medicare Plus Blue[SM] Group PPO

Medical Benefits with Prescription Drugs

BAC of Michigan Health and Welfare Fund – Option 3

Benefits-at-a-Glance

January 1, 2022 - December 31, 2022

The benefit information provided is a summary of what we cover and what you pay. A complete list of services is found in the *Evidence of Coverage* and *Medical Benefits Chart*. If you have any questions about this plan's benefits or costs, please call Medicare Plus Blue Group PPO Customer Service (phone numbers are on the back cover of this booklet). You can always view the most current *Evidence of Coverage* by requesting it from Customer Service.

To join Medicare Plus Blue Group PPO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area of the United States and its territories.

Standard Enhanced Formulary
35187602 01/22
Medicare Plus Blue is a PPO plan with a Medicare contract.
Enrollment in Medicare Plus Blue depends on contract renewal.

www.bcbsm.com/medicare H9572_Grp22ActiveBAAG_M FVNR 0821

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Medicare Advantage Plans

Benefit	In-network:	Out-of-network:
Premium	In addition to the Medicare Part B premium, you may also be required to pay a premium contribution as defined by your employer, union group, or third-party administrator.	
Combined Deductible	$250	
Out-of-Pocket Maximum	$2,000 In-network medical and hospital care services below apply to this annual amount.	Not Applicable
Combined Out-of-Pocket Maximum	$5,000 All medical and hospital care services below apply to this annual amount.	
Note: Services with a [1] may require prior authorization.		
Ambulance services[1] – medically necessary transport; coverage applies to each one-way trip	10% of approved amount, after deductible	20% of approved amount, after deductible
Cardiac rehabilitation services	10% of approved amount, after deductible	20% of approved amount, after deductible
Chiropractic care – covered services include manual manipulation of the spine to correct subluxation	$15	$35
Dental services	Original Medicare covers very limited medically necessary dental services. Your Medicare Plus Blue Group PPO plan will cover those same medically necessary services. For cost sharing information for those services (e.g. surgery, office visits, X-rays), contact Customer Service.	
Diabetes services and supplies[1] (includes coverage for glucose monitors, test strips, lancets, and self-management training)	Services are covered up to 100% of the approved amount for diabetes-related durable medical equipment or supplies and self-management training. Diabetic shoes covered up to 100% of approved amount, after deductible	Services are covered up to 100% of the approved amount for diabetes-related durable medical equipment or supplies and self-management training. Diabetic shoes covered up to 100% of approved amount, after deductible

Benefit	In-network:	Out-of-network:
Diagnostic tests, lab services, and radiology services[1] (costs for these services may vary based on place of service)	10% of approved amount, after deductible	20% of approved amount, after deductible
Durable medical equipment[1]	10% of approved amount, after deductible	20% of approved amount, after deductible
Emergency care – worldwide coverage for qualified medical emergencies and first aid services (copay waived if admitted to hospital within 3 days)	$65, not subject to the deductible	$65, not subject to the deductible
Hearing services • Diagnostic testing	10% of approved amount, after deductible	20% of approved amount, after deductible
Home health agency care[1]	Covered – 100%	Covered – 100%
Hospice care	Services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. Member may have to pay part of the costs for respite care and hospice-related outpatient prescription drugs.	
Inpatient facility evaluation and management[1]	10% of approved amount, after deductible	20% of approved amount, after deductible
Inpatient hospital care[1]	10% of approved amount, after deductible	20% of approved amount, after deductible
Inpatient mental health care[1]	10% of approved amount, after deductible	20% of approved amount, after deductible
Kidney disease • Dialysis services[1] • Professional charges	10% of approved amount, after deductible 10% of approved amount, after deductible	20% of approved amount, after deductible 20% of approved amount, after deductible

Benefit	In-network:	Out-of-network:
Office visits, including Diagnostic Hearing, Outpatient Substance Abuse, Podiatry, and Vision	$15 $25 with a specialist	$35 $45 with a specialist
Outpatient mental health care • Facility and clinic services	10% of approved amount, after deductible	20% of approved amount, after deductible
• Services in an office[1]	$15 $25 with a specialist	$35 $45 with a specialist
Outpatient physical, speech and occupational therapy[1]	10% of approved amount, after deductible	20% of approved amount, after deductible
Outpatient services[1]	10% of approved amount, after deductible	20% of approved amount, after deductible
Outpatient substance abuse services[1] • Facility and clinic services	10% of approved amount, after deductible	20% of approved amount, after deductible
Outpatient surgery[1], including services at hospital outpatient facilities and ambulatory surgery centers	10% of approved amount, after deductible	20% of approved amount, after deductible
Podiatry: • Medically necessary foot care services other than office visits[1]	10% of approved amount, after deductible	20% of approved amount, after deductible
Prosthetic and orthotic devices and supplies[1]	10% of approved amount, after deductible	20% of approved amount, after deductible
Skilled nursing facility[1] – covers up to 100 days per benefit period	10% of approved amount, after deductible	20% of approved amount, after deductible

Benefit	In-network:	Out-of-network:
Supervised exercise therapy	10% of approved amount, after deductible	20% of approved amount, after deductible
Urgent care visits – covered worldwide	$15, not subject to the deductible	$15, not subject to the deductible
Vision services • Diagnosis and treatment of diseases and injuries of the eye	10% of approved amount, after deductible	20% of approved amount, after deductible
Additional Benefits		
Chiropractic spinal X-rays, other chiropractic radiological, chiropractic physical therapy services, and evaluation and management services (must be provided by chiropractors or other qualified providers)	$15	$35
Foreign travel health care - not restricted to emergency or urgent care	Cost share same as if services were provided in the U.S.	Cost share same as if services were provided in the U.S.
Home infusion therapy	Covered up to 100% of approved amount	Covered up to 100% of approved amount
Hospice respite care – cost share for respite and drugs	Covered up to 100% of approved amount	Covered up to 100% of approved amount
Human organ transplants– additional coverage There is no lifetime maximum for non-Medicare covered organs.	10% of approved amount, after deductible	20% of approved amount, after deductible

Benefit	In-network:	Out-of-network:
Private duty nursing – services **do not** apply to the out-of-pocket maximum	50% of approved amount. Services **do not** apply to out-of-pocket maximum.	50% of approved amount. Services **do not** apply to out-of-pocket maximum.
Removal of Medicare therapy limits/thresholds for outpatient rehabilitation services	Medicare Part B therapy limits/thresholds **do not** apply to Outpatient Rehabilitation Services.	Medicare Part B therapy limits/thresholds **do not** apply to Outpatient Rehabilitation Services.
SilverSneakers® SilverSneakers is a registered trademark of Tivity Health, Inc. ©2021 Tivity Health, Inc. All rights reserved.	Covered up to 100% SilverSneakers is a comprehensive program that can improve overall well-being and social connections. Designed for all levels and abilities, SilverSneakers provides convenient access to a nationwide fitness network, a variety of programming options and activities beyond the gym that incorporate physical well-being and social interaction.	
Travel and lodging for covered transplants and clinical trials	Covered up to 100% of approved amount ($10,000 limit, for initial solid organ, $5,000 for approved clinical trial or bone marrow transplant.)	Covered up to 100% of approved amount ($10,000 limit, for initial solid organ, $5,000 for approved clinical trial or bone marrow transplant.)

Preventive Services and Wellness/Education Programs	

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Annual “Wellness” visit
- Bone mass measurement (bone density)
- Breast cancer screening (mammograms)
- Cardiovascular disease screening (behavioral therapy)
- Cervical and vaginal cancer screenings
- Colorectal cancer screenings
  o Screening fecal occult blood test
  o Screening flexible sigmoidoscopy
  o Screening colonoscopy
  o Screening barium enema
  o DNA based colorectal screening every 3 years
- Depression screenings
- Diabetes screening
- Diabetes self-management training
- Flu shots (vaccine)
- Glaucoma screening
- Hepatitis B shots (vaccine)
- Hepatitis C screening test
- HIV screening
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and counseling
- Pneumococcal shot
- Prostate cancer screening
  o Digital rectal exam
  o Prostate specific antigen (PSA) test
- Screening for lung cancer with low dose computed tomography (LDCT)
- Sexually transmitted infections screening and counseling
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Welcome to Medicare prevention visits (initial preventive physical exam)
Any additional preventive services approved by Medicare during the contract year will be covered.
	In-network and Out-of-network:
	
	Covered – 100%

Prescription Drugs

Formulary Type: Standard Enhanced Formulary

Phase 1: The Deductible Stage

$400

Phase 2: The Initial Coverage Stage

After you pay your yearly deductible, you pay the following until your out-of-pocket costs reach $7,050. See Chapter 6 Section 5.6 of the *Evidence of Coverage* for information about how Medicare counts your out-of-pocket costs.

Up to a 31-day supply	Preferred retail and preferred mail-order pharmacies	Standard retail and standard mail-order pharmacies
Tier 1 – Preferred Generic	$1	$4
Tier 2 – Generic	$15	$18
Tier 3 – Preferred Brand	$35	$45
Tier 4 – Non-Preferred Drug	45%	45%
Tier 5 – Specialty Tier	25%	25%

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.

32- to 90-day supply	Preferred retail and preferred mail-order pharmacies	Standard retail and standard mail-order pharmacies
Tier 1 – Preferred Generic	$2.50	$12
Tier 2 – Generic	$37.50	$54
Tier 3 – Preferred Brand	$87.50	$135
Tier 4 – Non-Preferred Drug	45%	45%
Tier 5 – Specialty Tier	Not offered	Not offered

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations.

Phases 3 & 4: The Coverage Gap & The Catastrophic Stages

Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* by contacting Customer Service. Phone numbers are on the back cover of this booklet.

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