Roofers Local 149
Security Benefit Trust Fund
Detroit Participants
Open Enrollment

ROOFERS LOCAL 149 FRINGE BENEFIT FUNDS

P.O. BOX 396
TROY, MICHIGAN 48099-0396
(248) 641-4949 (888) 868-6411

April 2021

IMPORTANT NOTICE FOR ACTIVE PARTICIPANTS IN THE ROOFERS LOCAL 149 SECURITY BENEFIT TRUST FUND
DETROIT PARTICIPANTS

This notice contains important information regarding coverage in the Roofers Local 149 Security Benefit Trust Fund (Fund). Please read this notice carefully.

Open Enrollment

During the open enrollment month of May, Active Employees may enroll eligible Dependents, i.e. Spouse or Children, not currently enrolled in the Roofers Local 149 Security Benefit Trust Fund (Fund). To do so, you must complete and return the enclosed form to the Fund Office by May 31, 2021. If you fail to do so, you will have to wait until May 2022 for another opportunity to enroll these Dependents.

Please see the attached enrollment form for additional information, including: (1) what to do if you are declining coverage for a Dependent because he/she has other coverage, and (2) special rules for adult children with employer provided coverage.

Currently Enrolled Dependents: You DO NOT have to complete and return this form for currently enrolled Dependents. They will remain covered under the Fund. Further, if you acquire new Dependents (for example, by birth or marriage) they may be enrolled during the course of the plan year.

Notice of Expiration of Certain Plan Deadlines

The following explains how extensions of certain plan deadlines during the COVID-19 pandemic are impacted by recent federal guidance. This supersedes any notices you may have previously received regarding extension of plan deadlines.

In light of the National Emergency created by the pandemic, on May 4, 2020, the Internal Revenue Service and Department of Labor adopted an emergency regulation which provides that the period between March 1, 2020 (the beginning date of the National Emergency), until 60 days after the end of the National Emergency (Outbreak Period) does not count for calculating:

- The COBRA election period,
- Timely payment of COBRA premiums,
- Timely notice from covered person of COBRA qualifying event,
- Timely notice from plan to covered person that they may elect COBRA,
- Timely election of HIPAA Special Enrollment rights,
- Timely filing of claims,
- Timely filing of appeals, and
- Timely filing of requests for external reviews.

Recently, however, guidance has been issued which clarifies that in no event will extension extend beyond one year. In other words, the end of the extension will be the earlier of:

(a) 1 year from the date a participant is first eligible for the extended deadline; or
(b) the end of the Outbreak Period, which is 60 days after the announced end of the National Emergency.

This notice gives examples of how this will apply to several deadlines under the Plan.

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COBRA Coverage (Health Plans)***:***

Examples:

1) Terry lost coverage on January 1, 2020 due to a reduction of hours and received a COBRA election notice on January 15, 2020. He did not elect COBRA coverage by March 15, 2020, which was the 60-day deadline under the normal (non-emergency) COBRA election rules. The first 45 days of his 60-day COBRA election period were prior to March 1, 2020, and therefore counted towards his election period. The last 15 days, however, were suspended until the earlier of March 1, 2021, one year after he became eligible for the extended deadline, or until the Outbreak Period is over. As the Outbreak Period is not yet over, Terry's election period will end on March 15, 2021.

2) Gail lost coverage due to a reduction of hours and received a COBRA election notice on September 1, 2020. Gail's COBRA election period under normal (non-emergency) COBRA election rules would have ended October 31, 2020, but the deadline was suspended during the Outbreak Period. Her election period will now end on the earlier of October 31, 2021, or 60 days after the end of the Outbreak Period.

3) Maria was receiving COBRA coverage on April 1, 2020. Maria made a timely COBRA premium payment for her April 2020 COBRA coverage, but has not made any payments since then. Under normal (non-emergency) COBRA rules, premium payments are due within a 30-day grace period that begins on the first day of the coverage month. For purposes of this example, assume that the Outbreak Period ends on July 30, 2021. Maria's premium payments for May 2020 through July 2021 are due within 30 days from the end of the Outbreak Period which is August 29, 2021. Her August premium would be due by August 30, 2021 (the 30-day grace period for her August premium payment).

NOTE: Although these COBRA deadlines may be extended, CLAIMS WILL NOT BE PAID UNTIL THE REQUIRED COBRA PREMIUMS ARE ACTUALLY RECEIVED BY THE PLAN.

Special Enrollment (Health Plans)***:***

Special enrollment allows (1) participants, spouses and new dependents to enroll following a marriage, birth, adoption, or placement for adoption and (2) permits participants and dependents to enroll upon loss of eligibility of other coverage, such as under a spouse's plan.

Examples:

1) Pat is the parent of a baby born on February 15, 2020. Under the normal (non-emergency) special enrollment rules, Pat had 30 days to enroll her baby in plan coverage. This deadline was suspended during the Outbreak Period. The first 14 days of the special enrollment period were prior to the Outbreak Period and counted toward the special enrollment period deadline, which was suspended March 1, 2020. Her baby's special enrollment period ends on the earlier of March 16, 2021, or 16 days after the end of the Outbreak Period.

2) David married his spouse on August 1, 2020. Under the normal (non-emergency) special enrollment rules, David had 30 days to enroll his new spouse in plan coverage. This deadline was suspended during the Outbreak Period. The spouse's special enrollment period ends on the earlier of August 30, 2021, or 30 days after the end of the Outbreak Period.

Claims and Appeals (All Employee Benefit Plans (DB, DC, Health, etc.)***:***

The deadlines for filing a claim for benefits, appealing a claim denial (an "adverse benefit determination") and filing a request for external review of an appeal denial were all suspended during the Outbreak Period.

Example:

Melanie received a claim denial (an "adverse benefit determination") on July 1, 2020. Under normal (non-emergency) plan rules, she would have 180 days from the claim denial to file an appeal, which would be December 28, 2020. This deadline was suspended during the Outbreak Period. Melanie's deadline to file an appeal now ends on the earlier of December 28, 2021, or 180 days after the end of the Outbreak Period.

Notice of Privacy Practices

The Fund Notice of Privacy Practices is available upon request, at no charge, at the Plan Office at BeneSys, Inc., P.O. Box 396, Troy, MI 48099-0396, telephone numbers (248) 641-4949 or (888) 868-6411.

Notice of Grandfathered Status

The Roofers Local 149 Security Benefit Trust Fund believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

CHIPRA Notice to Employees

Ineligibility for Medicaid/CHIP: A Participant or Dependent may enroll in the Plan if no longer eligible for coverage under Title XIX of the Social Security Act or a state child health plan under Title XXI of the Social Security Act, provided the individual requests enrollment within 60 days after such coverage ends.

Medicaid/CHIP Premium Assistance Eligibility: A Participant or Dependent may enroll in the Plan if he or she becomes eligible for assistance for Plan coverage under Title XIX of the Social Security Act or a state child health plan under Title XXI of the Social Security Act, provided the individual requests enrollment within 60 days of the date the individual is determined to be eligible for assistance.

The Women's Health and Cancer Rights Act of 1998 Annual Notice

The Health Care Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Not only is this notice being published to comply with the 1998 Omnibus Appropriations Bill, but it is very important that you understand that these benefits are available through your Health Care Plan.

Newborns' and Mothers' Health Protection Act 1996 Notice

The Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act) requires group health plans that offer maternity hospital benefits for mothers and newborns to pay for at least a 48-hour hospital stay for the mother and newborn following childbirth (or, in the case of cesarean section, a 96-hour hospital stay), unless the attending provider, in consultation with the mother, decides to discharge earlier.

If you have any questions regarding the content of this notice, or your coverage in general, please contact the Fund Office at P.O. Box 396, Troy, MI 48099-0396, (248) 641-4949 or (888) 868-6411.

Roofers Local 149 Security Benefit Trust Fund - Open Enrollment Form

Participant Information:

Name: _____ Last four digits Social Security No. _____

Address: _____ Birth Date: _____

Complete the following for each Dependent to be enrolled (if enrolling more than two, attach additional sheets):

Dependent

Name: _____ Relationship: _____ Spouse _____ Child

Birth Date: _____ Address: _____

Last four digits Social Security No. _____ Is this Dependent eligible for other health care coverage? _____ Yes _____ No

Dependent

Name: _____ Relationship: _____ Spouse _____ Child

Birth Date: _____ Address: _____

Last four digits Social Security No. _____ Is this Dependent eligible for other health care coverage? _____ Yes _____ No

If Your Dependent Has Other Coverage:

Dependents: If you have any Dependents (including children up to age 26) who are not enrolled in the Plan, this is your one-time annual option to elect coverage. If you decline coverage you will have to wait until the May 2022, open enrollment to elect coverage for your dependents. However, if you are declining coverage under the 149 Plan because your Dependent(s) has other coverage, please provide the following information and return this form to the Fund Office by May 31, 2021. If you do so and this coverage involuntarily terminates during the plan year, you can enroll your dependent in the 149 Plan if you request enrollment within 30 days of such termination. If you do not, you will have to wait until May 2022, for another enrollment opportunity.

Name of Dependent: _____

Does the Dependent have other comprehensive health plan coverage? ____ Yes ____ No

Provide the Name and Address of the other coverage:

_____

By signing below, I certify that: 1) the information provided above is correct; 2) Dependent coverage is contingent upon my maintaining eligibility as defined in the Plan Document; 3) I will be financially responsible for any claims paid for ineligible Dependents if any of the information above is inaccurate or misleading; and 4) I will provide the Fund office with any documentation necessary to verify that my Dependents are eligible for coverage under the terms of the 149 Plan.

Participant's Signature _____ Date_____

Please return this form to Roofers Local 149 Fringe Benefit Fund Office, P.O. Box 396, Troy, MI 48099-0396, (248) 641-4949 or (888) 868-6411. THIS ENROLLMENT FORM MUST BE RECEIVED BY THE FUND OFFICE BY MAY 31, 2021.

SUMMARY ANNUAL REPORT

For Roofers 149 Security Benefit Trust Fund

This is a summary of the annual report of the Roofers 149 Security Benefit Trust Fund, EIN 38-2481614, Plan No. 501, for period June 1, 2019 through May 31, 2020. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with Golden Dental Plans Inc., Hap Preferred Inc., Humana, Metropolitan Life Insurance Company and The Union Labor Life Insurance Company to pay health, dental, life insurance, stop loss, HMO and ADD claims incurred under the terms of the plan. The total premiums paid for the plan year ending May 31, 2020 were $2,250,069.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $15,908,464 as of May 31, 2020, compared to $15,297,500 as of June 01, 2019. During the plan year the plan experienced an increase in its net assets of $610,964. This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $13,238,966, including employer contributions of $11,365,969, employee contributions of $1,427,121, earnings from investments of $433,773, and other income of $12,103.

Plan expenses were $12,628,002. These expenses included $448,688 in administrative expenses, and $12,179,314 in benefits paid to participants.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- an accountant's report;
- financial information;
- assets held for investment;
- insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Roofers 149 Security Benefit Fund at P.O. Box 396, Troy, MI 48099-0396, or by telephone at (248) 641-4949. The charge to cover copying costs will be $0.00 for the full annual report, or $0.00 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (Roofers 149 Security Benefit Fund, 700 Tower Drive, Ste. 300, Troy, MI 48098-2808) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13)(PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 06/30/2022)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-248-641-4949 or 1-888-868-6411. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform.com.com or call 1-888-868-6411 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network & Out-of-Network: $250/person; $500/ two-person; $750/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes, routine/preventative care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Co-insurance: In-Network and Out-of-Network: $1,500/person; $3,000/family.	If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Self-payments, balance-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, see www.physicianscare.com or call 1-888-868-6411 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out of network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out -of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	30% of R&C after $15 copay	———— None ————
	Specialist visit	$15 copay per visit	30% of R&C after $15 copay	———— None ————
	Preventive care/screening/ immunization	No charge, other than: •10% coinsurance for immunization. •Mammograms, (one per year) are not subject to the deductible or coinsurance.	20% R&C after $10 copay (no coverage for Michigan residents); well-baby care only provided in-network, not covered out of network.	Routine well baby care and adult; age and frequency limits apply (includes office visits, immunizations, inoculations (infants) and diagnostic testing/screening/counseling (adults); immunizations not covered out of network for children up to age 19; for children over 19 out-of-network benefit not to exceed in-network allowance. You may have to pay for services that are not preventative. Ask your provider if the services you need are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after $15 co-payment per billing statement, not subject to the deductible.	30% R&C after deductible	In-Network: if occurs in doctor office or outside facility 10% coinsurance after $15 copay (not subject to deductible).
	Imaging (CT/PET scans, MRIs)	10% coinsurance after $15 co-payment per billing statement, not subject to the deductible.	30% R&C after deductible	———— None ————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com	Generic drugs	Retail (34-day supply): $15 copay Mail Order (90-day supply) $30 copay	Not covered.	Must use participating pharmacy. Proton pump inhibitors: subject to $15 copay (regardless of retail or mail); plan pays $50 per prescription and participant pays remainder.
	Preferred brand drugs	Retail (34-day supply): $40 copay Mail Order (90-day supply): $100 copay	Not covered.	If preferred brand drug received when generic equivalent available, must pay copay and cost between generic and brand name drug. Must use participating pharmacy.
	Non-preferred brand drugs	Retail (34-day supply): $40 copay Mail Order (90-day supply): $100 copay	Not covered.	
	Specialty drugs	Specialty Pharmacy (34-day supply): $100 copay	Not covered.	Coverage limited to certain injectible immunomodulators. Must use Envision Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible.	30% R&C after deductible.	———— None ————
	Physician/surgeon fees	No charge (subject to deductible).	30% R&C after deductible.	———— None ————
If you need immediate medical attention	Emergency room care	10% coinsurance after $100 copay.	30% R&C after $100 copay.	Coinsurance waived if accidental injury or admitted. For cost of related diagnostic tests, see page 2 for applicable coinsurance and R&C after deductible is satisfied.
	Emergency medical transportation	10% coinsurance after $50 copay per trip.	30% R&C after $50 copay per trip.	In-Network: No coinsurance if admitted as bed patient. Out-of-Network: 20% coinsurance if admitted as bed patient.
	Urgent care	$25 copay	30% R&C after $25 copay.	———— None ————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible.	30% R&C after $75 copay.	Limited to ward or semi-private room.
	Physician/surgeon fees	10% coinsurance after deductible.	30% R&C after deductible.	———— None ————

For more information about limitations and exceptions call 1-248-641-4949 or 1-888-868-6411 to request a copy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance after deductible.	20% R&C after deductible.	———— None ————
	Inpatient services	10% coinsurance after deductible.	20% R&C after deductible.	———— None ————
If you are pregnant	Office visits	10% coinsurance (not subject to deductible); $15 copay on first pre-natal office visit only.	30% R&C after deductible.	Maternity benefits only available to employees, spouses of active employees and surviving spouses of active employees for 9 months following death of such active employee.
	Childbirth/delivery professional services	10% coinsurance after deductible.	30% R&C after deductible; $75 copay upon admission.	
	Childbirth/delivery facility services	10% coinsurance after deductible.	30% R&C after deductible.	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible.	30% after deductible.	———— None ————
	Rehabilitation services	10% coinsurance after $15 copay.	30% R&C after deductible.	———— None ————
	Habilitation services	10% coinsurance after $15 copay.	30% R&C after deductible.	———— None ————
	Skilled nursing care	10% coinsurance after deductible.	30% coinsurance after deductible.	———— None ————
	Durable medical equipment	10% coinsurance after deductible.	30% R&C after deductible.	———— None ————
	Hospice services	10% coinsurance up to $90/day; 90 day combined in-patient and out-patient limit.	30% coinsurance up to $80/day; 80 day combined in-patient and out-patient limit.	———— None ————
If your child needs dental or eye care	Children's eye exam	$10 copay Optometrist $10 copay Ophthalmologist	$45 Maximum benefit - Optometrist $45 Maximum benefit - Ophthalmologist	Visit vsp.com or call 800.877.7195 for more details on coverage.
	Children's glasses	Frames: $150 benefit once every 2 years Lenses: Maximum benefit ranges from $95-$175 depending on lens prescription. Contacts: $150 maximum benefit.	Frames: $70 benefit once every 2 years Lenses: Maximum benefit ranges from $30-$65 depending on lens prescription. Contacts: $105 maximum benefit.	Visit vsp.com or call 800.877.7195 for more details on coverage.
	Children's dental check-up	50% coinsurance for routine oral exam	50% of R&C for routine oral exam and basic dental benefits	Dental coverage is available under the Plan by preferred dental providers at reduced fee. $1,200

For more information about limitations and exceptions call 1-248-641-4949 or 1-888-868-6411 to request a copy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				annual maximum benefit for covered individuals over age 18. Alternative coverage also available under Golden Dental. See below for contact info.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic Surgery (limited exceptions)
- Infertility treatment
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Dental care (Adult)
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information, and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Fund Office at 1-248-641-4949 or 1-888-868-6411, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

For more information about limitations and exceptions call 1-248-641-4949 or 1-888-868-6411 to request a copy.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [1-888-868-6411].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-888-868-6411].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[1-888-868-6411].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-888-868-6411].]

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$250
Specialist *[copayment]*	$15
Hospital (facility) *[coinsurance]*	10%
Other *[cost sharing]*	10%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$280
Copayments	$60
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,540**

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

The plan's overall deductible	$250
Specialist *[copayment]*	$15
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$265
Copayments	$500
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$845**

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

The plan's overall deductible	$250
Specialist *[copayment]*	$15
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	10%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

The plan would be responsible for the other costs of these EXAMPLE covered services.