Nomi Health

Introducing the Nomi Health Network

Dear Plumbers' Local 98 Insurance Fund Participant,

The Board of Trustees is pleased to introduce an exciting addition to your benefits: the Nomi Health Network.

Beginning August 1, 2026, your benefits will include access to the Nomi Health Network. Nomi Health is an additional provider network to make your healthcare experience more accessible, affordable, and tailored to your unique needs.

Your Nomi Health Network benefit includes:

- **$0 Out-of-Pocket Costs:** Get care that you need with no non-emergent copays, coinsurance, or deductibles when using the Nomi Network. This includes everything from routine check-ups and lab work to surgeries and physical therapy. For urgent and emergency care services, your traditional copay will apply.
- **Thousands of Top Providers:** Nomi Health Network includes Henry Ford Health, University of Michigan Health (Ann Arbor, Lansing, and West Michigan), Bronson Healthcare, MSU Health, ProMedica, Trinity Health Alliance of Michigan, and many more.
- **Simple Care Navigation:** Need help finding a specialist or scheduling an appointment? Visit our provider search at nomihealth.com/provider-search. Find your group ID number on the front of your Benefits ID card.
- **Comprehensive Services:** From routine check-ups to specialized treatments, Nomi Health covers all your healthcare needs.

By adding the Nomi Health Network, we're simplifying your healthcare experience and eliminating unexpected costs, so you can focus on what matters most: your health, your loved ones, and your future.

Please see the attached SBCs for the full, standard and basic plans for a summary of benefits and cost-sharing effective August 1, 2026.

You will receive additional informational mailings from Nomi Health in the next few weeks.

For any questions about your new benefits or how to get started with Nomi Health, please reach out to the Fund Office.

Thank you,
The Board of Trustees of the Plumbers' Local 98 Insurance Fund Plan

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 1-248-641-4988. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?	**TIER 1 – NOMI** Network: **$0** / person; **$0** / family	**TIER 2 – Health Alliance Plan Network** **$1,000**/person; **$2,000**/family	Out-of-Network: **$2,000**/person; **$4,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. All services rendered by Tier 1 Nomi providers are covered before you meet your deductible. In addition, Tier 2, In-network preventive services, in-network office visits, chiropractic care, and prescription benefits are covered before you meet your deductible.			This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**TIER 1 – NOMI** Network: ACA limit / person ACA limit / family	**TIER 2 – Health Alliance Plan** Network: **$2,500**/person; **$5,000**/family	Out-of-Network: **$5,000**/person; **$10,000**/family	The ACA Overall OOP (ACA limit) for copayments, deductibles, and in-Network essential benefits for 2026 is: $10,600 Individual / $21,000 Family. The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Self-payments, premiums, balance-billing 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. You pay the least if you use a provider in the **Nomi** network. You will pay more if you use a provider in the **Health Alliance Plan** network. See www.nomihealth.com or www.hap.org for a list of network providers.			You pay the least if you use a provider in the **Nomi** network. You will pay more if you use a provider in the **Health Alliance Plan** 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)	
		Nomi	Health Alliance Plan		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$25 copay/visit	30% coinsurance	Deductible does not apply to in-network visits
	Specialist visit	No charge	$25 copay/visit	30% coinsurance	Deductible does not apply to in-network visits
	Preventive care/screening/ immunization	No charge	No charge	30% coinsurance	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	30% coinsurance	———— None ————
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	30% coinsurance	———— None ————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-	Generic drugs (Tier 1)	Retail (34-day or 90-day supply): 25% coinsurance & $15 minimum-$75 maximum copay Mail Order (90-day supply): 25% coinsurance & $15 minimum-$75 maximum copay		Retail (34-day or 90-day supply): 25% coinsurance, copay $15 minimum - $75 maximum Mail Order (90-day supply): 25% coinsurance & $15	For all drug tiers, copay amounts are minimum and maximum limits. Drugs which cost over $400 are subject to coupon program, call 866-680-4859. Unless your physician prescribes otherwise, if you receive a brand drug when a generic equivalent is

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)	
		Nomi	Health Alliance Plan		
scripts.com				minimum -$75 maximum copay	available, you must pay the copay and the cost difference between generic and brand name drug. Must use Accredo Specialty Pharmacy for all specialty drugs and are limited to a 30-day supply. Mail order pharmacy may be contacted at ((800) 803 - 2523. Some drugs require preauthorization. A list of these drugs can be found at www.express-scripts.com**Error! Hyperlink reference not valid.** Wal-Mart and Sam's Club retail pharmacies excluded; you are unable to fill at these pharmacies. Out-of-Network claims must be submitted manually (paper claim).
	Preferred brand drugs (Tier 2)	Retail (34-day supply): 25% coinsurance & $15 minimum-$75 maximum copay Retail (90-day supply): 25% coinsurance, & $35 minimum - $175 maximum copay Mail Order (90-day supply) 25% coinsurance, & $35 minimum -$175 maximum copay		Retail (34-day supply): 25% coinsurance & $15-$75 copay Retail (90-day supply): 25% coinsurance & $35 minimum - $175 maximum copay	
	Non-preferred brand drugs (Tier 3)	Retail (34-day supply): 25% coinsurance & $15-$75 copay Retail (90-day supply): 25% coinsurance, & $35 minimum - $175 maximum copay Mail Order (90-day supply) 25% coinsurance,& $35 minimum -$175 maximum copay		Retail (34-day supply): 25% coinsurance & $15-$75 copay Retail (90-day supply): 25% coinsurance & $35 minimum - $175 maximum copay	
	Specialty drugs (Tier 4)	25% coinsurance, copay $100 minimum-$200 maximum		No coverage	
If you have	Facility fee (e.g.,		20% coinsurance		Preauthorization may be required for certain

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)	
		Nomi	Health Alliance Plan		
outpatient surgery	ambulatory surgery center)	No charge		30% coinsurance	procedures.
	Physician/surgeon fees	No charge	20% coinsurance	30% coinsurance	Preauthorization may be required for certain procedures.
If you need immediate medical attention	Emergency room care	$350 copay/visit	$350 copay/visit	$350 copay/visit	Copay waived if accidental injury or admitted. For cost of related diagnostic tests, see p. 2 for applicable coinsurance and UCR after deductible is satisfied.
	Emergency medical transportation	No charge (if available)		30% coinsurance	Coverage is for ground ambulances; benefit limited to 2 trips/confinement. Air Ambulance covered only when Medically Necessary.
	Urgent care	$25 copay/visit	$25 copay/visit	30% coinsurance	Deductible does not apply to in-network visits
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	30% coinsurance	Benefit is limited to a semi-private room; preauthorization required.
	Physician/surgeon fees	No charge	20% coinsurance	30% coinsurance	Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% coinsurance except for office visits, including telehealth which are $25	30% coinsurance	———— None ————
	Inpatient services	No charge	20% coinsurance	30% coinsurance	Preauthorization required.
If you are pregnant	Office visits	No charge	20% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	20% coinsurance	30% coinsurance	Separate cost-sharing applies for Mother and Newborn. No coverage for a Dependent child (benefit is only available for a Participant [i.e., an active employee, pensioner, surviving spouse] and his or her spouse.)

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)	
		Nomi	Health Alliance Plan		
	Childbirth/delivery facility services	No charge	20% coinsurance	30% coinsurance	Separate cost-sharing applies for Mother and Newborn. No coverage for a Dependent child (benefit is only available for a Participant [i.e., an active employee, pensioner, surviving spouse] and his or her spouse.)
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	30% coinsurance	Preauthorization required.
	Rehabilitation services	No charge	20% coinsurance	30% coinsurance	
	Habilitation services	No charge	20% coinsurance	30% coinsurance	
	Skilled nursing care	No charge	20% coinsurance	30% coinsurance	Preauthorization required
	Durable medical equipment	No charge	20% coinsurance	30% coinsurance	Durable Medical Equipment over $500 requires preauthorization
	Hospice services	No charge	20% coinsurance	30% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	VSP Discount Program Included		VSP Discount Program Included	VSP Discount Program details set forth in VSP brochures and summaries. Contact information: vsp.com or 248-350-2082.
	Children's glasses	VSP Discount Program Included		VSP Discount Program Included	VSP Discount Program details set forth in VSP brochures and summaries. Contact information: vsp.com or 248-350-2082.
	Children's dental check-up	No Charge once every six months		No Charge once every six months	$1,500 maximum benefit per individual per calendar year. Out-of-network provider may balance bill.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic Surgery (with limited exceptions)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the United States
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

For more information about limitations and exceptions, call 1-248-641-4949 or 1-888-866-8919 to request a copy of the plan.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Private Duty Nursing	• Chiropractic Care • Hearing Aids (TruHearing must be used for coverage)	• Routine Dental Care (Adult)

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. 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 on how 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 by calling the number on the back of your ID card. Or, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 216-267-3344 or 888-424-7488.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 216-267-3344 or 888-424-7488.]

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 216-267-3344 or 888-424-7488..]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 216-267-3344 or 888-424-7488..]

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 under the Standard Plan using the Health Alliance Plan (Tier 2) Network. If you use the Nomi (Tier 1) network, you may be able to reduce your costs. For more information about the plan's network tiers, please contact the Fund Office.

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,000
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,920**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$0***
- **Other coinsurance** **20%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$80
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,180**

The plan would be responsible for the other costs of these EXAMPLE covered services. * Copay waived for accidental injury or if admitted.

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Important Questions	Answers			Why This Matters:
What is the overall deductible?	**TIER 1 – NOMI** Network: **$0** / person; **$0** / family	**TIER 2 – Health Alliance Plan** Network: **$500** / person; **$1,000** / family	Out-of-Network: **$1,000**/person; **$2,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. All services rendered by Tier 1 Nomi providers are covered before you meet your deductible. In addition, Tier 2, In-network preventive services, in-network office visits, chiropractic care, and prescription benefits are covered before you meet your deductible.			This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**TIER 1 – NOMI** Network**:** ACA limit / person ACA limit / family	**TIER 2 – Health Alliance Plan** Network**:** **$1,000**/person; **$2,000**/family	Out-of-Network: **$2,000**/person; **$4,000**/family	The ACA Overall OOP (ACA limit) for copayments, deductibles, and in-Network essential benefits for 2026 is: $10,600 Individual / $21,000 Family. The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Self-payments, premiums, balance-billing 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. You pay the least if you use a provider in the **Nomi** network. You will pay more if you use a provider in the **Health Alliance Plan** network. See www.nomihealth.com or www.hap.org for a list of network providers.			You pay the least if you use a provider in the **Nomi** network. You will pay more if you use a provider in the **Health Alliance Plan** 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)	
		Nomi	Health Alliance Plan		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$20 copay/visit	20% coinsurance	Deductible does not apply to in-network visits
	Specialist visit	No charge	$20 copay/visit	20% coinsurance	Deductible does not apply to in-network visits
	Preventive care/screening/ immunization	No charge	No charge	20% coinsurance	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	10% coinsurance	20% coinsurance	———— None ————
	Imaging (CT/PET scans, MRIs)	No charge	10% coinsurance	20% coinsurance	———— None ————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs (Tier 1)	Retail (34-day or 90-day supply): 25% coinsurance & $15 minimum-$75 maximum copay Mail Order (90-day supply): 25% coinsurance & $15 minimum-$75 maximum copay		Retail (34-day or 90-day supply): 25% coinsurance, copay $15 minimum - $75 maximum Mail Order (90-day supply): 25%	For all drug tiers, copay amounts are minimum and maximum limits. Drugs which cost over $400 are subject to coupon program, call 866-680-4859. Unless your physician prescribes otherwise, if you receive a brand drug when a generic equivalent is

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)	
		Nomi	Health Alliance Plan		
www.express-scripts.com				coinsurance & $15 minimum - $75 maximum copay	available, you must pay the copay and the cost difference between generic and brand name drug. Must use Accredo Specialty Pharmacy for all specialty drugs and are limited to a 30-day supply. Mail order pharmacy may be contacted at (800) 803-2523. Some drugs require preauthorization. A list of these drugs can be found at www.express-scripts.com Wal-Mart and Sam's Club retail pharmacies excluded; you are unable to fill at these pharmacies. Out-of-Network claims must be submitted manually (paper claim).
	Preferred brand drugs (Tier 2)	Retail (34-day supply): 25% coinsurance & $15 minimum-$75 maximum copay Retail (90-day supply): 25% coinsurance, & $35 minimum - $175 maximum copay Mail Order (90-day supply) 25% coinsurance, & $35 minimum -$175 maximum copay		Retail (34-day supply): 25% coinsurance & $15-$75 copay Retail (90-day supply): 25% coinsurance & $35 minimum - $175 maximum copay	
	Non-preferred brand drugs (Tier 3)	Retail (34-day supply): 25% coinsurance & $15-$75 copay Retail (90-day supply): 25% coinsurance, & $35 minimum - $175 maximum copay Mail Order (90-day supply) 25% coinsurance,& $35 minimum -$175 maximum copay		Retail (34-day supply): 25% coinsurance & $15-$75 copay Retail (90-day supply): 25% coinsurance & $35 minimum - $175 maximum copay	
	Specialty drugs (Tier 4)	25% coinsurance, copay $100 minimum -$200 maximum	25% coinsurance, copay $100 minimum -$200 maximum	No coverage	

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)	
		Nomi	Health Alliance Plan		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	10% coinsurance	20% coinsurance	Preauthorization may be required for certain procedures
	Physician/surgeon fees	No charge	10% coinsurance	20% coinsurance	Preauthorization may be required for certain procedures.
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	$250 copay/visit	Copay waived if accidental injury or admitted. For cost of related diagnostic tests, see p. 2 for applicable coinsurance and UCR after deductible is satisfied.
	Emergency medical transportation	No charge (if available)	10% coinsurance	20% coinsurance	Coverage is for ground ambulances; benefit limited to 2 trips/confinement. Air Ambulance covered only when Medically Necessary.
	Urgent care	$20 copay/visit	$20 copay/visit	20% coinsurance	Deductible does not apply to in-network visits
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% coinsurance	20% coinsurance	Benefit is limited to a semi-private room; preauthorization required.
	Physician/surgeon fees	No charge	10% coinsurance	20% coinsurance	Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	10% coinsurance except for office visits, including telehealth which are $20 copay / visit	20% coinsurance	———— None ————
	Inpatient services	No charge	10% coinsurance	20% coinsurance	Preauthorization required.
If you are pregnant	Office visits	No charge	10% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	10% coinsurance	20% coinsurance	Separate cost-sharing applies for Mother and Newborn. No coverage for a Dependent child (benefit is only available for a Participant [i.e., an active employee, pensioner, surviving spouse] and his or her spouse.)

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)	
		Nomi	Health Alliance Plan		
	Childbirth/delivery facility services	No charge	10% coinsurance	20% coinsurance	Separate cost-sharing applies for Mother and Newborn. No coverage for a Dependent child (benefit is only available for a Participant [i.e., an active employee, pensioner, surviving spouse] and his or her spouse.)
If you need help recovering or have other special health needs	Home health care	No charge	10% coinsurance	20% coinsurance	Preauthorization required.
	Rehabilitation services	No charge	10% coinsurance	20% coinsurance	———— None ————
	Habilitation services	No charge	10% coinsurance	20% coinsurance	———— None ————
	Skilled nursing care	No charge	10% coinsurance	20% coinsurance	Preauthorization required
	Durable medical equipment	No charge	10% coinsurance	20% coinsurance	Durable Medical Equipment over $500 requires preauthorization
	Hospice services	No charge	10% coinsurance	20% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	VSP Discount Program Included		VSP Discount Program Included	VSP Discount Program details set forth in VSP brochures and summaries. Contact information: vsp.com or 248-350-2082.
	Children's glasses	VSP Discount Program Included		VSP Discount Program Included	VSP Discount Program details set forth in VSP brochures and summaries. Contact information: vsp.com or 248-350-2082.
	Children's dental check-up	No charge once every six months		No charge once every six months	$1,500 maximum benefit per individual per calendar year. Out-of-network provider may balance bill.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic Surgery (with limited exceptions)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the United States
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Private Duty Nursing
- Chiropractic Care
- Hearing Aids (TruHearing must be used
- Routine Dental Care (Adult)
- Cologuard cancer screening

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

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. 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 on how 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 by calling the number on the back of your ID card. Or, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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.

Language Access Services:

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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 under the Full Plan using the Health Alliance Plan (Tier 2) Network. If you use the Nomi (Tier 1) network, you may be able to reduce your costs. For more information about the plan's network tiers, please contact the Fund Office.

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **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	$500
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **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	$500
Copayments	$800
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$0***
- **Other coinsurance** **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	$500
Copayments	$60
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$660**

The plan would be responsible for the other costs of these EXAMPLE covered services. * Copay waived for accidental injury or if admitted.

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 1-248-641-4988. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?	**TIER 1 – NOMI** Network: **$0** / person; **$0** / family	**TIER 2 – Health Alliance Plan** Network: **$1,500**/person; **$3,000**/family	Out-of-Network: **$5,000**/person; **$10,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. All services rendered by Tier 1 Nomi providers are covered before you meet your deductible. In addition, the following services rendered by Tier 2 Health Alliance Plan providers are also covered before you meet your deductible: in-network preventive services, in-network office visits, chiropractic care, and prescription benefits.			This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**TIER 1 – NOMI** Network: ACA limit / person ACA limit / family	**TIER 2 – Health Alliance Plan** Network: **$5,350**/person; **$10,700**/family	Out-of-Network: **$10,000**/person; **$20,000**/family	The ACA Overall OOP (ACA limit) for copayments, deductibles, and in-network essential benefits for 2026 is: $10,600 Individual / $21,000 Family. The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Self-payments, premiums, balance-billing 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. You pay the least if you use a provider in the **Nomi** network. You will pay more if you use a provider in the **Health Alliance Plan** network. See www.nomihealth.com or www.hap.org for a list of network providers.			You pay the least if you use a provider in the **Nomi** network. You will pay more if you use a provider in the **Health Alliance Plan** 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)	
		Nomi	Health Alliance Plan		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$25 copay/visit	40% coinsurance	Deductible does not apply to in-network visits
	Specialist visit	No charge	$50 copay/visit	40% coinsurance	Deductible does not apply to in-network visits
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	40% coinsurance	———— None ————
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	40% coinsurance	———— None ————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs (Tier 1)	Retail (34- or 90-day supply): 25% coinsurance, copay $15 minimum-$75 maximum Mail Order (90-day supply): 25% coinsurance, copay $15 minimum-$75 maximum		Retail (34- or 90-day supply): 25% coinsurance, copay $15 minimum -$75 maximum	For all drug tiers, copay amounts are minimum and maximum limits. Drugs which cost over $400 are subject to coupon program, call 866-680-4859. Unless your physician prescribes otherwise, if you receive a brand drug when a generic equivalent is available, you must pay the copay and the cost difference between generic and brand name drug. Must use Accredo Specialty Pharmacy for all specialty drugs, which are limited to a 30-day supply.
	Preferred brand drugs (Tier 2)	Retail (34-day supply): 25% coinsurance, copay $15 minimum -$75 maximum Retail (90-day supply): 25%		Retail (34-day supply): 25% coinsurance, copay $15 minimum-$75 maximum	

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)	
		Nomi	Health Alliance Plan		
		coinsurance, copay $35 minimum - $175 maximum Mail Order (90-day supply): 25% coinsurance, copay $35 minimum - $175 maximum		Retail (90-day supply): 25% coinsurance, copay $35 minimum - $175 maximum	Mail order pharmacy may be contacted at (800) 803-2523 Some drugs require preauthorization. A list of these drugs can be found at www.express-scripts.com Wal-Mart and Sam's Club retail pharmacies excluded; you are unable to fill at these pharmacies. Out-of-Network claims must be submitted manually (paper claim).
	Non-preferred brand drugs (Tier 3)	Retail (34-day supply): 25% coinsurance, copay $15 minimum-$75 maximum Retail (90-day supply): 25% coinsurance, copay $35 minimum - $175 maximum Mail Order (90-day supply): 25% coinsurance, copay $35 minimum - $175 maximum		Retail (34-day supply): 25% coinsurance, copay $15 minimum-$75 maximum Retail (90-day supply): 25% coinsurance, copay $35 minimum - $175 maximum	
	Specialty drugs (Tier 4)	25% coinsurance, copay $100 minimum -$200 maximum		No coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	40% coinsurance	Preauthorization may be required for certain procedures.
	Physician/surgeon fees	No charge	30% coinsurance	40% coinsurance	Preauthorization may be required for certain procedures.
If you need immediate medical attention	Emergency room care	$450 copay / visit	$450 copay / visit	$450 copay / visit	Copay waived if accidental injury or admitted. For cost of related diagnostic tests, see p. 2 for applicable coinsurance and UCR after deductible is satisfied.
	Emergency medical transportation	No charge (if available)	30% coinsurance	40% coinsurance	Coverage is for ground ambulances; benefit limited to 2 trips/confinement. Air Ambulance covered only when Medically Necessary.
	Urgent care	$25 copay / visit	$25 copay / visit	40% coinsurance	Deductible does not apply to in-network visits
If you have a	Facility fee (e.g.,	No charge	30% coinsurance	40% coinsurance	Benefit is limited to a semi-private room;

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)	
		Nomi	Health Alliance Plan		
hospital stay	hospital room)				preauthorization is required.
	Physician/surgeon fees	No charge	30% coinsurance	40% coinsurance	Preauthorization may be required for certain procedures.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	30% coinsurance except for office visits, including telehealth which are $25 copay / visit	40% coinsurance	Deductible does not apply to in-network office visits, including telehealth. (Deductible applies to all other in-network outpatient services).
	Inpatient services	No charge	30% coinsurance	40% coinsurance	Preauthorization required.
If you are pregnant	Office visits	No charge	30% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	30% coinsurance	40% coinsurance	Separate cost-sharing applies for Mother and Newborn. No coverage for a Dependent child (benefit is only available for a Participant [i.e., an active employee, pensioner, surviving spouse] and his or her spouse.)
	Childbirth/delivery facility services	No charge	30% coinsurance	40% coinsurance	No coverage for a Dependent child (benefit is only available for a Participant [i.e., an active employee, pensioner, surviving spouse] and his or her spouse.)
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	40% coinsurance	Preauthorization required.
	Rehabilitation services	No charge	30% coinsurance	40% coinsurance	———— None ————
	Habilitation services	No charge	30% coinsurance	40% coinsurance	———— None ————
	Skilled nursing care	No charge	30% coinsurance	40% coinsurance	Preauthorization required
	Durable medical equipment	No charge	30% coinsurance	40% coinsurance	Durable Medical Equipment over $500 requires preauthorization
	Hospice services	No charge	30% coinsurance	40% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	VSP Discount Program Included		VSP Discount Program Included	VSP Discount Program details set forth in VSP brochures and summaries. Contact information: vsp.com or 248-350-2082.
	Children's glasses	VSP Discount Program Included		VSP Discount Program	VSP Discount Program details set forth in VSP

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)	
		Nomi	Health Alliance Plan		
				Included	brochures and summaries. Contact information: vsp.com or 248-350-2082.
	Children's dental check-up	No Charge once every six months		No Charge once every six months	$1,500 maximum benefit per individual per calendar year. Out-of-network provider may balance bill.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic Surgery (with limited exceptions)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the United States
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Private Duty Nursing
- Chiropractic Care
- Hearing Aids (TruHearing must be used for coverage)
- Routine Dental Care (Adult)

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For more information about limitations and exceptions, call 1-248-641-4949 or 1-888-866-8919 to request a copy of the plan.

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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.

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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$1,500
Copayments	$0
Coinsurance	$3,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,860**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$1,500
Copayments	$1,000
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,420**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) copayment	$0*
Other coinsurance	30%

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	$1,500
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

The plan would be responsible for the other costs of these EXAMPLE covered services. * Copay waived for accidental injury or if admitted.