

# SAGINAW LOCAL 85 PLUMBERS, STEAMFITTERS, AND HVACR SERVICE TECHNICIANS HEALTH AND WELFARE FUND



**Summary Plan Description**  
Effective January 1, 2025



## **PART ONE:** **GENERAL INFORMATION**

### **WHY AM I RECEIVING THIS SUMMARY PLAN DESCRIPTION?**

The Saginaw Plumbers and Pipefitters Local 85 Health & Welfare Fund is furnishing this Summary Plan Description (“SPD”) to you so that you have a summary of your benefits. Additionally, Federal law requires that you, as a participant under the Plan (the “*Participant*”) periodically be provided with an SPD. This SPD incorporates all the amendments and benefit updates. **This SPD will supersede and replace all prior Plan SPDs, as well as any Summary of Material Modification that you may have received since that time. This SPD is effective as of January 1, 2025.** You are advised to read this SPD in its entirety and keep it for your records.

As a reminder, this is only a summary of your benefits and rights. The legal rules that govern those benefits and rights are contained in the actual Plan Document. If you wish to view the Plan Document or obtain a copy of it, you can do so by contacting the *Plan Administrator*, whose contact information is listed within this SPD. **In the event of any discrepancy or conflict between this SPD and the provisions of the Plan Document, the Plan Document controls.**

Also, if certain provisions in this SPD are amended or are changed after you receive this document, you will be sent a Summary of Material Modifications (“SMM”), which will explain those changes to you.

### **WHAT IS THE PURPOSE OF THIS SPD?**

The SPD provides a general description of the benefits that are available to both you and your Dependents, including the answers to questions such as:

- How do you or your *Dependents* become eligible to participate?
- How do you or your *Dependents* stay eligible?
- What benefits the *Plan* does and does not pay for?
- How much your cost-sharing is, including your co-insurance and deductibles?
- How do you file a *claim* or *appeal* a claim that has been denied?

### **DEFINED TERMS**

Certain terms will be used in this SPD that have a specific meaning. These terms are defined below and will be *italicized* or capitalized when they appear throughout the SPD. Those defined terms are listed in the attached *Appendix A*.

### **ARE THE BENEFITS THIS PLAN PROVIDES GUARANTEED TO ME?**

No. The benefits provided by this *Plan* are not vested, guaranteed, or considered lifetime benefits. The Board of Trustees may modify or discontinue benefits at any time. If the *Plan* is terminated, any claim for benefits pending at the time of such termination will be considered a priority claim against the remaining assets of the *Plan*, to the extent permitted by law.

## WHO IS RESPONSIBLE FOR THE ADMINISTRATION OF THE PLAN?

As required by federal law, your *Plan* is operated by the Board of Trustees made up of an equal number of representatives from the sponsoring *Union*, the *Plan*, the *Employers*, as well as various *Employer* associations who contribute to the *Plan* as required by the *Collective Bargaining Agreement*. The *Plan* Trustees are known as the "named fiduciaries," are subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), and, as such, will have the maximum possible discretionary authority to administer all aspects of the *Plan's* operations, including but not limited to, the exclusive right and discretion to interpret all terms and provisions of the *Plan's* Governing Documents, such as this *Plan*, the Trust Agreement, Summary Plan Description, Summary of Material Modifications, policies and procedures, resolutions, directives, or any document, instrument, or record used in the administration of the *Plan*, as well as any amendments or modifications thereof and to apply the same as they deem appropriate.

The Board of Trustees' original intent is and continues to be the ability to exercise their discretionary authority to the fullest extent permitted by the law, and all Trustee determinations made pursuant to this authority, whether prospectively or retroactively, will be entitled to the highest possible deference allowed by law, in case of review by any court or governmental authority of competent jurisdiction. Unless otherwise expressly provided by applicable law, the Board of Trustees' determination on all matters pertaining to the *Plan* will be final and binding on all concerned parties to the extent permitted by law.

## WHO ARE THE MEMBERS OF THE BOARD OF TRUSTEES?

### Labor Trustees

Steve Najawicz, Chairman  
UA Local 85  
3535 Bay Road  
Saginaw, MI 48603  
(989) 799-5261

### Management Trustees

Rick Wenzlick, Secretary  
William E. Walter, Inc.  
1563 Treanor  
Saginaw, MI 48601  
(989) 755-2971

Tim Danielak  
UA Local 85  
3535 Bay Road  
Saginaw, MI 48603  
(989) 799-5261

Steven Schneider  
6553 Deer Run Trail  
Saginaw, MI 48603  
(989) 615-2140

Justin Pomerville  
UA Local 85  
3535 Bay Road  
Saginaw, MI 48603  
(989) 799-5261

Jason Sample  
Monarch Welding & Engineering  
1566 Tech Drive  
Bay City, MI 48706  
(989) 684-3400

## WHAT IF I HAVE QUESTIONS?

Throughout this SPD you will be referred to the *Plan Administrator* for questions and assistance. The *Plan Administrator* keeps the Plan's records, is responsible for its day-to-day operations, and has representatives who can assist you with any questions you may have. The *Plan Administrator* is BeneSys, Inc., and it can be reached at (800) 582-6181 or (248) 641- 4985. Notices, payments, and other documents that you may be required to send will almost always be sent to the *Plan Administrator*, so make special note of its address and contact information.

## WHAT IF I WANT TO REVIEW ANY GOVERNING DOCUMENTS?

If you want to review a copy of the Plan Document (and its amendments), Trust Agreement (and its amendments), or latest annual report, please notify the *Plan Administrator* in writing of your request. You may be subject to a fee where permitted by law not to exceed the lesser of (a) the actual cost of production or (b) \$0.25 per page.

## GENERAL INFORMATION ABOUT YOUR PLAN

The name of your *Plan* is the Saginaw Plumbers and Pipefitters Local 85 Health & Welfare Fund (the "*Plan*"). The *Plan's* tax identification number is 38-1525304. The *Plan* number is 501. This *Plan* provides some benefits on a self-funded basis, meaning that the *Plan* pays claims out of its general assets, while others are provided by purchasing contracts of insurance. The assets of the *Plan* come from *Employer Contributions* and investment earnings on these *contributions*. The Board of Trustees reserves the right to modify which part of the benefits schedule is insured, if any, through an insurance carrier and which part will be self-funded.

## WHO IS THE PLAN'S LEGAL COUNSEL?

The *Plan's* legal counsel is Novara Tesija Catenacci, McDonald & Baas PLLC. Their address is 888 West Big Beaver Road, Suite 600, Troy, Michigan 48084, and their phone number is (248) 354-0380. The *Plan's* attorneys are responsible for handling all legal matters that affect the *Plan* and its operation.

## HOW ARE LEGAL DOCUMENTS SERVED ON THE PLAN?

If you wish to serve legal documents on the *Plan*, the documents should be delivered to the *Plan Administrator* and/or the *Plan's* legal counsel.

## WHEN IS OPEN ENROLLMENT?

Open enrollment is available only for *Dependents* who were previously declined coverage, who were not eligible for coverage, or who were not previously enrolled in the *Plan*.

The open enrollment period runs from October 1<sup>st</sup> through November 30<sup>th</sup> of each year for coverage to begin on January 1. This is the period when new *Dependents* can enroll in coverage or those who previously missed an earlier opportunity to enroll. The conditions for coverage are the following: (a) the *Dependent* must be under the age of twenty-six (26) on January 1 of the year in which coverage would begin, and (b) the annual Open Enrollment Form must be completed and signed in its entirety and submitted to the *Plan Administrator* by November 30<sup>th</sup> to enroll for the next year.

**Note, a *Dependent Child's* coverage under the *Plan* will terminate on the last day of the month in which he or she turns twenty-six (26) years of age.**

## SPECIAL NOTICES

Federal law requires that the *Plan* inform you about certain benefits. The *Plan Administrator* also will provide the following notices on an annual basis, or with certain benefit statements when required by law:

- **Rights under the Women’s Health and Cancer Rights Act.** The *Plan*, as required by the Women’s Health and Cancer Rights Act of 1998 (“WHCRA”), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Please contact the *Plan Administrator* for more information.
  
- **Rights under the Newborns’ and Mothers’ Health Protection Act.** Under the Newborn’s and Mothers’ Health Protection Act (“Newborns’ Act”), 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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (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 issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).
  
- **Notice Regarding Special Enrollment.** When the requirements for eligibility under this *Plan* have been met and you or your *Dependents* are offered an opportunity to enroll in coverage, under some circumstances you may choose to decline coverage. 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). 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. To request special enrollment or obtain more information, contact the *Plan Administrator*. These rights and obligations are also discussed again in detail in the “What Are My Rights and Responsibilities” section of this *SPD*, which begins on Page 34.
  
- **Non-Discrimination.** The *Plan* complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The *Plan* does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The *Plan* further provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats), and provides free language services to people whose primary language is not English, such as qualified interpreters, and information written in other languages. If you need these services, please contact the *Plan Administrator*. If you believe that the *Plan* has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of

Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F HHH Building  
Washington, D.C. 20201  
Toll Free: 1-800-368-1019  
800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- **Provider Non-Discrimination.** The *Plan* will not discriminate with respect to participation under the *Plan* against any *Medical Provider* or other health care provider who is acting within the scope of his/her license or certification under applicable state law.
- **Notice of Privacy Practices.** The *Plan* maintains a Notice of Privacy Practices for Protected Health Information which informs you about your rights and the *Plan's* legal duties and privacy practices concerning your protected health information. This Notice has previously been provided to all *participants*. A copy of this Notice can be obtained by contacting the Plan Office.

## RECIPROCITY FOR WORK IN OTHER UNION JURISDICTIONS

The Board of Trustees has entered into reciprocity agreements with other health and welfare plans covering plumbing, pipefitting, and related crafts throughout the country. *Employer Contributions* made on your behalf will be transferred from one plan to another, in accordance with the prevailing UA reciprocity agreement. The hours worked for which the contributions are transferred to this *Plan* will be prorated for eligibility purposes in this *Plan*.

## **PART TWO:** **ESTABLISHING AND CONTINUING ELIGIBILITY FOR BENEFITS**

### ELIGIBILITY IN GENERAL

You become eligible for benefits as a *Participant* in this *Plan* by satisfying the conditions that apply to you, depending on what type of employee you are. For example, if you were an office *Employee* of an *Employer*, your eligibility requirements are different from a person who is working in the field.

The *Plan Administrator* will automatically determine *Initial Eligibility*. All classes of *Participants* must complete all requested enrollment forms to begin receiving benefits. Some benefits also require you, in addition to satisfying the eligibility requirements, to meet certain deductibles, co-pays and/or other requirements before you can receive those benefits.

**If you make a false statement, material misrepresentation, or commit an act of fraud, coverage for you and your *Dependents* may be retroactively rescinded.**

Also, please note eligibility for coverage does *not* automatically make you eligible for all benefits offered by the *Plan*. Furthermore, some benefits also require you, in addition to satisfying the eligibility requirements, to meet certain deductibles, co-pays, and/or other requirements before you can receive those benefits. You also, as a condition of receiving benefits, agree to complete any required enrollment forms and comply with requests for documentation, such as birth certificates, marriage certificates, proof of custodial arrangements, evidence of other coverage, etc.

The coverage of *Spouses* and *Dependent Children* is tied to the eligibility of the primary Participant (meaning the person who is the *Active, Retiree, or Disabled Participant*). If the *Primary Participant* loses coverage, so do his or her *Spouse* and *Dependent Children*.

## ELIGIBILITY FOR ACTIVE PARTICIPANTS/EMPLOYEES WORKING IN THE FIELD

### **How do I become eligible for benefits?**

As an *Active Employee* (meaning you are working and not *retired* or *disabled*) you establish *Initial Eligibility* benefits under the Community Blue PPO Plan (or the CORE Benefit Plan if you have other qualifying coverage available and elect to be in the CORE Benefit Plan) for 3 months on the first day of the month following the month in which you earn, through working in *Covered Employment*, at least 160 hours of *Employer Contributions* in a consecutive 2-month period. You must also complete the required enrollment forms, which will be provided to you by the *Plan Administrator*. The 160-hour threshold applies only to the very first time you establish eligibility. Thereafter, if your eligibility terminates, you gain coverage again under the reinstatement rule of 435 hours, described in detail below. Your *Employer* has a 1-month "bookkeeping" period to remit the fringe benefit *contributions*. For example, this means that *contributions* for the month of January would not be due until the 15th of February. You cannot self-pay to establish *Initial Eligibility*.

### **How do I stay eligible for benefits?**

If you are working in *Covered Employment*, there are two benefit plans available to you once you meet the *Initial Eligibility* requirements: the Community Blue PPO Plan and the CORE Benefit Plan. As described below,

you will see that the hours-of-service requirements to initially qualify for each plan are the same (160), but the monthly requirements to stay eligible are lower for the CORE Benefit Plan (75). However, because hospital and medical benefits are not provided for those in the CORE Plan, to be eligible under this program you must complete an election form that also contains a representation that you have other coverage that provides medical and surgical benefits (for example from a *Spouse* or a parent if you are a *Dependent child*), that is “affordable” and provides “minimum value” under the Patient Protection and Affordable Care Act. The *Plan Administrator* will provide you with this form when you become eligible for coverage under this Plan. If you do not have other coverage that meets these PPACA standards, you cannot elect to be in the CORE Benefit Plan.

Once you have established Eligibility, you remain eligible in the *Plan* by (1) working sufficient hours each month or (2) if you do not work enough hours in a month, by using your Hour Bank or making self-payments if you are eligible to do so. To continue eligibility solely through working, you must work 145 hours each month. *Continuing Eligibility* is tracked using a three-month bookkeeping method, which is summarized for you in the chart below:

Hours you work in		Count for eligibility in
January	→	April
February	→	May
March	→	June
April	→	July
May	→	August
June	→	September
July	→	October
August	→	November
September	→	December
October	→	January
November	→	February
December	→	March

If you work more than 150 hours in any month (*Continuing Eligibility* requires 145 or 75 hours depending on coverage, whether you are in the PPO or the CORE Plan), the excess hours will be treated as *Credited Reserve Hours* until the maximum number of *Credited Reserve Hours*, currently 290 hours, is reached. Credited Reserve Hours are credited to the *IAP* at the rate of \$6.00 an hour. Once the maximum of 290 is reached, your *IAP* will begin to be funded at the rate set by the Board of Trustees.

**EXAMPLE:** During your first 3 months of work, the *Plan* receives 250 hours of *Employer Contributions* on your behalf. The *Plan* will take 160 of those hours for *Initial Eligibility*, and the excess 90 hours will be counted as *Credited Reserve Hours*. During the next 8 months, you work

155 hours each month. At the end of that period, you will have 130 *Credited Reserve Hours* (90 + the 5 excess hours for each of those months). Once you reach 290 *Credited Reserve Hours*, the excess hours will begin to fund your *IAP* at the rate set by the Board of Trustees.

### **Continuing Coverage by Making Self-Payments**

Self-payments are made to continue coverage when your *Credited Reserve Hours* have been exhausted. You can make up to 12 consecutive monthly self-payments provided you are continuing to search for work and are registered on the *Union's* out-of-work list. If, after 12 consecutive self-payments, you have not worked enough hours to be reinstated to coverage, you will be offered coverage under COBRA. The self-payment rate is calculated by taking the number of hours you need to stay eligible less the hours you worked, multiplied by the contribution rate. There is a maximum self-payment rate that applies for the twelve months of self-payments provided under this *Plan*. Currently, the rates are as follows: Single Coverage = \$376.50; Two Person Coverage = \$497.50; Family Coverage = \$525.00.

**To be eligible to make self-payments, you must be available for work from a Contributing Employer to the Plan. You demonstrate availability for work by registering on the Union's out of work list. If you fail to register, or drop your book with the Union, it will be presumed you no longer available for work. This requirement will not apply if you are disabled or on a leave of absence, such as a medical or military leave. Participants who are not eligible to continue coverage through self-payments will be offered coverage under COBRA if eligible.**

### **If I lose eligibility for benefits, how can I reinstate my coverage?**

If you lose coverage, meaning you did not work enough hours to continue eligibility and you did not make a self-payment, you reinstate coverage for 3 months under the Community Blue PPO Plan upon receipt by the *Plan* of 435 hours of *Employer Contributions* within 12 consecutive months. For the CORE Benefit Plan, you need 435 hours of *Employer Contributions*, but only 225 of those hours will be used to reinstate coverage. The balance will be counted as *Credited Reserve Hours* up to the maximum of 290 hours, with any remainder going to your *IAP* at the rate set by the Board of Trustees. See Part 4 of this SPD for an explanation and examples of how the *IAP* is funded.

	Initial	Continuing	Excess Hours	Self-Payments	Reinstate
<b>Community Blue PPO Plan</b>	160	145	Counted as <b>Credited Reserve Hours</b> up to the 290-hour max, then to the <b>IAP</b>	Up to 12 consecutive months, then COBRA coverage is offered if you fail to reinstate coverage	435 hours in 12 consecutive months
<b>CORE Benefit Plan</b>	160	75	Counted as <b>Credited Reserve Hours</b> up to the 290-hour max, then to the <b>IAP</b>	Up to 12 consecutive months, then COBRA coverage is offered if you fail to reinstate coverage	435 hours in 12 consecutive months, 225 hours go towards coverage and the remainder go to <b>Credited Reserve Hours</b>

## ELIGIBILITY FOR RETIRED PARTICIPANTS

The eligibility requirements for *Retired* Participants are discussed below.

### **How do I become eligible for benefits if I retire?**

To qualify for coverage as a *Retiree*, you must meet the following criteria:

- Have been eligible as an *Active Participant* for at least 10 years prior to the date of retirement and for 12 of the previous 24 months immediately preceding the date of retirement;
- Retire from *Covered Employment*;
- Be receiving pension benefits from a pension plan sponsored by the *Union* or have received a determination of Social Security Disability; and
- Apply for coverage by completing the required enrollment forms.

### **How do I stay eligible for benefits?**

*Retirees* remain eligible for any period earned while they were an *Active Participant*. Once this period of eligibility is exhausted, any balance of *Credited Reserve Hours* is exhausted for coverage eligibility. Once the *Retiree* has exhausted his/her balance of *Credited Reserve Hours*, self-payments at rates established by the Board of Trustees must be made to continue coverage under the *Plan*.

You will be notified by the *Plan Administrator* of the monthly amount due by you to the *Plan* to maintain your coverage. Coverage for *Retirees* is not “vested” and therefore it can be changed or eliminated at any time. If you are eligible for Medicare, *Retiree* coverage is provided through a Medicare Advantage Plan from Blue Cross Blue Shield of Michigan. If you are 65 or over or become eligible for Medicare because you were determined by the Social Security Administration to be *disabled*, the *Plan* will treat you as if you have elected both Parts A and

B. You should ensure you have properly enrolled in order to avoid any gaps in coverage. You can make arrangements for self-payments to be made automatically from other funds, such as your pension plan.

Effective May 1, 2022, a *Retiree* is not permitted to use their *IAP* balance to self-pay coverage at the maximum self-payment cap. In other words, a *Retiree* self-paying for coverage from their *IAP* must pay the full rate for the type of coverage they elect under this *Plan*. However, once the *IAP* is exhausted, the *Retiree* can self-pay at the subsidized self-payment cap rate.

#### **What if my eligibility terminates, can I reinstate my coverage?**

If you fail to make a self-payment and lose coverage under this *Plan*, you may enroll again for coverage during the next open enrollment period.

#### **What if I return to work while I am retired?**

If you return to work, you must continue to make full or partial self-payments. Any *Employer Contributions* received on your behalf will be used to offset the cost of the self-payment. Excess *contributions* beyond those that fully offset the cost of your self-payment will not be treated as *Credited Reserve Hours* or used to fund the *IAP*.

## **ELIGIBILITY FOR DISABLED PARTICIPANTS**

#### **How do I establish eligibility as a Disabled Participant?**

You establish eligibility as a *Disabled Participant* by meeting the following criteria:

- You are *Disabled*.
- You were eligible as an *Active Participant* at the time of your disability.
- You submit to an examination by an independent medical examiner.

#### **How do I continue eligibility?**

*Disabled Participants* who continue to meet the requirements for eligibility noted above will receive disability credits. Under the Community Blue PPO Plan and the CORE Benefit Plan, you will receive 37 hours of credit per week for a maximum of 52 weeks. Upon expiration of disability credits, you can continue coverage by making self-payments as permitted by this *Plan* at the rate set by the Board of Trustees.

Once your disability credits are exhausted, if you fail to make a timely self-payment, or do not qualify for coverage as a *Retiree*, you will be offered coverage under COBRA. If you exhaust your COBRA coverage, you then must reinstate coverage as an *Active Participant* to return to coverage from this *Plan*.

**The Trustees retain the right to, at their discretion, verify that you continue to meet the Plan's definition of *Disabled*. As a condition of coverage as a *Disabled Participant*, you agree to submit to an Independent Medical Examination if requested by the Board of Trustees, and upon reasonable notice and terms based upon your medical condition.**

## ELIGIBILITY FOR SURVIVING SPOUSES AND DEPENDENTS

### What classes of Participants are eligible for this coverage?

*Initial Eligibility* for Surviving Spouses is slightly different depending on whether the deceased was an *Active Participant* at the time of death or was a *retired Participant*. The rules for initially becoming eligible in each case are discussed directly below:

- **For Surviving Spouses of Active Participants**, the Surviving *Spouse* may continue coverage provided the deceased *Active Participant* was eligible at the time of death and had been continuously eligible for the 2 years immediately preceding his/her death. The Surviving *Spouse* must elect to continue coverage within 60 days of the date coverage would have been lost by the deceased *Active Participant*. Failure to timely return the enrollment forms will result in a permanent loss of coverage, and the Surviving *Spouse* will then only be offered coverage under COBRA.
- **For Surviving Spouses of Retired Participants**, the deceased *Retired Participant* need only have been eligible at the time of death for his/her *Spouse* to continue coverage. The Surviving *Spouse* must still complete the enrollment forms within 60 days from the date the coverage of the *Retired Participant* would have ended.

### How do I continue coverage as a Surviving Spouse or surviving Dependent Child?

All Surviving *Spouses* and their Dependents remain eligible by making self-payments at the rates established by the Board of Trustees. A Surviving *Spouse* may use any *Credited Reserve Hours* or the *IAP* to continue coverage before self-payments are required. Disability credits may not be used by a Surviving *Spouse* to continue coverage.

### When does coverage terminate?

Your coverage will terminate on the first day of the month following the occurrence of any of the events listed below. Once terminated, coverage cannot be reinstated.

- If you are a Surviving *Spouse* and you remarry.
- You become eligible for group coverage as an employee of any employer.

- If you are a *Dependent Child*, upon your 26<sup>th</sup> birthday.
- If you fail to make a timely self-payment.

## OTHER COVERAGE SITUATIONS

### **How does the Plan treat court-ordered coverage for minor children?**

Coverage will be provided in accordance with any valid order of a court, determined by the Board of Trustees to be a *Qualified Medical Child Support Order* under applicable law, which creates or recognizes the right of an alternate recipient to benefits as an eligible *Dependent* under the *Plan*. A QMCSO must create or recognize an alternative recipient's right to receive benefits for which an eligible *Dependent* is eligible to receive under this *Plan*, provide a reasonable description of the benefits of this *Plan*, and the period to which the QMCSO applies.

The *Plan Administrator* will establish reasonable methods to notify individuals affected by the order, segregate any amounts payable under the order, determine whether the order is qualified and distribute the benefits under the QMCSO. Any payment made by the *Plan* under a QMCSO or reimbursement for expenses paid by the *Dependent Child* or the *Dependent Child's* custodial parent or legal guardian will be made in accordance with applicable law. A request for coverage under a QMCSO must be submitted to the *Plan Administrator* within 30 days of the entry of the QMCSO.

### **What if I am eligible for benefits but am also a Spouse or Dependent Child of an Active Participant?**

If you are a *Dependent* of an *Active Participant* but are also working in *Covered Employment*, you can elect the CORE Benefit Plan and remain covered as a *Dependent* on your parent's Community Blue PPO coverage. For additional information on this specific coverage election, please contact the *Plan Administrator*.

### **What coverage is available under the Family Medical Leave Act?**

An *Employer* which is a "covered employer" as that term is defined by the Family Medical Leave Act ("FMLA"), is required to notify the *Plan* when an eligible *Participant* has been granted family or medical leave. Both the *Employer* and the *Participant* are required to provide the notices, information, and documentation as may be required by the Board of Trustees and by law. The *Plan* will continue coverage during the period of any leave for which you are eligible under the provisions of the FMLA provided the *Employer* remits the required *contributions* and fully complies with all requirements established by the Board of Trustees. If you have questions about ensuring you and your *Employer* are complying with FMLA leave, contact the *Plan Administrator*.

### **What if I go out on military leave?**

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), if you leave *Covered Employment* to enter service in the Armed Forces, or other uniformed services of the United States, you may continue coverage under the *Plan*. The *Contributions* accrued in your *Credited Reserve Hours* can be used to continue coverage, or frozen for use upon your return. You may elect to continue coverage for medical, surgical, and prescription drug benefits under the *Plan* for a period which is the lesser of the 24-month period beginning

on the last day of *Covered Employment*, or the day the *Participant* fails to apply for or return to *Covered Employment*.

If you elect to continue coverage, you may use your *Credited Reserve Hour Bank* and *IAP* to continue coverage. Beyond that, you will be charged either: (1) the monthly COBRA premium rate or (2) the *active Participant* rate, whichever is less. If your period of service is fewer than 31 days, coverage shall be provided at no additional cost to you.

Upon discharge from uniformed services under honorable conditions, you must return to work, apply for reemployment, or register on the *Union's* out-of-work list within the following time frames:

- For periods of service of 1-30 days, time is allotted to travel home, plus eight (8) hours of rest, then upon the beginning of the next working day.
- For periods of service of 31-180 days, within 14 days after completing service.
- For periods of service over 180 days, within 90 days after completing service.

The period in which you must return to work, apply for reemployment, or register on the *Union's* out-of-work list is extended to two (2) years after completion of service if you are recovering from an illness or injury incurred or aggravated during the performance of service.

Upon return to *Covered Employment* or registration on the *Union's* out-of-work list, you will be eligible for coverage without having to reestablish eligibility. However, if the period of military service exceeds five (5) years, you must again establish *Initial Eligibility* before your coverage will be reinstated. You will also need to submit copies of your induction and discharge papers to the *Plan Administrator*.

## CONTINUATION OF COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") offers *Participants* and their *Dependents* the opportunity to temporarily extend their health care coverage at group rates, in certain instances, after coverage under the *Plan* would normally end. The Board of Trustees sets the cost of COBRA coverage; however, it is subject to maximums imposed by law.

### **How do you become eligible to receive COBRA coverage?**

To be eligible for coverage under COBRA, you must experience a Qualifying Event. Persons who experience a qualifying event are called qualified *beneficiaries* under COBRA and can elect COBRA coverage provided they comply with the *Plan's* notice requirements.

### **When will I receive information regarding COBRA?**

The *Plan Administrator* will provide COBRA information in the following two (2) instances:

- Within the first ninety (90) days of you and your *Dependents* receiving coverage under this *Plan*, you

will receive a general notice that describes your rights under COBRA; and;

- If a qualifying event occurs, you and your *Dependents* will receive an election notice within fourteen (14) days of receiving notice that the qualifying event has occurred. Such election notice will describe your COBRA rights and how to elect COBRA coverage.

### **What are Qualifying Events for COBRA?**

If you are an *Active Participant*:

- Reduction in your hours of employment
- Termination of your employment for reasons other than gross misconduct
- Your former *Employer* files a Chapter 11 petition for bankruptcy
- You are determined to be *disabled* by the Social Security Administration

If you are a *Spouse or Dependent Child*:

- The death of your *Active Participant* parent or *Spouse*.
- Divorce or legal separation.
- Eligibility for Medicare.
- Loss of status as a *Dependent Child* (i.e., turning age 26).

### **What are the notice requirements if I experience a qualifying event?**

When you experience a qualifying event, written notice is required to the *Plan Administrator*. The requirements for this notice are summarized below.

- **If the qualifying event is due to divorce, marital separation, or loss of dependency status:** You (NOT YOUR EMPLOYER) must notify the *Plan Administrator* within sixty (60) days starting from the latest of (1) the date the qualifying event occurred; (2) the date the *Participant* or *Dependent* would lose coverage under the *Plan* as a result of the qualifying event; or (3) the date the *Participant* or *Dependent* is informed (through the furnishing of the SPD or COBRA general notice) of the responsibility to notify the *Plan*. In the case of divorce or legal separation, the *Participant* or *Dependent* must provide the *Plan* with a copy of the decree of divorce or legal separation to qualify for COBRA continuation coverage.
- **For all other qualifying events:** your *Employer* or former *Employer* must notify the *Plan Administrator* within thirty (30) days starting from the latest of (a) the date the qualifying event occurred; (b) the date the *Participant* or *Dependent* would lose coverage under the *Plan* as a result of the qualifying event; or (c) the date the *Participant* or *Dependent* is informed (through furnishing of the SPD or COBRA general notice) of the responsibility to notify the *Plan*.

**Failure to provide timely notice to the *Plan* of Qualifying Event will result in the immediate termination of coverage and the denial of any incurred but yet to be paid claims. In addition, the *Plan* may take legal action to recoup the amount of claims paid or the COBRA premiums that should have been paid to the *Plan* had the required notice been provided to the *Plan*.**

**How long does COBRA coverage last?**

The length of coverage available is summarized in the chart below.

Qualifying Event	Maximum Continuation Period		
	Employee	Spouse	Child
Reduction in work hours	18 months	18 months	18 months
Termination (other than for misconduct)	18 months	18 months	18 months
You are determined to be disabled by the SSA	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your <i>Spouse</i> divorce	N/A	36 months	36 months
Your <i>child</i> no longer qualifies as a <i>Dependent</i>	N/A	N/A	36 months

**Under what circumstances can COBRA coverage be extended after the initial Qualifying Event?**

The initial period of COBRA coverage can be extended if you experience a second qualifying event and provide the required notice to the *Plan*.

- **If you become Disabled:** if the initial Qualifying Event was due to a reduction in work hours or the termination of your employment, your COBRA coverage can be extended for a total period of twenty-nine (29) months for the following reasons; (1) you are found to be *disabled* as determined by the Social Security Administration (“SSA”); and (2) there is a second and independent qualifying event during the first eighteen (18) months of coverage under COBRA.

To be eligible for the extension, you must notify the *Plan Administrator* in writing of the Social Security Disability award within the first eighteen (18) months of your COBRA coverage and within sixty (60) days of the last of the following events to occur:

1. The date the SSA determined you were *disabled*.

2. The date on which coverage was lost due to a reduction in hours or termination of employment (i.e., the qualifying event),
3. The date on which a qualified *beneficiary* (such as your *Spouse* or *Child*) would lose coverage because of your loss of coverage due to your termination or reduction in hours (i.e., the qualifying event).
4. The date the qualified *beneficiary* is informed (by provision of the SPD or COBRA general notice) of the responsibility to notify the *Plan* and the procedures for doing so.

**If you fail to timely provide the required notice of your Social Security Disability Award you will NOT be eligible for the extension of your coverage.**

**Also, if you lose your SSD status, you must notify the *Plan Administrator* within 30 days of the date the Social Security Administration notifies you of its position and provide a copy of the notice to the *Plan Administrator*.**

#### **Can I extend my COBRA coverage again after a second qualifying event?**

- **If a second Qualifying Event occurs:** If you and your family are on COBRA due to your termination or reduction in hours (i.e. the first qualifying event), you and your *Dependents* may be entitled to an additional eighteen (18) months of coverage under COBRA, for a total coverage period of thirty-six (36) months, in the event of your (1) your death, (2) due to divorce, (3) becoming eligible for Medicare, or (4) your *Dependent Child* turns age 26 or otherwise ceases to meet the *Plan's* definition of a *Dependent*. The second qualifying event must cause a loss of coverage as if the first qualifying event had not occurred in order for the extension to be offered.

You must provide the *Plan Administrator* with written notice of the second qualifying event within sixty (60) days of the later of (a) the date of the second qualifying event; (b) the date that your *Spouse* or *Child* would lose coverage under the *Plan* due to the second qualifying event (such as turning age 26); or (c) the date you or your *Spouse* or *Child* is informed (by provision of the SPD or COBRA general notice) of the responsibility to notify the *Plan*.

**If you fail to timely provide the required notice you will NOT be eligible for the extension of your coverage. If you are unsure on how or when to provide this notice, please contact the *Plan Administrator* for assistance.**

**If you are unsure about when or how to provide the required notice, please contact the *Plan Administrator*.**

## **PART THREE:** **BENEFITS UNDER THIS PLAN**

### **WHAT BENEFITS ARE AVAILABLE UNDER THIS PLAN?**

The Schedules of Benefits for this *Plan* are incorporated in this SPD within the following Appendices to this SPD:

- Appendix B for the Schedule of Benefits for *Active Participants* under the Community Blue PPO Plan
- Appendix C for the Schedule of Benefits for *Active Participants* under the CORE Plan
- Appendix D for the Schedule of Benefits for *Early Retirees*
- Appendix E for the Schedule of Benefits for the Medicare Advantage Program
- Appendix F for the Hearing Care Benefit
- Appendix G for the Life Insurance Benefit
- Appendix H for the Dental Benefit
- Appendix I for the Vision Benefit
- Appendix J for the Critical Illness Program Benefit

In addition to the benefits listed in the Appendices above, the *Plan* also provides the benefits detailed in the sections below.

### **DEATH BENEFITS**

The *Plan* provides a death and accidental death ("Death") benefit to the appropriate *Beneficiary* upon proof of the eligible *Participant's* death. The amount of the Death benefit is ten-thousand dollars (\$10,000. You should designate a *Beneficiary* by filling out a form with the *Plan Administrator*.

Subject to any legal restrictions, or to the rights of any irrevocably appointed *Beneficiary*, you may from time to time change the *Beneficiary*. In the absence of a subsequent appointment or change in *Beneficiary*, the *Beneficiary* who is named at the time of the *Participant's* termination of service, will remain the *Beneficiary* for purposes of receiving the Death benefit.

Unless there is a legal requirement requiring a different distribution, if you have not designated *Beneficiaries*, the benefit will pass in descending order to the following individuals:

- Your surviving *Spouse*; but if there is no surviving *Spouse*, then to
- Your surviving *Children*, in equal shares; but if there are no surviving *Children*, then to
- Your surviving parent(s), in equal shares; but if there are no surviving parents, then to

- Your surviving siblings, in equal shares; but if there are no surviving siblings, then to
- Your estate.

### **What if the named Beneficiary is a minor?**

If any named *Beneficiary* is a minor or otherwise incapable of giving a valid release for any payment due, Death benefit proceeds payable to such *Beneficiary* will be paid to the *Beneficiary's* duly appointed guardian.

### **What happens if the named Beneficiaries die before me?**

Should any legally designated *Beneficiary* die before you, the insurance proceeds designated will be payable equally to the remaining legally designated *Beneficiaries*, if any, who survive the *Participant*, unless otherwise specified by you or unless the law requires a different distribution.

## **SHORT-TERM DISABILITY BENEFITS**

*Active Participants* receive Short-Term Disability Benefits in the amount of five hundred dollars (\$500) per week for a maximum of fifty-two (52) weeks so long as the Participant continues to meet the eligibility requirements. These benefits are taxable, and appropriate income taxes will be withheld from your payments, and they will be coordinated with any other benefits you may receive during your disability period.

### **To qualify for these benefits, you must:**

- Be an *Active Participant* or an Alumni who is eligible for benefits under the *Plan*.
- Fill out the required forms within 90 days of the incident that caused your disability.
- Suffer from a non-occupational injury that prevents you from working at your occupation; and
- Be under the regular care of a qualified *Medical Provider*.

### **Short Term Disability benefits are NOT payable under the following conditions:**

- For any period of disability during which you are not under the direct care of a *Medical Provider*.
- For a disability due to accidental bodily injuries arising out of and in the course of your employment.
- For a disability due to occupational disease. Occupational disease means a disease for which the *Participant* submitting the claim is entitled to receive workers' compensation or other benefits provided by law.
- For a disability because of an automobile accident.

- For a disability resulting from alcoholism or drug abuse.
- For any disability caused by or related to engaging in a criminal act.

Absences you have resulting from a disability within eight (8) weeks of active employment will be treated as within a single disability period unless the new disability is a result of a different cause from any prior disability. In addition, no disability will be considered as starting more than three (3) days prior to your first visit to a *Medical Provider*.

**When will Short-Term Disability benefits be paid?**

Disability payments will be made to you beginning:

- With the first (1<sup>st</sup>) day of disability due to the accident or injury.
- The first (1<sup>st</sup>) day of hospitalization.
- The first (1<sup>st</sup>) day of a surgical procedure performed in an outpatient facility.
- With the eight (8<sup>th</sup>) day of disability due to an illness.

Any balance of benefits that has not been paid by the end of the disability period will be paid only if your *Medical Provider* provides the *Plan Administrator* with the required medical evidence or certification of disability.

**Short Term Disability benefits are NOT payable during period in which you work, whether in Covered Employment or otherwise. IF YOU RETURN TO WORK, YOU MUST NOTIFY THE PLAN ADMINISTRATOR IMMEDIATELY. If you fail to notify the Plan of your return to work, you will be required to refund any benefits that were improperly paid to you. The Plan reserves the right to offset against any of your current or future benefits to recoup improperly paid benefits.**

**PART FOUR:**  
**RESTRICTIONS ON YOUR COVERAGE**

**ARE ANY SERVICES EXCLUDED UNDER THE PLAN?**

Generally speaking, only *Medically Necessary* services are covered. Unless required by law, *experimental or investigational services* are not covered. Other benefits that may not be *Medically Necessary* (such as annual wellness exams or preventive services required to be covered under the Affordable Care Act) are covered pursuant to requirements under existing law, or at the option of the Board of Trustees. The benefits and services covered are included in the attached Appendices, and in the enrollment materials you received. For more information, or if you cannot locate the copies of your enrollment materials, please contact the *Plan Administrator*. If you are a *Retired Participant* and need this information, please contact the *Plan Administrator*.

## DISEASE MANAGEMENT PROGRAMS

In an effort to ensure *Participants* are provided with the appropriate and *medically necessary* care for their particular condition, the Trustees have adopted the following disease management programs:

- **Prior Authorization.** The *Plan's* Prior Authorization Program helps to ensure the appropriate usage of certain medications by applying Food and Drug Administration (FDA) approved indications and manufacturer guidelines for using certain drugs. Certain medical procedures may also have to be authorized in advance. A list of services and medications subject to the Prior Authorization Program is available from Blue Cross Blue Shield of Michigan at [www.bcbsm.com](http://www.bcbsm.com). In addition, a copy can be obtained from the *Plan Administrator*. The Prior Authorization Program is not applicable to emergency services.
- **Step Therapy.** The Step Therapy Program addresses *participants* using prescription drugs to treat certain chronic or ongoing medical conditions. Many of the drugs used to manage these conditions have serious side effects. The Step Therapy Program is designed to ensure that the condition is being managed with a medication that is safe, medically appropriate and cost-effective. It also aids the *Plan* in controlling the costs of prescription drug coverage. Prescription drugs that are placed under the Step Therapy Program generally require a *Participant* to have failed therapy with one or more alternative drugs before coverage for the drug included within the Step Therapy Program will be approved. The Step Therapy Program can be bypassed in whole or in part where the treating *Medical Provider* establishes that certain clinical criteria have been met. A list of medications subject to step therapy, as well as a list of the clinical criteria to bypass the Step Therapy Program, is available from Blue Cross Blue Shield of Michigan at [www.bcbsm.com](http://www.bcbsm.com) or from the *Plan Administrator*.
- **Quantity Limits & Mail-Order Program.** Certain medications will only be dispensed in quantity limits that are set by the drug's manufacturer, the FDA, or the pharmacy benefit manager. In addition, certain medications may be required to be filled through the *Plan's* mail-order pharmacy. A list of drugs subject to these limitations and requirements is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.

- **Establishment of Formulary.** The *Plan* has contracted with a pharmacy benefit manager, Blue Cross Blue Shield of Michigan, which is responsible for establishing the *Plan's* prescription drug formulary. The formulary sets the tiering of covered prescription drugs and identifies what drugs are, and are not, included within the formulary and therefore covered by the *Plan*. A copy of the formulary is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Case Management.** In selected cases involving high-risk, complicated, or high-cost treatment, professional advisers from Blue Cross Blue Shield will offer, on a voluntary basis, counsel and education regarding alternative treatment options and methods to improve clinical outcomes. Information on the *Plan's* Case Management Program is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Utilization Review.** Utilization review is a process to make sure that the care you receive is *medically necessary*, delivered in the most appropriate location, and follows common medical practice. Blue Cross Blue Shield performs utilization review for the *Plan*. Information on the *Plan's* U/R Program is available from Blue Cross Blue Shield of Michigan or the *Plan Administrator*.
- **Other Programs.** The *Plan* may also implement additional disease management and wellness programs that are necessary to ensure that *participants* are provided with appropriate medical care and to help control costs. If such additional programs are adopted, you will receive a notice and supplement to this Summary Plan Description.
- **Out of Pocket Maximum.** The Maximum Out-of-Pocket Limit ("MOOP Limit") is the total maximum amount any eligible *Participant* of this *Plan* is required to pay during the *Benefit Year*, inclusive of deductibles, copayments and coinsurance, for covered services rendered in-network. The MOOP Limit does not include premiums, amounts balance billed, amounts paid for non-covered services, or amounts paid for any services rendered out-of-network. Once any *Participant* of this *Plan* has reached the MOOP Limit for the *Benefit Year*, the *Plan* begins to pay 100% of the approved amount for in-network covered services. The MOOP Limit will be reviewed annually by the Trustees.

## COORDINATION OF BENEFITS WITH OTHER POLICIES AND INSURANCE

Coordination of Benefits ("COB") is a set of rules for the order of payment of covered charges when two (2) or more plans (not including a motor vehicle policy where the *Participant* or *Dependent* has not signed a subrogation agreement) cover the same individual to avoid duplicate or overlapping payments. The COB rules apply generally to all medical, surgical, as well as dental and vision benefits provided by this *Plan*. The COB rules do not apply to death benefits.

The plan that pays first (primary) according to the rules will pay as if there were no other plans involved. The other plans (secondary) will pay the balance due up to one hundred percent (100%) of the allowable expenses under the terms of that plan. When this *Plan* pays secondary, it will not make payments until the other insurance has fully paid up to its policy limits.

**What happens if I, my Spouse, or my Dependent Children are covered under more than one Plan?**

COB rules are in effect whenever any individual has coverage under this *Plan* and or any other health and welfare plan, or plan providing dental or vision coverage. The COB rules are generally summarized in the chart below:

COVERAGE TYPE	PRIMARY	SECONDARY
Policy that has no coordination provisions	Plan without coordination provision	Plan with coordination provision
Employer-provided coverage	Plan covering individual as an <i>Employee</i>	Plan covering individual as <i>Spouse</i> or <i>Child</i>
Coverage for a <i>Child</i>	Plan covering parent whose birthday is earlier in the year***	Plan covering the parent whose birthday is later in the year***
Coverage for a <i>Child</i> with divorced parents with a court order	Plan of the parent as specified as primary insurer under Judgement of Divorce	Other parent's plan
Coverage for a <i>Child</i> with divorced parents without a court order	Plan covering parent with physical custody	Plan of <i>Spouse</i> with physical custody
Motor vehicle coverage	Motor vehicle plan	N/A

\*\*\*If the parents have the same birthday, the plan and coverage in effect for the longest will be primary.

If one of the policies or plans is issued in another state that does not use birthdays for coordination of benefits and each policy or plan by its terms is secondary, then the out-of-state policy or plan will be secondary. Each policy or plan will then be responsible for a maximum of fifty percent (50%) of his or her allowed expense or benefit.

**COORDINATION WITH MEDICARE**

The rules for coordination with Medicare are summarized below: When Medicare is primary, you must file any medical claims with Medicare first. After Medicare makes payment, the *Plan* will coordinate benefits with Medicare. In general, if you remain working then this *Plan* is primary, and Medicare will be secondary. The *Plan* will cover the Medicare Part A deductible and Part B deductible and twenty percent (20%) of the Medicare-approved charges, otherwise covered by the *Plan*.

### SUMMARY OF COORDINATION OF BENEFITS WITH MEDICARE

COVERAGE	PRIMARY	SECONDARY
You are age 65 or older, but do not retire and continue to work as an <i>Active Participant</i> .	This Plan	Medicare
You retire, but later return to work as an <i>Active Participant</i> and you work sufficient hours to meet the requirements for <i>Active Participant Coverage</i> .	This Plan	Medicare
You are age 65 or older and are a <i>Retired Participant</i> .	Medicare	This Plan
You are age 65 or older but have coverage through your <i>Spouse</i> based on their current employment and eligibility for benefits from this Plan.	This Plan	Medicare
If you are <i>Disabled, Retired</i> , and UNDER age 65.	This Plan	Medicare
If you are <i>Disabled, Retired</i> , and age 65 or over.	Medicare	This Plan
You turn age 65 while continuing coverage through COBRA, and do NOT have End Stage Renal Disease (ESRD).	Medicare	This Plan/COBRA
You have ESRD and have coverage through this Plan through any option.	This Plan for the first 30 months of Medicare eligibility.	In month 31, this Plan will be secondary.

The above table is representative of some common scenarios, but not all possible scenarios. You should always keep the *Plan* informed of any other coverage that you or your *Spouse* maintains. If you have specific questions on coordination with Medicare, please contact the *Plan Administrator*.

## COVERAGE FOR CAR AND MOTORCYCLE ACCIDENTS

**In the case of a car or motorcycle accident, this *Plan* provides only secondary, or “excess” coverage, for medical *claims* resulting from, or related to, a motor vehicle or motorcycle accident and only if you sign a reimbursement agreement.** This *Plan* directly disavows coverage and shifts the burden to any automotive or motorcycle insurance carrier or coverage covering any injured person seeking benefits under this *Plan* for any *claim* for which the *claimant* had any no-fault, third-party, or any other insurance coverage (including uninsured motorist coverage) that is applicable to any motor vehicle or motorcycle accident. **It is strongly recommended that you review your insurance policy with your insurance agent or carrier to ensure you have selected the proper coverage options for your policy.**

## THE PLAN'S SUBROGATION RIGHTS

The *Plan* has subrogation rights, which means that if it pays benefits on your behalf and you later recover money or other property from a third party to compensate you, your rights to that recovery are “subrogated” to the *Plan* up to the amount of benefits the *Plan* provided to you. The *Plan* is also automatically granted a lien against any settlement, judgment, or other payment that you may receive. By receiving benefits, you also agree to assist the *Plan* in preserving its subrogation and lien rights. The *Plan* may require you to sign a subrogation or similar agreement before paying *claims*.

## **PART FIVE:** **CLAIMS AND APPEALS**



**If you are aged 65 or older, or are on Medicare due to disability, and are covered by the *Plan*'s Medicare benefit, claims for medical and prescription drug benefits as well as appeals of denied claims are NOT handled by the *Plan Administrator* nor under this section of this SPD. You must instead contact the insurance company that provides your medical and prescription drug benefits, by contacting the number listed on your insurance card.**

## GENERALLY

Benefits are paid either directly to the service provider (with your written authorization) who has agreed to accept payment from the *Plan* or as a reimbursement to you after you incur a covered expense. Before benefits can be paid to you, you may need to obtain the appropriate *claim* form(s).

*Claims* on fully-insured benefits offered under the *Plan* (such as life insurance or critical illness benefits through Aflac) need to be made directly through the provider, and not with the *Plan* or *Plan Administrator*.

There may be more than one *Claims Administrator* depending upon the type of benefit involved. For example, *Active Participants' claims* are processed by Benesys, while Blue Cross Blue Shield of Michigan processes pharmacy *claims*. Please refer to the definition sections, specifically to the definition of *Claims Administrator*, for a listing of this *Plan's Claims Administrators*. If your *claim* is denied, there are two levels of internal *appeals* under this *Plan*. The applicable *Claims Administrator* hears the first level or "Step 1 *Appeal*". If your *claim* is denied at Step 1, then you can *appeal* a second time. The Board of Trustees hears the second level or "Step 2 *Appeal*". As described in more detail below, certain types of *Adverse Benefit Determinations* and *Final Adverse Benefit Determinations* may be eligible for external *appeal* (review by a third party). You may authorize a representative to submit *claims* as well as *appeals* on your behalf.

## HOW TO SUBMIT A CLAIM FOR BENEFITS

Most *claims* will be submitted for payment by the doctor or hospital that performed the service and will be handled by the *Plan Administrator*. For *Claims* that you for reimbursement, you must completely fill out a *Claim* form and attach an ORIGINAL copy of all bills for services rendered (keep photocopies for your records) and mail the *Claim* form(s) with the original copy of the bills to the *Claims Administrator*. All bills must show:

- Name of *Plan*.
- *Employee's* name.
- *Employee's* social security number.
- Name of patient.
- Name, address, telephone number and tax ID number of the provider of care.
- Identify the specific medical condition or symptom treated.
- Identify the specific treatment, service, or product for which approval is requested.
- Dates of service.
- Charges.

## HOW LONG DO I HAVE TO SUBMIT A CLAIM FOR BENEFITS?

*Claims* must be submitted within one year of their occurrence (however, *Claims* for Short Term Disability Benefits must be submitted within 90 days of the incident causing the disability). *Claims* filed later than that date may be declined/reduced unless it was not reasonably possible to submit the *Claim* within the one-year period.

## AFTER A CLAIM IS SUBMITTED, WHEN WILL I BE NOTIFIED OF A DECISION?

The notification period can depend on the type of *claim* you have submitted. The types of *claims* and the associated time periods are described below. The time periods for review begin when a *Claim* is filed correctly (i.e., identifies the individual and condition and is sent to the proper department), even if some additional information is needed to decide the *Claim*. If an extension of time is needed, the period to decide a *Claim* is generally suspended until the additional information is provided, or the period given to you to provide the information expires.

- **Urgent Care Claims.** If submitted properly, these *Urgent Care Claims* will be decided within seventy-two (72) hours. If more information is needed to decide on an *Urgent Care Claim*, you will be notified within twenty-four (24) hours of the receipt of the *Claim*. Such notification may be oral unless you request written notification. You will then have at least forty-eight (48) hours to provide the information needed. You will then be notified of the decision within forty-eight (48) hours of the receipt of the information, or within the forty-eight (48) hours you had to supply it. You may be notified orally of the decision, but you still will be provided a written decision on the *Claim* within three (3) days of the oral notification.
- **Pre-Service Claims.** If enough information is available, *Pre-Service Claims* will be decided within fifteen (15) days of the receipt of the *Claim*. If more information is required, this period can be extended by an additional fifteen (15) days. The notice will explain the reason for the delay and provide an estimate of when the *Claim* will be decided. If more information is required to decide your *Claim*, then you will be given at least forty-five (45) days to provide that information. The *Claim* will then be decided within fifteen (15) days of you supplying the information, or by the end of the forty-five (45) day period you had to supply that information, whichever period expires first.
- **Post-Service Claims.** If enough information is available, *Post-Service Claims* will be decided within thirty (30) days of the receipt of the *Claim*. If more time is needed, this period can be extended by fifteen (15) days. You will be notified prior to the expiration of the initial thirty (30) day period if an extension is needed. The notice will explain the reason for the delay and give an estimate of when the *Claim* will be decided. If more information is required to decide your *Claim*, then you will be given at least forty-five (45) days to provide that information. The *Claim* will then be decided within fifteen (15) days of you supplying the information, or by the end of the forty-five (45) day period you had to supply that information, whichever period expires first.
- **Concurrent Care Claims.** If the length of treatment approved is reduced or terminated prior to the

end of the period or the full number of treatments (unless the reduction or termination occurs as the result of a *Plan* amendment or termination), you will be provided with written notice within a sufficient amount of time prior to the reduction or termination for you to *Appeal* that decision. If you request to extend a course of treatment, you will be notified within twenty-four (24) hours of the receipt of your request for that extension if you requested the extension at least twenty-four (24) hours prior to the expiration of the approved length of treatment.

- **Disability Claims.** Disability *Claims* will generally be decided within forty-five (45) days after the receipt of the *Claim*. If more time is needed to decide your *Claim*, this period can be extended by thirty (30) days. In such an instance, prior to the 45-day period, you will be given notice of the reasons for the extension and give an estimate of when the *Claim* will be decided. This period may be extended again for an additional thirty (30) days. If this occurs, you will be given notice of this second extension prior to the end of the first thirty (30) day extension period, which will explain the reasons for the second extension and give an estimate of when the *Claim* will be decided. If more information is required to decide your *Claim* during either extension period, then you will be given at least forty-five (45) days to provide that information. The *Claim* will then be decided within thirty (30) days of you supplying the information, or by the end of the forty-five (45) day period you had to supply that information, whichever period expires first.
  
- **Air Ambulance Claims.** A *Claim* also includes a request that *participant* cost-sharing for out-of-network emergency services and facilities, and out-of-network air ambulance services be no more expensive than for those services if they were in-network, and also that emergency procedures not be subjected to preauthorization, all in compliance with the No Surprises Act, codified at Title II of Division BB of the Consolidate Appropriations Act.
  
- **All other claims:** the *Claims Administrator* may extend the time to reach a decision up to an additional ninety (90) days. Written notice of the extension will be furnished to you prior to the termination of the initial ninety (90) day period and will explain the circumstances requiring an extension of time, as well as identify the time and date by which the *Claims Administrator* expects to reach a decision.

## WHAT HAPPENS IF MY CLAIM IS DENIED?

In the event your *Claim* is denied, the *Plan* will send you a notice (called an “*Adverse Benefit Determination*”) explaining the reasons for the denial and outlining your rights to *appeal*. If more information is needed to decide your *claim*, the notice will explain what information is required.

## WHAT ARE MY RIGHTS TO APPEAL A DENIED CLAIM?

There are levels of *appeal* when a Claim has been denied. The *Plan Administrator* or network provider will review your *Claim* during the Step 1 *Appeal*. If your first *Appeal* is denied, then you may proceed to a second *appeal* directly to the Board of Trustees.

### **How do I file the first appeal?**

You have one-hundred eighty (180) days from the mailing date of your *Claim* denial to file your first *Appeal* with the *Plan Administrator*. You may submit your *Appeal* yourself, or you may have an authorized representative submit the *Appeal* on your behalf. Once your *Appeal* has been timely filed, you:

- Can review necessary and pertinent documents on which the denial in whole or in part is based and may submit written comments, documents, records, and other information relating to the *Claim* for benefits; and
- Will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your *Claim* for benefits. A document is considered relevant to the *Claim* if the document:
  - Was relied upon in making the benefit determination.
  - Was submitted, considered, or generated while making the benefit decision.
  - Demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the *Plan* and be consistent when applied to similarly situated *Claimants*.

### **When considering your Appeal, the Claims Administrator will:**

- Consider all comments, documents, records, and other information submitted by the *Claimant* relating to the *Claim*, without regard to whether such information was submitted or considered in the initial determination.
- Not afford deference to the initial denial of your *Claim*.
- Ensure a different person other than the individual, including his/her subordinate, who initially denied your *Claim* considers your *Appeal*.
- May consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment when your *Appeal* is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is *Experimental or Investigational*, or not *Medically Necessary* or appropriate and who was not consulted in the initial denial of your *Claim*. The *Plan Administrator* will provide you the identity of this individual even if his or her opinion is not relied upon when considering your *Appeal*.

- For an *Urgent Care Claim*, offer an expedited review process whereby the request may be provided by you orally or in writing; and all information, may be provided to you by telephone, facsimile, or any other similar method.
- For *Disability Claims*, if a decision is based upon any new evidence, provide you with the new evidence in advance of the date on which the notice of the *Adverse Benefit Determination* is due.

**IF MY FIRST APPEAL IS DENIED, HOW DO I APPEAL TO THE BOARD OF TRUSTEES?**

Following the denial of your first *Appeal*, you will again receive a notice explaining the reasons for the denial and an explanation of your appeal rights. You then have one-hundred eighty (180) days after your first *Appeal* was denied to submit your *Appeal* to the *Plan Administrator* to be heard by the Board of Trustees. The written notice should: (a) state your name, address, and the fact you are appealing the decision of the *Plan Administrator*; and (b) give the date of the decision appealed.

When the Board of Trustees reviews your *Step 2 Appeal*, any new evidence or additional rationale that is considered, relied upon, generated by (or at the discretion of) the Board of Trustees (or its professional advisors) will be provided to you automatically and free of charge. This information will be provided to you within sufficient time before the Board of Trustees decides on your *Appeal*, so you have an opportunity to respond to it.

If this new evidence or additional rationale is received too late for you to have a reasonable opportunity to respond to it before the Board of Trustees is required to decide your *Appeal*, the time for issuing a final decision on your *Claim* will be suspended for a reasonable period of time until you have responded to the new evidence or rationale, or failed to respond within the time given to you. In this instance, a decision will be made as soon as possible, considering any medical exigencies.

In the event of a denial by the Board of Trustees, you will receive a notice (often called a *Final Adverse Benefit Determination*) explaining the reason for the decision and advising you of your rights relative to their decision under ERISA, including the right to an external *Appeal* (discussed later). You will also be notified if your *Claim* is approved.

**WHEN I WILL BE NOTIFIED OF A DECISION ON MY APPEAL?**

Whether your *appeal* is a first-level *appeal* or a second-level *appeal* to the Board of Trustees, you will be notified of a decision within the following timeframes:

Type of Appeal	Urgent	Pre-Service	Post-Service	Disability
Notification of Decision	72 hours	15 days	30 days	45 days*

*\*The timeframe for deciding Disability Appeals may be extended by an additional 45 days. In such an instance, you will be notified prior to the expiration of the initial 45-day period, with an explanation of the reasons for the extension, identification of any information needed, and the date a decision is expected to be made.*

## EXTERNAL APPEALS

If the Board of Trustees denies your *appeal*, you may be eligible to seek an external *appeal* if your *appeal* involves:

- **Claims** involving an exercise of medical judgment.
- **Claims** that resulted in a *Rescission* of coverage.
- Coding errors, but only to the extent a coding error involved an exercise of medical judgment.

*Claims* regarding the application of other provisions of this *Plan*, for example, whether or not you met the eligibility requirements, are not subject to an external *Appeal*.

If the Board of Trustees denies your *Claim* (you receive a *Final Adverse Benefit Determination*), you have four (4) months to request an external review. If there is no corresponding date four (4) months after the date of receipt of the denial, then the request must be filed by the first (1<sup>st</sup>) day of the fifth (5<sup>th</sup>) month following the receipt of the notice that the Board of Trustees denied your second appeal.

Requests for external *appeals* are to be filed with the *Plan Administrator*. If the *Plan Administrator* receives a request for an external *appeal*, the following rules apply:

- **Preliminary Review.** Within five (5) business days following the receipt of the request for an external review, the *Plan* will complete a preliminary review of the request to determine the following:
  1. Whether you were covered under the *Plan* at the time the health care item or service was requested, or, in the case of a retrospective review, you were covered under the *Plan* at the time the health care item or service was provided.
  2. Whether the *Adverse Benefit Determination* or the *Final Adverse Benefit Determination* relates to your failure to meet this *Plan's* requirements for eligibility (e.g., worker classification or similar determination)
  3. Whether you have exhausted the *Plan's* internal *Appeal* process unless you were not required to exhaust the internal *Appeals* process.
  4. Whether you have provided all the information and forms required to process an external review.

- **Post-Preliminary Review.** Within one (1) business day after completion of the preliminary review, the *Plan* will issue a written notice to you noting the reasons, if the *Claim* is not eligible for external review, along with contact information for the Employee Benefits Security Administration (“EBSA”), or, the information needed if the application for the review is not complete. You will have the latter of: (a) the four (4)-month filing period, or (b) the forty-eight (48)-hour period following your receipt of the notification to provide any additional information that is needed.
- **Referral to Independent Review Organization (“IRO”).** At the conclusion of the preliminary review, the *Plan* will then refer eligible *Claims* to a randomly selected IRO and immediately provide coverage if the decision of the *Plan* is overturned. The *Plan* will adhere to all terms of the contract with the IRO. No costs will be imposed on you for filing an external review.

## IS THERE AN OPTION FOR AN EXPEDITED EXTERNAL APPEAL?

Yes. You may request an expedited external review at the time you receive either of the following:

- An *Adverse Benefit Determination* that involves a medical condition where delay would jeopardize your health or ability to regain maximum function and you made a request for an expedited internal *Appeal*; or
- A *Final Adverse Benefit Determination* that involves a medical condition where the timeframe for a normal external review would jeopardize your health or ability to regain maximum function, or, if the determination involves an admission, availability of care, continued stay, or a health care or service for which you received emergency services but have not yet been discharged.

The process for seeking an expedited external *Appeal* is outlined below:

- **Preliminary Review.** Immediately upon receipt of the request for an expedited external review, the *Plan* will determine whether the request meets the requirements for external review. This determination is made by applying the criteria for a standard external preliminary review set forth in the preceding paragraphs.
- **Post Preliminary Review.** Within one (1) business day after completion of the preliminary review, the *Plan* will issue a written notice to you. It will note the reasons, if the *Claim* is not eligible for external review, along with contact information for EBSA, or, the information needed if the application for the review is not complete. You will have the latter of (a) the four (4)-month filing period, or (b) the forty-eight (48)-hour period following your receipt of the notification to provide any additional information that is needed.

- **Referral to Independent Review Organization.** If the *Plan* determines your request is eligible for external review, then an IRO must be assigned the *Claim* in the same manner as for a standard external review. The *Plan* will provide the IRO with all the information used in making the benefit determination in the most expeditious manner available. If the IRO overturns the decision of the Board of Trustees, the *Plan* will immediately provide coverage. No costs will be imposed on you for filing an expedited external *Appeal*.

## DO I HAVE TO GO THROUGH THE APPEALS PROCESS?

You are generally required to exhaust the internal *Claims* and *Appeals* processes of this *Plan* before you are permitted to seek external *Appeal* or file a lawsuit with respect to your *Claim*. However, if the *Plan Administrator* or the Board of Trustees fails to strictly adhere to the *Claims* and *Appeals* process outlined in this section, and its error is of a serious nature, you can be deemed to have exhausted the internal *Appeals* process and can proceed directly to requesting an external *Appeal* or filing a civil action in court under ERISA.

However, if the error of the *Plan Administrator* or the Board of Trustees is only minor or “de minimis,” then you must complete the internal *Appeals* process first before proceeding with an external *Appeal* or filing a lawsuit. A minor error is, generally, one that is not material and does not prejudice the outcome or the review of your *Appeal*, or that is part of a good faith exchange of information between you and the *Plan Administrator* or the Board of Trustees. In these instances, you must complete both levels of the internal *Appeals* process before seeking an external *Appeal* or filing a lawsuit.

If you believe the *Claims* process has not been strictly adhered to, you may request a statement from the *Plan Administrator* or the Board of Trustees. The *Plan Administrator* or the Board of Trustees will provide you with a response within ten (10) days. If you pursue an external *Appeal* or a lawsuit, and a court or the entity that considers the external *Appeal* rejects your assertion that the *Plan Administrator* or the Board of Trustees did not strictly adhere to the *Claims* process, you will be able to return to the internal *Claims* and *Appeals* processes of this Plan.

## **PART SIX:** **YOUR RIGHTS AND RESPONSIBILITIES**

### WHAT ARE MY RIGHTS UNDER ERISA?

As a *Participant* in this *Plan*, you are entitled to certain rights and protections under ERISA. ERISA provides that all *Participants* are entitled to:

- Examine, without charge, the Governing Documents, including the *Plan Document*, insurance contracts, the *Collective Bargaining Agreements*, updated *Summary Plan Description*, copies of the latest annual report (Form 5500 series), and any documents filed by the *Plan* with the U.S. Department of Labor, such as detailed financial reports, etc. This examination may take place at the *Plan Administrator* office and at other specified locations such as the work site or the union hall;
- Obtain, upon written request to the *Plan Administrator*, copies of documents governing the *Plan*, including the *Plan Document*, insurance contracts, the *Collective Bargaining Agreement*, updated *Summary Plan Description*, and copies of the latest annual report (Form 5500 series). The *Plan Administrator* may make a *Reasonable and Customary Charge* for the copies.
- Receive a summary of the *Plan's* annual financial report. The *Plan Administrator* is required by law to furnish each *Participant* with a copy of this summary annual report;
- Obtain a statement telling you what rights you have with respect to benefits offered by the *Plan*. *This statement must be requested in writing and is not required to be given more than once a year.* The *Plan* must provide the statement free of charge;
- Continue health care coverage for yourself or your *Dependents* if there is a loss of coverage under the *Plan* because of a Qualifying Event. You or your *Dependents* may have to pay for such coverage; and
- Review this *Summary Plan Description* and the documents governing the *Plan* on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for *Participants*, ERISA imposes duties upon the people who are responsible for the operation of the *Plan*. The Board of Trustees, who operate your plan and are called "fiduciaries" of the plan, have a duty to do so prudently, and in the interest of you and other *Participants* and *Beneficiaries*. No one, including your *Employer*, your *Union* or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA. In addition:

- If your *Claim* for a benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to *Appeal* any denial, within certain time schedules.
- Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the *Plan* and do not receive them within thirty (30) days, you may file a 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

one-hundred ten dollars (\$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 that 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 domestic relations order or a medical child support order, you may file suit in federal court.
- If you have a *Claim* for benefits, that 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 concerning a QDRO or QMCSO, you may file suit in federal court. Furthermore, if the *Plan's* fiduciaries misuse the *Plan'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 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 if, for example, it finds your *claim* is frivolous.

If you have any questions about this statement, or about your rights under ERISA, you should first contact the *Plan Administrator* and then contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor, listed in your telephone directory or the Division of Technical Assistance & Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

## CIVIL ACTIONS AGAINST THE PLAN

You must file a lawsuit to challenge any denial by the *Plan* of your right to current or future benefits within one (1) year after your *Claim* for benefits (or to establish a right to future benefits) is finally denied by the *Plan*. Other *Plan*-based lawsuits must be brought within one (1) year after they accrue. How this limitation works in practice is explained below. The Board of Trustees will provide you with periodic additional notices of the limit at least annually and at other appropriate times (i.e., in letters from the *Plan* itself concerning your benefit *claims*). These requirements apply even though all *Plan* communications may not remind you of them.

**The One (1)-Year Limit.** The one (1)-year limit begins on the date your right to *Plan* benefits is fixed (without judicial action). For example, the one (1)-year limit will begin:

- On the day following the date on which the *Plan* finally denies your *Claim* for benefits (or right to future benefits);
- On the day following the last day for you to *Appeal* a *Plan* denial of your *Claim* for benefits or future benefits (if you decide not to *Appeal* that denial); or

→ On the day following the last date on which you could file a *Claim* for benefits under the Plan (if you do not file a *Claim* before the applicable *Claim*-filing deadline).

**The *Plan* requires generally requires you to exhaust your internal remedies before filing a civil action. If you do not exhaust these remedies, you may be foreclosed from pursuing a civil action until you have done so.**

**If you are unsure about when or how to provide the required notice, please contact the *Plan Administrator*.**

The one (1)-year limit does not apply to *Plan*-related rights that you have that are not based on the *Plan* itself. For example, the one (1)-year limit does not apply to *Claims* that *Plan* fiduciaries have violated their ERISA fiduciary duties.

## WHAT ARE MY RIGHTS UNDER HIPAA, HITECH, AND GINA?

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and The Health Information Technology for Economic and Clinical Health Act (“HITECH”), enacted as part of the American Recovery and Reinvestment Act of 2009, require that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the *Plan’s* privacy notice, which was distributed to you upon enrollment and is available from the *Plan Administrator*. If you have questions about the privacy of your health information please contact the *Plan’s* legal counsel, set forth above. If you wish to file a complaint under HIPAA, please contact the *Plan Administrator*. In addition, under the Genetic Information Non-Discrimination Act (“GINA”), the *Plan* will not discriminate based on and cannot request genetic information when making determinations regarding your eligibility for coverage.

## NOTIFICATIONS TO THE PLAN & SPECIAL ENROLLMENT RIGHTS

Under some circumstances, you will be required to notify the *Plan Administrator* of certain events. Your failure to do so may affect your coverage. These events also qualify as Benefit Events that allow you to add individuals to coverage outside of the normal enrollment period. Accordingly, the *Plan Administrator* must be notified in writing of any changes regarding the following:

- **Marriage** - To add a *Spouse* and any eligible stepchildren to coverage, the marriage must be reported within thirty (30) days. A copy of the certificate of marriage must be filed with the *Plan Administrator*. The *Spouse* and any eligible stepchildren will then be covered from the moment of marriage.
- **New Children** - To add your newborn *Child* to coverage, the birth must be reported within thirty (30) days. A copy of the birth certificate must be filed with the *Plan Administrator*. The *Child* will be covered from the moment of birth, as provided herein.
- **Adoptions** - Adoption or placement of a *Child* must be reported within thirty (30) days to add the *Child* as an eligible *Dependent* and a copy of the legal adoption papers or court order for placement must be filed with the *Plan Administrator*.
- **Change of Address** - Any change of address must be reported within thirty (30) days.
- **Name Change** - Any name change must be reported within thirty (30) days.
- **Deaths** - Deaths must be reported immediately. A certified copy of the death certificate is required.
- **Divorce** - Divorce must be reported immediately and a copy of the judgment of divorce must be filed in the *Plan Administrator*. A former *Spouse* is no longer eligible for benefits as of the date of the divorce, except as provided under COBRA. Eligible *Children* will continue to be covered if they continue to qualify as *Children* under this *Plan*.
- **26<sup>th</sup> Birthday** - Children attaining the age of twenty-six (26) are no longer eligible for coverage as of the last day of the month in which they turn age twenty-six (26). Once no longer eligible for coverage, children who age out of coverage may elect continuation of coverage under the COBRA provision of the *Plan*.
- **Change of Employment Status** - If you or your *Spouse* switches *employers*, returns from a leave of absence, or moves to full or part-time employment, then you must notify the *Plan Administrator* within thirty (30) days.

Note, you may still enroll yourself, your *Spouse*, and/or your *Child*, if you do not notify the *Plan Administrator* within thirty (30) days. However, coverage will begin on the date of notification and will not apply retroactively back to the date of the Benefit Event.

## WHAT HAPPENS WHEN CIRCUMSTANCES OR BENEFITS CHANGE?

If an amendment or termination is made to the provisions of the Plan, you will receive a notice describing the changes and how they affect you. These notices are typically referred to as a Summary of Material Modifications (“SMM”).

The *Plan* may be terminated, in whole or in part, merged, or combined with another plan. The Board of Trustees may also terminate the *Plan* when a *Collective Bargaining Agreement* requiring *Employer Contributions* to the *Plan* no longer exists, or as otherwise permitted by law.

While the Board of Trustees has broad authority to make changes, it may not amend the *Plan* in a way that would: (a) authorize or permit any part of the *Plan* assets to be used for purposes other than the exclusive benefit of *Participants* or their *Beneficiaries*; or (b) cause any part of the *Plan’s* assets to revert to the *Employers*.

## **PART SEVEN:** **APPENDICES**

### **APPENDIX A:** **DEFINITIONS**

- **Adverse Benefit Determination:** A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) of a *Claim*, including any such denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon your eligibility to participate in the *Plan* or resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be an *Experimental or Investigational*, or not *Medically Necessary* or appropriate. A rescission of coverage is included in this definition, irrespective of whether the rescission had an adverse effect on any particular benefit at that time. Rescissions will be treated in accordance with 45 CFR §147.128, as amended, and any person affected by a *rescission* will receive thirty (30) days advance written notice.
- **Appeal:** An *Appeal* of an *Adverse Benefit Determination* that is filed in accordance with this *Plan's* procedures for filing an *Appeal*.
- **Beneficiary(ies):** Person(s) who, because of a relationship to the *Participant*, may be entitled to benefits from the *Plan*, or who are designated by a *Participant* to receive benefits from the *Plan* in the event of his/her death, or in the absence of an effective designation, if such designated person(s) will have died, the first of the following classes of *Beneficiaries*, then surviving, in successive preference, the *Participant's*: (a) *Spouse*; (b) *Children*; (c) parents; (d) brothers and sisters; and (e) estate.
- **Benefit Year or Calendar Year:** The twelve (12)-month period starting on January 1 of any year and ending on December 31 of that year.
- **Child(ren):** Any *Child(ren)* of the *Participant*, including:
  - A son, daughter, stepchild, adopted child, child lawfully placed for adoption, a child meeting the definition of a "foster child" under applicable law that is lawfully placed with the *Participant* by an authorizing placing agency or by court order, and is under the age of twenty-six (26). In case of divorce, proof of the *Participant's* obligation to provide coverage for a child shall be required, such as a judgment of divorce;
  - Any illegitimate children under the age of twenty-six (26), so long as the *Participant* provides the *Plan Administrator* with proof of paternity by presenting a registered birth certificate, naming the *Participant* as the father, order of filiation, or adoption order;

- Any handicapped child who is incapable of self-sustaining employment because of a mental or physical handicap; and who the *Participant* is required by court order to provide support and maintenance; and whose handicap began before age twenty-six (26);
  - An individual named under the terms of a *Qualified Medical Child Support Order*; and
  - Any person for whom a court has appointed the *Participant* as his/her legal guardian; and who is under the age of twenty-six (26).
- **Claim:** A request for a *Plan* benefit made by a *Claimant* in accordance with this *Plan's* procedures for filing or appealing a *Claim* for benefits. A *Claim* must generally name a specific *Claimant*, identify a specific medical condition or symptom, identify a specific treatment, service, or produce for which approval is requested, and be received by a person or organizational unit of the *Claims Administrator* that is customarily responsible for handling benefit matters.
- **Claimant:** A person or his/her authorized representative, who has submitted a *Claim* for a *Plan* benefit in accordance with this *Plan's* procedures for filing or appealing a *Claim* for benefits.
- **Claims Administrator:** The entity responsible for processing and adjudicating *Claims* or *Appeals*, and for providing notices to you or your *Beneficiaries* of *Claim* determinations and adjudications, as well as *Appeal* determinations. The *Claims Administrator* is the *Plan Administrator* in all instances.
- **Collective Bargaining Agreement:** A contract or participation agreement between an *Employer* and the *Union* that requires fringe benefit *contributions* to be made to this Health and Welfare *Plan*.
- **Concurrent Care Claims:** Any *Claim* regarding an ongoing course of treatment to be provided over a period of time or number of treatments, which has previously been approved by the *Plan*.
- **Continuing Eligibility:** The requirements for a *Participant* to continue eligibility for benefits under the *Plan* after (s)he has met the requirements for *Initial Eligibility*.
- **Contribution Hours:** The hours an *Employee* worked in *Covered Employment* for which an *Employer* has made actual contributions to this Health and Welfare *Plan* pursuant to a *Collective Bargaining Agreement*, or other written agreement. Only the hours for which contributions are actually received by the *Plan* (i.e., an *Employer* has paid the contributions to the *Plan*) will be deemed *Contribution Hours*.
- **Covered Employment:** Employment with an *Employer*, for which the *Employer* has agreed, through a *Collective Bargaining Agreement* with the *Union*, or other written agreement, to make contributions to this *Plan* for work performed by an *Employee* covered by that *Collective Bargaining Agreement*.

- **Credited Reserve Hours:** *Contribution Hours* above those required to meet the requirements for *Continuing Eligibility*. The maximum number of hours that can be accumulated is 290 hours.
- **Dependent:** The *Spouse* and/or *Child* of a *Participant*. Your *Spouse*; provided, however, that a *Spouse* who is a full-time *Employee* and who is eligible to enroll in employer-sponsored coverage from his/her employer must enroll in such coverage as soon as such coverage becomes available to the working *Spouse*. The *Plan* will apply its coordination of coverage provisions as if the working *Spouse* had elected the employer-sponsored coverage, unless the working *Spouse* has family coverage, in which case the *Plan's* normal coordination of benefits provisions will apply. The cost of the working *Spouse's* coverage may be reimbursed from the *Participant's SCRA*, provided however, the *SCRA* may not be used to reimburse the cost of individual coverage purchased on an Exchange or Marketplace.
- Your son, daughter, stepchild, adopted *Child*, *Child* lawfully placed for adoption or guardianship, or *Child* meeting the definition of a "foster child" under applicable law that is lawfully placed with you by an authorizing placing agency or by court order, and is under the age of twenty-six (26). A copy of the order of adoption, guardianship or placement order must be provided to the *Plan Administrator*;
  - Any illegitimate *Child*, so long as the *Participant* provides the *Plan Administrator* with proof of paternity by presenting a registered birth certificate, naming the *Participant* as the father, order of filiation or adoption order;
  - Each handicapped *Child*, who is incapable of self-sustaining employment because of a mental or physical handicap, and who is dependent on you for support and maintenance. (S)he will remain your *Dependent* and be eligible for coverage so long as you remain eligible for benefits as a *Retiree*, *early Retiree* or *Disabled Participant*; and (b) such incapacity began before the date the *Child's* coverage would otherwise terminate under the *Plan* (for example, the disability began before the *Child* was age twenty-six (26)). Proof of the *Child's* incapacity must be submitted to the *Plan Administrator* within thirty-one (31) days of the date such *Dependent's* coverage would have otherwise terminated;
  - An individual through a valid order of a court, by the Board of Trustees to be a QMCSO under applicable federal law, which creates or recognizes the right of an alternate recipient to benefits as your eligible *Dependent* under the *Plan*; or
  - Any person for whom a court has appointed you as his/her legal guardian and who is under the age of twenty-six (26).
- **Disabled:** As a result of a physical or mental condition, that the Board of Trustees finds, on the basis of medical evidence, to permanently and totally prevent the *Participant* from engaging in any work within the jurisdiction claimed by the United Association ("UA") for remuneration or profit. The disability must

be, on the basis of medical evidence, expected to continue during the remainder of his/her life or will be expected to continue for at least one (1) year. To be *Disabled*, such disability cannot have been caused by: (a) the use of illegal narcotics; (b) the performance of or engagement in illegal activity; or (c) the result of a self-inflicted injury that is not the result of a medical condition.

- **Effective Date:** The effective date of this SPD, the effective date of a specific benefit, or the date an *Employee* or *Dependent* becomes eligible for benefits. The *Effective Date* of this SPD will be November 1, 2024.
- **Employee:** Any person who is or has been employed by an *Employer* in *Covered Employment*, or such other employment for which the *Employer* is obligated by a *Collective Bargaining Agreement*, or any other written agreement, to contribute to the *Plan*.
- **Employer:** Any of the following:
  - Any member of an *Employer Association* and any other individual, partnership, corporation or business entity that is employing the services of individuals performing work that is within the trade jurisdiction of the *Union* and which has a *Collective Bargaining Agreement* or any other written agreement in effect, requiring contributions to the *Plan*;
  - Any other *Employer* engaged in work coming within the trade, craft, and geographical jurisdiction of the *Union*, who is obligated by a *Collective Bargaining Agreement*, or such other written agreement, to make contributions to this *Plan* on behalf of its *Employees*;
  - The *Union*, and its related international bodies, solely to the extent that it acts in the capacity of an *Employer* of its business representative or its *Employees*, provided it agrees to make contributions to the *Plan* on behalf of such *Employees*;
  - Any training or other similar program operated in whole or in part by the *Union*, or with its approval, or in which the *Union* participates;
  - Any board of trustees, committee or other agency established to administer or be responsible for fringe benefit plans, educational or other programs established through collective bargaining by the *Union*, the members of which maintain a collective bargaining relationship with the *Union* or one of its constituent Locals;
  - Any council, committee, or other body composed of representatives of one or more labor organizations of which the *Union* or one of its constituent Locals is a member and agrees in writing to participate herein; or

- Any sponsoring *Employer Association*, whose members maintain a collective bargaining relationship with the *Union*, solely in its capacity as an *Employer of Employees*, on whose behalf it has agreed in writing to make contributions to this *Plan*.
- **Employer Contributions:** The fringe benefit contributions received by the *Plan* for each hour worked in *Covered Employment*. Generally, only contributions received by the *Plan* will be deemed Employer Contributions for eligibility purposes, except as otherwise provided in this SPD.
- **Experimental or Investigational:** Means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:
- Items within the research, investigational, or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
  - Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials or at least one or more large, controlled, national, multi-center, population-based studies;
  - Items based on anecdotal and unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
  - Items that have been identified through research-based evidence to not be effective for a medical condition and/or do not have a beneficial effect on health outcomes;
  - FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology, TM or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the *Plan* and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-

reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence;

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

→ **Final Adverse Benefit Determination:** An *Adverse Benefit Determination* that has been upheld by the Board of Trustees at the completion of the internal *Appeals* process.

→ **Individual Account Plan (IAP):** A notional account that does not vest that you can use to pay for certain expenses not covered by the *Plan*. Only certain expenses approved by the IRS and Board of Trustees can be reimbursed.

→ **Initial Eligibility:** The requirements that a covered individual and his/her *Dependents* must meet to become initially eligible for coverage under the *Plan*.

→ **Medical Provider or Physician:** Any of the following:

- A doctor of medicine, osteopathy, chiropractor, podiatry or optometry, legally qualified and licensed to practice medicine, perform surgery, or provide services at the time and place services are performed;
- A person who is licensed or certified as a psychologist (but not including a person acting within the scope of a partial or limited license or certification);
- A person who is a member or Fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where such person renders service; and
- A Physician's Assistant, nurse, or person of a similar position working under the direction of the treating *Physician*. The *Plan* will provide coverage for services administered by a Physician's Assistant or an otherwise qualified person working under a *Physician*, however, the *Plan* or its network provider may seek *Physician* verification prior to approving payment for any claims or benefits or audit claims.

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

- In accordance with Generally Accepted Standards of Medical Practice; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the *Participant's* illness, injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for the person's convenience or that of the person's doctor or other health care provider; and
- Is the most appropriate, most cost-efficient level of service(s), supply, or drug that can be safely provided to the person and that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the person's illness, injury, disease, or symptoms.

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

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

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

- **Participant:** An *Employee* who has met the requirements established by the Board of Trustees to be eligible for benefits under this *Plan*. Includes *Active, Retiree, Early Retiree, and Disabled Participants*.
- **Plan Year or Fiscal Year:** The time period of January 1 through December 31.
- **Post-Service Claims:** Any *Claim* that is not a *Pre-service, Urgent Care, or Concurrent Care Claim*.
- **Pre-Service Claim:** Any *Claim* that, under the terms of the *Plan*, conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

→ **Qualified Medical Child Support Order:** A medical support order:

- Which creates or recognizes the existence of an alternate recipient's right to receive benefits as a *Dependent* under this *Plan*, and
- Includes:
  - The name and the last known mailing address (if any) of the *Participant* and the name and mailing address of each alternate recipient covered by the order;
  - A reasonable description of the type of coverage to be provided by the *Plan* to each such alternate recipient, or the manner in which such type of coverage is to be determined (not to exceed the level of coverage offered by the *Plan*);
  - The period to which such order applies; and
  - The legal name of this *Plan*.

→ **Reasonable and Customary Charge:** Charges that do not exceed charges normally made by other hospitals, physicians, or service providers in this geographic area. For purposes of foregoing, covered charges will mean the actual cost or charge to an eligible *Participant* or *Dependent*, but only to the extent they will be deemed *Reasonable and Customary Charges* for *Medically Necessary* care and services that are ordered by a legally qualified *Physician*, but not to exceed the maximums provided in the Schedule of Benefits.

→ **Rescission:** A cancellation of coverage that has a retroactive effect and that is not the result of fraud or an intentional misrepresentation of a material fact. Cancellation of coverage due to non-payment of premiums or contributions toward the cost of coverage, including self-payments or COBRA premiums, is not a *Rescission*. Prospective cancellations of coverage will not be based upon any health factor, as defined in 26 CFR 54.9802-1.

→ **Residential Treatment Center:** A licensed facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. Patients with such facilities are medically monitored with twenty-four (24) hour medical availability and twenty-four (24)-hour onsite nursing services for patients with Mental Illness and/or Substance Abuse disorders. It does not include halfway houses, supervised living, group homes, wilderness, equine or similar programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such

facilities; any services, irrespective of whether they are based on *Medically Necessity*, at the specified and/or related facilities will not be covered under the *Plan*.

- **Retiree:** An individual who has met the initial eligibility requirements for coverage as a Retiree under the *Plan* and who has established and continuously maintained eligibility for benefits under this *Plan*. Residential *Employees* and their *Dependents* are not eligible for coverage under the *Plan*.
- **Sickness:** Disease, mental, emotional, or nervous disorders, and covered pregnancy. A recurrent *Sickness* will be considered as one (1) *Sickness*. All related *Sicknesses* will be considered as one (1) *Sickness*. Concurrent *Sicknesses* will be deemed to be one (1) *Sickness* unless such *Sicknesses* are totally unrelated.
- **Spouse:** The individual to whom a *Participant* is legally married (a marriage certificate will be required as proof of spousal relationship).
- **Union:** The Saginaw 85 Plumbers and Pipefitters Local Union No. 85, its affiliate Local *Unions*, or any successor thereto.
- **Urgent Care Claims:** Any *Claim* for medical care or treatment that cannot be decided under normal time frames because (a) it can seriously jeopardize the life or health of the *claimant* or the ability of the *Claimant* to regain maximum function, or (b) in the opinion of a *Medical Provider* with knowledge of the *Claimant's* medical condition, would subject the *Claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *Claim*. Any *Claim* that a *Medical Provider* with knowledge of the *Claimant's* medical condition determines is an *Urgent Care Claim* will be treated as an *Urgent Care Claim* by the *Plan*. Otherwise, the determination regarding whether a *Claim* involves *Urgent Care* will be made by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

**APPENDIX B:**  
**SCHEDULE OF BENEFITS**  
**ACTIVE PARTICIPANTS AND THEIR DEPENDENTS**  
**COMMUNITY BLUE PPO PROGRAM**

This *Plan* offers coverage for various benefits, some of which require the satisfaction of applicable deductibles, co-pays, limitations, exclusions or separate eligibility requirements. Full credit will be given for deductibles and co-pays satisfied under the terms of the Predecessor Plan in the current *benefit year*. The following benefit levels currently apply:

<b>Participant's responsibility (deductibles, copays, coinsurance and dollar maximums)</b>		
<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Deductibles</b> - per calendar year **4 <sup>th</sup> quarter carryover – dollars paid in the last quarter of each year will be credited to the year following	\$500 per member \$1,000 per family	\$1,000 per member \$2,000 per family
<b>Copays</b> • Fixed Dollar Copays	Office visits - \$20 copay  Urgent care services - \$20 copay  Facility medical emergency - \$50 copay  Generic drugs - \$10 copay for retail 30-day supply; \$20 copay for mail order 90-day supply  Preferred brand drugs - \$40 copay for retail 30-day supply; \$80 copay for mail order 90-day supply  Non-preferred brand drugs - \$70 copay for retail 30-day supply; \$140 copay for mail order 90-day supply	Office visits – 40% after deductible  Urgent care services – 40% after deductible  Facility medical emergency - \$50 copay  Generic drugs - \$10 copay plus an additional 25% of BCBSM approved amount for the drug  Preferred brand drugs - \$40 copay plus an additional 25% of BCBSM approved amount for the drug  Non-preferred brand drugs - \$70 copay plus an additional 25% of the BCBSM approved amount for the drug
<b>Coinsurance</b> • Percent Coinsurance	20% of approved amount	40% of approved amount  <b>Note:</b> Services without a network are covered at the in-network level.
<b>Annual coinsurance maximums</b> – applies to coinsurance amounts for all covered services – but <b>does not</b> apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts.	\$2,000 per member \$4,000 per family	\$4,000 per member \$8,000 per family
<b>Annual out-of-pocket maximums</b> – applies to deductibles, flat dollar copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable	\$4,000 per member \$8,000 per family	\$8,000 per member \$16,000 per family

Benefits	In-Network	Out-of-Network
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%	Covered – 40% after deductible
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%	Covered – 40% after deductible
Well-Childcare 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 \$20 copay	Covered – 40% after deductible
Online Visits – when rendered by BCBS providers	Covered - 100% after \$20 copay	Covered – 40% after deductible
Office Consultations	Covered - 100% after \$20 copay	Covered – 40% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered – 40% after deductible

Emergency Medical Care		
Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - \$50 copay; copay waived if admitted or accidental injury	Covered - \$50 copay; copay waived if admitted or accidental injury
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - \$20 copay	Covered – 40% after deductible

Benefits	In-Network	Out-of-Network
Ambulance Services - Medically Necessary Ground Transport Only	Covered - 20% after deductible	Covered - 30% after deductible

## Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 20% after deductible	Covered - 40% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 20% after deductible	Covered - 40% after deductible
Radiation Therapy and Chemotherapy	Covered - 20% after deductible	Covered - 40% after deductible

## Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 40% after deductible
Delivery and Nursery Care	Covered - 100%	Covered - 40% after deductible

## Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 20% after deductible	Covered - 40% after deductible
Inpatient Medical Care	Covered - 20% after deductible	Covered - 40% after deductible

## Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100%	Covered - 100%
Home Health Care	Covered - 20% after deductible	Covered - 40% after deductible
Skilled Nursing	Covered - 20% after deductible	Covered - 40% after deductible

## Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 20% after deductible	Covered - 40% after deductible

Benefits	In-Network	Out-of-Network
Bariatric Surgery	Covered - 20% after deductible	Covered - 40% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 20% after deductible	Covered - 40% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 40% after deductible

Human Organ Transplants		
Benefits	In-Network	Out-of-Network
Specified Organ Transplants <b>In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)</b> <b>-\$10,000 travel &amp; lodging; meals not covered</b>	Covered - 100%	Not Covered
Kidney, Cornea, Bone Marrow and Skin	Covered - 20% after deductible	Covered - 40% 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 - 20% after deductible	Covered - 40% after deductible
Outpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 20% after deductible	Covered - 40% 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 -	Covered - 20% after deductible	Not Covered
<b>Note:</b> 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.		
Physical, Occupational and Speech Therapy**	Covered - 20% after deductible	Not Covered
Nutritional Counseling	Covered - 20% after deductible	Not Covered

Other Covered Services		
Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 20% after deductible	Covered - 40% after deductible
Chiropractic Spinal Manipulation – 24 visit maximum per calendar year	Covered - \$20 copay	Covered - 40% after deductible
Durable Medical Equipment	Covered - 20% after deductible	Covered - 40% after deductible
Prosthetic and Orthotic Devices	Covered - 20% after deductible	Covered - 40% after deductible
Private Duty Nursing Care	Covered – 20% coinsurance	Covered – 40% coinsurance
Allergy Testing and Therapy	Covered - 100%	Covered - 40% after deductible

Therapy Services		
Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy <b>Limited to 60 visits combined per year not per condition</b>	Covered - 20% after deductible	Covered - 40% after deductible

Prescription Drug Coverage		
Benefits	In-Network	Out-of-Network
Generic Drugs	\$10 co-pay for retail 30-day supply; \$20 co-pay for mail order 90-day supply.	\$10 co-pay, plus an additional 25% of BCBSM approved amount for the drug.
Preferred Brand Drugs	\$40 co-pay for retail 30-day supply; \$80 co-pay for mail order 90-day supply.	\$40 co-pay, plus an additional 25% of BCBSM approved amount for the drug.
Non-preferred Brand Drugs	\$70 co-pay for retail 30-day supply; \$140 co-pay for mail order 90-day supply.	\$70 co-pay, plus an additional 25% of BCBSM approved amount for the drug.

**Disease Management Programs.** In an effort to ensure *participants* are provided with the appropriate and *medically necessary* care for their particular condition, the Trustees have adopted the following disease management programs:

- **Prior Authorization.** The *Plan's* Prior Authorization Program helps to ensure the appropriate usage of certain medications by applying Food and Drug Administration (FDA) approved indications and manufacturer guidelines for using certain drugs. Certain medical procedures may also have to be authorized in advance. A list of services and medications subject to the Prior Authorization Program is available from Blue Cross Blue Shield of Michigan at [www.bcbsm.com](http://www.bcbsm.com). In addition, a copy can be obtained from the *Plan Administrator*. The Prior Authorization Program is not applicable to emergency services.
- **Step Therapy.** The Step Therapy Program addresses *participants* using prescription drugs to treat certain chronic or ongoing medical conditions. Many of the drugs used to manage these conditions have serious

side effects. The Step Therapy Program is designed to ensure that the condition is being managed with a medication that is safe, medically appropriate and cost-effective. It also aids the *Plan* in controlling the costs of prescription drug coverage. Prescription drugs that are placed under the Step Therapy Program generally require a *Participant* to have failed therapy with one or more alternative drugs before coverage for the drug included within the Step Therapy Program will be approved. The Step Therapy Program can be bypassed in whole or in part where the treating *Medical Provider* establishes that certain clinical criteria have been met. A list of medications subject to step therapy, as well as a list of the clinical criteria to bypass the Step Therapy Program, is available from Blue Cross Blue Shield of Michigan at [www.bcbsm.com](http://www.bcbsm.com) or from the *Plan Administrator*.

- **Quantity Limits & Mail-Order Program.** Certain medications will only be dispensed in quantity limits that are set by the drug's manufacturer, the FDA, or the pharmacy benefit manager. In addition, certain medications may be required to be filled through the *Plan's* mail-order pharmacy. A list of drugs subject to these limitations and requirements is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Establishment of Formulary.** The *Plan* has contracted with a pharmacy benefit manager, Blue Cross Blue Shield of Michigan, which is responsible for establishing the *Plan's* prescription drug formulary. The formulary sets the tiering of covered prescription drugs and identifies what drugs are, and are not, included within the formulary and therefore covered by the *Plan*. A copy of the formulary is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Case Management.** In selected cases involving high-risk, complicated, or high-cost treatment, professional advisers from Blue Cross Blue Shield will offer, on a voluntary basis, counsel and education regarding alternative treatment options and methods to improve clinical outcomes. Information on the *Plan's* Case Management Program is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Utilization Review.** Utilization review is a process to make sure that the care you receive is *medically necessary*, delivered in the most appropriate location, and follows common medical practice. Blue Cross Blue Shield performs utilization review for the *Plan*. Information on the *Plan's* U/R Program is available from Blue Cross Blue Shield of Michigan or the *Plan Administrator*.
- **Other Programs.** The *Plan* may also implement additional disease management and wellness programs that are necessary to ensure that *participants* are provided with appropriate medical care and to help control costs. If such additional programs are adopted, you will receive a notice and supplement to this Summary Plan Description.
- **Out of Pocket Maximum.** The Maximum Out-of-Pocket Limit ("MOOP Limit") is the total maximum amount any eligible *Participant* of this *Plan* is required to pay during the *Benefit Year*, inclusive of deductibles, copayments and coinsurance, for covered services rendered in-network. The MOOP Limit does not include premiums, amounts balance billed, amounts paid for non-covered services, or amounts paid for any services rendered out-of-network. Once any *Participant* of this *Plan* has reached the MOOP Limit for the *Benefit Year*, the *Plan* begins to pay 100% of the approved amount for in-network covered services. The MOOP Limit will be reviewed annually by the Trustees.

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

**APPENDIX C:  
 SCHEDULE OF BENEFITS  
 ACTIVE PARTICIPANTS AND THEIR DEPENDENTS  
 CORE BENEFIT PROGRAM**

This *Plan* offers coverage for solely prescription drug benefits.

**Participant’s responsibility (deductibles, copays, coinsurance and dollar maximums)**

Benefits	In-Network	Out-of-Network
<b>Deductibles</b> - per calendar year **4 <sup>th</sup> quarter carryover – dollars paid in the last quarter of each year will be credited to the year following	This Plan does not have a deductible	This Plan does not have a deductible
<b>Annual coinsurance maximums</b> – applies to coinsurance amounts for all covered services – but <b>does not</b> apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts.	\$2,000 per member \$4,000 per family	\$4,000 per member \$8,000 per family
<b>Annual out-of-pocket maximums</b> – applies to deductibles, flat dollar copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable	\$4,000 per member \$8,000 per family	\$8,000 per member \$16,000 per family

**Prescription Drug Coverage**

Benefits	In-Network	Out-of-Network
Generic Drugs	\$10 co-pay for retail 30-day supply; \$20 co-pay for mail order 90-day supply.	\$10 co-pay, plus an additional 25% of BCBSM approved amount for the drug.
Preferred Brand Drugs	\$40 co-pay for retail 30-day supply; \$80 co-pay for mail order 90-day supply.	\$40 co-pay, plus an additional 25% of BCBSM approved amount for the drug.
Non-preferred Brand Drugs	\$70 co-pay for retail 30-day supply; \$140 co-pay for mail order 90-day supply.	\$70 co-pay, plus an additional 25% of BCBSM approved amount for the drug.

**Disease Management Programs.** In an effort to ensure *participants* are provided with the appropriate and *medically necessary* care for their particular condition, the Trustees have adopted the following disease management programs:

- **Prior Authorization.** The *Plan’s* Prior Authorization Program helps to ensure the appropriate usage of certain medications by applying Food and Drug Administration (FDA) approved indications and manufacturer guidelines for using certain drugs. Certain medical procedures may also have to be authorized in advance. A list of services and medications subject to the Prior Authorization Program is

available from Blue Cross Blue Shield of Michigan at [www.bcbsm.com](http://www.bcbsm.com). In addition, a copy can be obtained from the *Plan Administrator*. The Prior Authorization Program is not applicable to emergency services.

- **Step Therapy.** The Step Therapy Program addresses *participants* using prescription drugs to treat certain chronic or ongoing medical conditions. Many of the drugs used to manage these conditions have serious side effects. The Step Therapy Program is designed to ensure that the condition is being managed with a medication that is safe, medically appropriate and cost-effective. It also aids the *Plan* in controlling the costs of prescription drug coverage. Prescription drugs that are placed under the Step Therapy Program generally require a *Participant* to have failed therapy with one or more alternative drugs before coverage for the drug included within the Step Therapy Program will be approved. The Step Therapy Program can be bypassed in whole or in part where the treating *Medical Provider* establishes that certain clinical criteria have been met. A list of medications subject to step therapy, as well as a list of the clinical criteria to bypass the Step Therapy Program, is available from Blue Cross Blue Shield of Michigan at [www.bcbsm.com](http://www.bcbsm.com) or from the *Plan Administrator*.
- **Quantity Limits & Mail-Order Program.** Certain medications will only be dispensed in quantity limits that are set by the drug's manufacturer, the FDA, or the pharmacy benefit manager. In addition, certain medications may be required to be filled through the *Plan's* mail-order pharmacy. A list of drugs subject to these limitations and requirements is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Establishment of Formulary.** The *Plan* has contracted with a pharmacy benefit manager, Blue Cross Blue Shield of Michigan, which is responsible for establishing the *Plan's* prescription drug formulary. The formulary sets the tiering of covered prescription drugs and identifies what drugs are, and are not, included within the formulary and therefore covered by the *Plan*. A copy of the formulary is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Case Management.** In selected cases involving high-risk, complicated, or high-cost treatment, professional advisers from Blue Cross Blue Shield will offer, on a voluntary basis, counsel and education regarding alternative treatment options and methods to improve clinical outcomes. Information on the *Plan's* Case Management Program is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Utilization Review.** Utilization review is a process to make sure that the care you receive is *medically necessary*, delivered in the most appropriate location, and follows common medical practice. Blue Cross Blue Shield performs utilization review for the *Plan*. Information on the *Plan's* U/R Program is available from Blue Cross Blue Shield of Michigan or the *Plan Administrator*.
- **Other Programs.** The *Plan* may also implement additional disease management and wellness programs that are necessary to ensure that *participants* are provided with appropriate medical care and to help control costs. If such additional programs are adopted, you will receive a notice and supplement to this Summary Plan Description.
- **Out of Pocket Maximum.** The Maximum Out-of-Pocket Limit ("MOOP Limit") is the total maximum amount any eligible *Participant* of this *Plan* is required to pay during the *Benefit Year*, inclusive of deductibles, copayments and coinsurance, for covered services rendered in-network. The MOOP Limit does not include premiums, amounts balance billed, amounts paid for non-covered services, or amounts

paid for any services rendered out-of-network. Once any *Participant* of this *Plan* has reached the MOOP Limit for the *Benefit Year*, the *Plan* begins to pay 100% of the approved amount for in-network covered services. The MOOP Limit will be reviewed annually by the Trustees.

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

**APPENDIX D:  
 SCHEDULE OF BENEFITS  
 EARLY RETIREES AND THEIR DEPENDENTS**

This benefit is a self-funded benefit with the provider network provided by Blue Cross Blue Shield of Michigan for Early Retirees.

**Participant’s responsibility (deductibles, copays, coinsurance and dollar maximums)**

Benefits	In-Network	Out-of-Network
<b>Deductibles</b> - per calendar year **4 <sup>th</sup> quarter carryover – dollars paid in the last quarter of each year will be credited to the year following	\$500 per member \$1,000 per family	\$1,000 per member \$2,000 per family
<b>Copays</b> • Fixed Dollar Copays	Office visits - \$20 copay  Urgent care services - \$20 copay  Facility medical emergency - \$50 copay  Generic drugs - \$10 copay for retail 30-day supply; \$20 copay for mail order 90-day supply  Preferred brand drugs - \$40 copay for retail 30-day supply; \$80 copay for mail order 90-day supply  Non-preferred brand drugs - \$70 copay for retail 30-day supply; \$140 copay for mail order 90-day supply	Office visits – 40% after deductible  Urgent care services – 40% after deductible  Facility medical emergency - \$50 copay  Generic drugs - \$10 copay plus an additional 25% of BCBSM approved amount for the drug  Preferred brand drugs - \$40 copay plus an additional 25% of BCBSM approved amount for the drug  Non-preferred brand drugs - \$70 copay plus an additional 25% of the BCBSM approved amount for the drug
<b>Coinsurance</b> • Percent Coinsurance	20% of approved amount	40% of approved amount  <b>Note:</b> Services without a network are covered at the in-network level.
<b>Annual coinsurance maximums</b> – applies to coinsurance amounts for all covered services – but <b>does not</b> apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts.	\$2,000 per member \$4,000 per family	\$4,000 per member \$8,000 per family
<b>Annual out-of-pocket maximums</b> – applies to deductibles, flat dollar copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable	\$4,000 per member \$8,000 per family	\$8,000 per member \$16,000 per family
<b>Lifetime dollar maximum</b>	Unlimited	

<b>Preventive Care Services</b>		
<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
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%	Covered – 40% after deductible
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%	Covered – 40% after deductible
Well-Childcare No frequency restrictions	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

<b>Physician Office Services</b>		
<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Office Visits	Covered - 100% after \$20 copay	Covered – 40% after deductible
Online Visits – when rendered by BCBS providers	Covered - 100% after \$20 copay	Covered – 40% after deductible
Office Consultations	Covered - 100% after \$20 copay	Covered – 40% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered – 40% after deductible

<b>Emergency Medical Care</b>		
<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Hospital Emergency Room Qualified medical emergency	Covered - \$50 copay; copay waived if admitted or accidental injury	Covered - \$50 copay; copay waived if admitted or accidental injury
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - \$20 copay	Covered – 40% after deductible
Ambulance Services - Medically Necessary Ground Transport Only	Covered - 20% after deductible	Covered - 30% after deductible

## Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 20% after deductible	Covered - 40% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 20% after deductible	Covered - 40% after deductible
Radiation Therapy and Chemotherapy	Covered - 20% after deductible	Covered - 40% after deductible

## Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 40% after deductible
Delivery and Nursery Care	Covered - 100%	Covered - 40% after deductible

## Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 20% after deductible	Covered - 40% after deductible
Inpatient Medical Care	Covered - 20% after deductible	Covered - 40% after deductible

## Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100%	Covered - 100%
Home Health Care	Covered - 20% after deductible	Covered - 40% after deductible
Skilled Nursing	Covered - 20% after deductible	Covered - 40% after deductible

## Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 20% after deductible	Covered - 40% after deductible
Bariatric Surgery	Covered - 20% after deductible	Covered - 40% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 20% after deductible	Covered - 40% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 40% after deductible

<b>Human Organ Transplants</b>		
<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Specified Organ Transplants <b>In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)</b> <b>-\$10,000 travel &amp; lodging; meals not covered</b>	Covered – 100%	Not Covered
Kidney, Cornea, Bone Marrow and Skin	Covered - 20% after deductible	Covered - 40% after deductible

<b>Behavioral/Mental Health Care and Substance Abuse Treatment Services</b>		
<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Inpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 20% after deductible	Covered - 40% after deductible
Outpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered – 20% after deductible	Covered - 40% after deductible

<b>Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18</b>		
<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Applied Behavioral Analysis (ABA) - Pre-authorization required -	Covered - 20% after deductible	Not Covered
<b>Note:</b> 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.		
Physical, Occupational and Speech Therapy**	Covered - 20% after deductible	Not Covered
Nutritional Counseling	Covered - 20% after deductible	Not Covered

<b>Other Covered Services</b>		
<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Cardiac Rehabilitation	Covered - 20% after deductible	Covered - 40% after deductible
Chiropractic Spinal Manipulation – 24 visit maximum per calendar year	Covered - \$20 copay	Covered - 40% after deductible
Durable Medical Equipment	Covered - 20% after deductible	Covered - 40% after deductible
Prosthetic and Orthotic Devices	Covered - 20% after deductible	Covered - 40% after deductible
Private Duty Nursing Care	Covered – 20% coinsurance	Covered – 40% coinsurance
Allergy Testing and Therapy	Covered - 100%	Covered - 40% after deductible

## Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy <b>Limited to 60 visits combined per year not per condition</b>	Covered - 20% after deductible	Covered - 40% after deductible

## Prescription Drug Coverage

Benefits	In-Network	Out-of-Network
Generic Drugs	\$10 co-pay for retail 30-day supply; \$20 co-pay for mail order 90-day supply.	\$10 co-pay, plus an additional 25% of BCBSM approved amount for the drug.
Preferred Brand Drugs	\$40 co-pay for retail 30-day supply; \$80 co-pay for mail order 90-day supply.	\$40 co-pay, plus an additional 25% of BCBSM approved amount for the drug.
Non-preferred Brand Drugs	\$70 co-pay for retail 30-day supply; \$140 co-pay for mail order 90-day supply.	\$70 co-pay, plus an additional 25% of BCBSM approved amount for the drug.

**Disease Management Programs.** In an effort to ensure *participants* are provided with the appropriate and *medically necessary* care for their particular condition, the Trustees have adopted the following disease management programs:

- **Prior Authorization.** The *Plan's* Prior Authorization Program helps to ensure the appropriate usage of certain medications by applying Food and Drug Administration (FDA) approved indications and manufacturer guidelines for using certain drugs. Certain medical procedures may also have to be authorized in advance. A list of services and medications subject to the Prior Authorization Program is available from Blue Cross Blue Shield of Michigan at [www.bcbsm.com](http://www.bcbsm.com). In addition, a copy can be obtained from the *Plan Administrator*. The Prior Authorization Program is not applicable to emergency services.
- **Step Therapy.** The Step Therapy Program addresses *participants* using prescription drugs to treat certain chronic or ongoing medical conditions. Many of the drugs used to manage these conditions have serious side effects. The Step Therapy Program is designed to ensure that the condition is being managed with a medication that is safe, medically appropriate and cost-effective. It also aids the *Plan* in controlling the costs of prescription drug coverage. Prescription drugs that are placed under the Step Therapy Program generally require a *Participant* to have failed therapy with one or more alternative drugs before coverage for the drug included within the Step Therapy Program will be approved. The Step Therapy Program can be bypassed in whole or in part where the treating *Medical Provider* establishes that certain clinical criteria have been met. A list of medications subject to step therapy, as well as a list of the clinical criteria to bypass the Step Therapy Program, is available from Blue Cross Blue Shield of Michigan at [www.bcbsm.com](http://www.bcbsm.com) or from the *Plan Administrator*.

- **Quantity Limits & Mail-Order Program.** Certain medications will only be dispensed in quantity limits that are set by the drug's manufacturer, the FDA, or the pharmacy benefit manager. In addition, certain medications may be required to be filled through the *Plan's* mail-order pharmacy. A list of drugs subject to these limitations and requirements is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Establishment of Formulary.** The *Plan* has contracted with a pharmacy benefit manager, Blue Cross Blue Shield of Michigan, which is responsible for establishing the *Plan's* prescription drug formulary. The formulary sets the tiering of covered prescription drugs and identifies what drugs are, and are not, included within the formulary and therefore covered by the *Plan*. A copy of the formulary is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Case Management.** In selected cases involving high-risk, complicated, or high-cost treatment, professional advisers from Blue Cross Blue Shield will offer, on a voluntary basis, counsel and education regarding alternative treatment options and methods to improve clinical outcomes. Information on the *Plan's* Case Management Program is available from Blue Cross Blue Shield of Michigan or from the *Plan Administrator*.
- **Utilization Review.** Utilization review is a process to make sure that the care you receive is *medically necessary*, delivered in the most appropriate location, and follows common medical practice. Blue Cross Blue Shield performs utilization review for the *Plan*. Information on the *Plan's* U/R Program is available from Blue Cross Blue Shield of Michigan or the *Plan Administrator*.
- **Other Programs.** The *Plan* may also implement additional disease management and wellness programs that are necessary to ensure that *participants* are provided with appropriate medical care and to help control costs. If such additional programs are adopted, you will receive a notice and supplement to this Summary Plan Description.
- **Out of Pocket Maximum.** The Maximum Out-of-Pocket Limit ("MOOP Limit") is the total maximum amount any eligible *Participant* of this *Plan* is required to pay during the *Benefit Year*, inclusive of deductibles, copayments and coinsurance, for covered services rendered in-network. The MOOP Limit does not include premiums, amounts balance billed, amounts paid for non-covered services, or amounts paid for any services rendered out-of-network. Once any *Participant* of this *Plan* has reached the MOOP Limit for the *Benefit Year*, the *Plan* begins to pay 100% of the approved amount for in-network covered services. The MOOP Limit will be reviewed annually by the Trustees.

**Gene, Cellular and CAR-T Therapies.** These treatments are covered when prescribed by a physician and the treatment must be approved by the Food and Drug Administration for the use it is being proscribed for at the time the treatment is provided, and the *Participant* must comply with all applicable step-therapy and prior authorization protocols. The *Participant* must also comply with, and participate in, the *Plan's* case management programs. Coverage is provided for all phases of related treatment, including but not limited to, genetic testing, treatment, procedures, services, supplies, and medicines provided in connection with admission, cell extraction, administration of the medication, as well as any necessary treatment and follow up care. Approved treatments will be subject to the *Plan's* cost sharing provisions (deductibles, copayments, coinsurance) as applicable. Cost

sharing requirements will vary if the treatment is administered by out of network providers, subject to any applicable restrictions of the No Surprises Act.

**APPENDIX E:**  
**SCHEDULE OF BENEFITS**  
**MEDICARE ADVANTAGE PROGRAM**  
**MEDICARE PLUS BLUE PPO**



**This Schedule of Benefits is informational only. Any questions or concerns about the information below should be directed to Blue Cross Blue Shield of Michigan.**

**Medicare PLUS Blue™ PPO**



**Blue Cross  
 Blue Shield**  
 of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

**Saginaw Plumbers and Pipefitters UA Local 85**

2025 MAPD PPO	
Quote Date	07/29/2024
Coverage Effective Date	01/01/2025
Coverage End Date	12/31/2025
Coverage Length (Months)	12
Plan Type	MAPD
Estimated Membership	388
Option Number	0
Option Description	-
Group Number(s)	26562
Group Suffix(es)	601
<b>Medicare Advantage Medical / Surgical Group Benefits and Services</b>	<b>Schedule B</b>
PPO Benefit Structure (Active / Passive)	<b>PASSIVE</b> (Out-of-Network Cost-Shares are the Same as In-Network)
<b>Member Out-of-Pocket Cost-Sharing Options</b>	<b>Deductibles, Coinsurances, and Copays</b>
Combined Out-of-Pocket Maximum	\$1,000
Single Deductible (Applies to In-Network and Out-of-Network Services)	\$100
Coinsurance	0%
<b>In- and Out-of-Network Cost-Shares</b>	
<b>&gt; Core Benefits</b>	
Inpatient Facility Services (No Member Cost-Share for Home Health Care)	Ded,Coins,OOPM Will Apply
Outpatient Facility Services	Ded,Coins,OOPM Will Apply
<b>&gt; Physician / Practitioner Benefits</b>	
Office Visits and Consultations	\$10
Telehealth (Online) Visits	\$0
Chiropractic Services	\$10
Specialist Services	\$20
Psychiatric and Psychotherapy Services	\$10
Facility Evaluation and Management Services	Ded,Coins,OOPM Will Apply
Other Physician Services (No Member Cost-Share for Clinical Labs)	Ded,Coins,OOPM Will Apply
Surgical Services (Includes Anesthesia Services, Cardiac Catheterization Services, and Therapeutic Cardiovascular Services)	Ded,Coins,OOPM Will Apply
<b>&gt; Emergency / Other Benefits</b>	
Urgent Care	\$10
Emergency Department / Emergency Room Care	\$65
Ambulance Services	Ded,Coins,OOPM Will Apply
DME, P & O, and Supplies	Ded,Coins,OOPM Will Apply
Preventive Services	No member cost-share

**Medicare PLUS Blue™ PPO**



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**Saginaw Plumbers and Pipefitters UA Local 85**

	2025 MAPD PPO
Quote Date	07/29/2024
Coverage Effective Date	01/01/2025
Coverage End Date	12/31/2025
Coverage Length (Months)	12
Plan Type	MAPD
Estimated Membership	388
Option Number	0
Option Description	-
Group Number(s)	26562
Group Suffix(es)	601

**Additional Medicare Advantage Group Benefits** Schedule B, continued

Annual Physical (removes Office Visit cost-share)	Included	No Member Cost-Share for these Services
Chiropractic Enhanced Services (Approved Radiological, E & M, and Physical Therapy)	Included	Cost-Share Same as Chiropractic Services above
Determination of Refractive State	Included	Deductible, Coinsurance, OOPM Will Apply
Foreign Travel (removes Emergency Room and Urgent Care restrictions)	Included	Cost-Share Same as if Services were provided in the U.S.
<b>Hearing Services</b>		
> Exam, Fitting, and Evaluation (measurement of hearing ability)	Included	Cost-Share Same as Office Visit above
> Hearing Aids	Included	Covered up to \$4,000 every 24 months
Home Infusion Therapy	Included	No Member Cost-Share for these Services
Hospice Care (Cost-Share associated with Respite and Drugs)	Included	No Member Cost-Share for these Services
Human Organ Transplant (removes lifetime maximum for non-Medicare-covered organs per organ type)	Included	Cost-Share Same as Surgical Services above
Removal of Medicare Caps for Therapy Services (associated with Physical Therapy, Speech-Language Pathology, and Occupational Therapy)	Included	Cost-Share same as Other Physician Services above
Silver Sneakers Fitness Program	Included	No Member Cost-Share for these Services
Skilled Nursing Facility (120 Days)	Included	Cost-Share same as Inpatient Facility Services above
Travel and Lodging (associated with Human Organ Transplant benefits)	Included	Covered up to \$10,000 (must be 100+ miles from home)

**Medicare PLUS Blue™ PPO**



Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

**Saginaw Plumbers and Pipefitters UA Local 85**

	2025 MAPD PPO
Quote Date	07/29/2024
Coverage Effective Date	01/01/2025
Coverage End Date	12/31/2025
Coverage Length (Months)	12
Plan Type	MAPD
Estimated Membership	388
Option Number	0
Option Description	-
Group Number(s)	26562
Group Suffix(es)	601

Medicare Advantage Group Pharmacy Benefits		Schedule B, continued	
Formulary		Comprehensive Enhanced Formulary	
Prior Authorization/Step Therapy/Clinical Edits		Yes	
Pharmacy Deductible		\$0	
	Preferred Cost-Shares	Standard Cost-Shares	
<b>Tier 1 (Preferred Generic)</b>	\$5	\$10	
32-90 Day Supply Mail Order Copay Multiplier	1.5	2.0	
Minimum / Maximum Charge per Claim (applies only to coinsurance cost-shares and is subject to copay multipliers)	Minimum: N/A / Maximum: N/A		
<b>Tier 2 (Generic)</b>	\$5	\$10	
32-90 Day Supply Mail Order Copay Multiplier	1.5	2.0	
Minimum / Maximum Charge per Claim (applies only to coinsurance cost-shares and is subject to copay multipliers)	Minimum: N/A / Maximum: N/A		
<b>Tier 3 (Preferred Brand)</b>	\$25	\$30	
32-90 Day Supply Mail Order Copay Multiplier	2.0	2.5	
Minimum / Maximum Charge per Claim (applies only to coinsurance cost-shares and is subject to copay multipliers)	Minimum: N/A / Maximum: N/A		
<b>Tier 4 (Non-Preferred Drug)</b>	\$55	\$60	
32-90 Day Supply Mail Order Copay Multiplier	2.5	3.0	
Minimum / Maximum Charge per Claim (applies only to coinsurance cost-shares and is subject to copay multipliers)	Minimum: N/A / Maximum: N/A		
<b>Tier 5 (Specialty)</b>	\$55	\$60	
32-90 Day Supply Mail Order Copay Multiplier	Not Applicable - Tier 5 Unavailable for 32-90 Day Mail Order		
Minimum / Maximum Charge per Claim (applies only to coinsurance cost-shares and is subject to copay multipliers)	Minimum: N/A / Maximum: N/A		

**APPENDIX F:  
 SCHEDULE OF BENEFITS  
 NATIONS HEARING CARE BENEFIT**

Generally: The *Plan* will provide up to a \$2,000 reimbursement for hearing aids every twenty-four months. Additionally, the *Plan* has made discounted rates for hearing care services available to *participants* through Nations Hearing. The discounted rates are as follows:

<b>Hearing Care Benefit</b>		
<b>Benefits</b>	<b>Price Per Aid</b>	<b>Price Per Two Aids</b>
Entry	\$500	\$1,000
Basic	\$675	\$1,350
Prime	\$975	\$1,950
Advanced	\$1,575	\$3,150
Premium	\$1,975	\$3,950

<b>Additional Hearing Services and Products</b>	
<b>Services</b>	<b>Price</b>
Hearing Test	No Charge, once per calendar year or in accordance with Benefit Plan Design
Administration Fee	No Charge, once per calendar year or in accordance with Benefit
Adjustments	No Charge for 3 follow-up adjustments
Hearing Aid Warranty	No Charge for 36 months
Money Back Guarantee and Return Policy	60 days
Ear Molds	No Charge, first set of earmold(s), when needed
Lost, Stolen and Damaged	One time only replacement
Coverage	Deductible per hearing aid
Batteries	3-year hearing aid battery supply (up to 48 batteries per year per hearing aid) at no charge

If the *Participant* receives hearing care benefits from a Nations Hearing Medical Provider in excess of the Benefit Levels noted in this Appendix F, the *Participant* shall be liable for costs in excess of the applicable Benefit Levels. To the extent the *Participant* receives hearing care benefits from Nations Hearing for a cost that is greater than the applicable Benefit Levels, Nations Hearing and/or the Nations Hearing Medical Provider shall notify the *Participant*, at the time of selecting the hearing care benefit, of his or her liability for costs in excess of the benefit. Nations Hearing shall then collect the remaining liability from the *Participant*.

**APPENDIX G:  
 SCHEDULE OF BENEFITS  
 METLIFE DEATH, ACCIDENTAL DEATH, AND DISMEMBERMENT COVERAGE**

Saginaw Plumbers & Pipefitters Local 85 provides Basic Term Life Insurance to eligible members through MetLife. This Life and AD&D benefit will be paid to your designated *beneficiary* in the event of your death while covered under our plan.

<b>Basic Term Life and AD&amp;D Insurance</b>	
<b>Benefits</b>	
Basic Life	\$50,000
Accidental Death and Dismemberment	An amount equal to your basic life insurance
Plan Maximum	\$50,000
Non-Medical Maximum	\$50,000
<b>Term Life Features</b>	
<ul style="list-style-type: none"> <li>• Continuation of Life Insurance while totally disabled as defined by the group policy</li> <li>• Life Settlement Account</li> <li>• Portability</li> <li>• Grief Counseling</li> <li>• Funeral Discounts and Planning Services</li> </ul>	
<b>Term AD&amp;D Features</b>	
<ul style="list-style-type: none"> <li>• Seat Belt Benefit</li> <li>• Child Care Benefit</li> <li>• Life Settlement Account</li> <li>• Air Bag Benefit</li> <li>• Common Carrier Benefit</li> </ul>	

Eligible members are also able to purchase additional Supplemental Term Life and AD&D Insurance for themselves, their spouse, or their *dependent children* through MetLife. If you elect above the guaranteed issue amount your coverage may be subject to evidence of insurability. To enroll spouses and *dependent children*, the member must also be enrolled in this coverage.

**Supplemental Term Life and AD&D Insurance**

Benefits	Member	Spouse	Child
Life Coverage: provides a benefit in the event of death	Increments of \$25,000	Increments of \$12,500	Flat \$5,000
Non-Medical Maximum	\$150,000	\$50,000	\$5,000
Overall Benefit Maximum	The lesser of 5 times your basic annual earnings or \$200,000	The lesser of 50% of the member's supplemental life insurance or \$100,000	\$5,000
AD&D Coverage: provides a benefit in the event of death or dismemberment resulting from a covered accident	Yes (benefit amount is same as Supplemental Term Life coverage)	Yes (benefit amount is same as Supplemental Term Life coverage)	Yes (benefit amount is same as Supplemental Term Life coverage)
AD&D Maximum	Maximum amount is same as Supplemental Term Life coverage	Maximum amount is same as Supplemental Term Life coverage	Maximum amount is same as Supplemental Term Life coverage
Member Contribution	100%	100%	100%

**APPENDIX H:  
 SCHEDULE OF BENEFITS  
 DELTA DENTAL COVERAGE**

Saginaw Plumbers & Pipefitters Local 85 offers a dental program through Delta Dental. The chart below is a brief outline of the plan. To find in-network providers visit the link below:

<https://www.deltadental.com/us/en/member/find-a-dentist.html>.

<b>Dental Coverage</b>	
Annual Deductible	Individual - \$0 Family - \$0
Annual Maximum	\$2,000 per person and family
Preventive Care Coverage	100%
Basic Services Coverage	80%
Major Services Coverage	50%
<b>Orthodontia</b>	
Benefit Percentage	50%
Adults	Not covered
Dependent Children	Covered
Lifetime Maximum	\$2,000

<b>Delta Dental PPO Dentists</b>	<ul style="list-style-type: none"> <li>• No balance billing on covered services</li> <li>• Most significant network discounts</li> <li>• Dentists file claims for members</li> </ul>
<b>Delta Dental Premier Dentists</b>	<ul style="list-style-type: none"> <li>• No balance billing on covered services</li> <li>• Significant network discounts with most office locations</li> <li>• Dentists file claims for members</li> </ul>
<b>Out of Network Dentists</b>	<ul style="list-style-type: none"> <li>• Balance billing</li> <li>• No network discount</li> <li>• May need to file own claims</li> </ul>

**APPENDIX I:  
 SCHEDULE OF BENEFITS  
 VSP VISION COVERAGE**

Saginaw Plumbers & Pipefitters Local 85 offers a vision program through VSP. The chart below is a brief outline of the plan. To find in-network providers visit the link below:

<https://www.vsp.com/eye-doctor/>.

<b>Vision Service Plan</b>	
<b>Service</b>	
Well Vision Exam	Once every calendar year \$50 with purchase of a complete pair of prescription glasses 20% savings without purchase
Retinal Screening	Guaranteed pricing with Well Vision Exam, not to exceed \$39
<b>Material Limitations</b>	
<b>Unlimited Annual Material Use</b>	
Frames	25% savings when a complete pair of prescription glasses is purchased
Lenses	With purchase of a complete pair of prescription glasses:
Single vision	\$40
Lined bifocals	\$60
Lined trifocals	\$75
Polycarbonate for children	\$0
Contact Lenses	15% savings on contact lens exam (fitting and evaluation) You are responsible for 100% of the contact lens material cost
Lens Enhancements	Average savings of 20-25% on lens enhancements such as: Progressive, scratch-resistance, and anti-reflective coatings
Sunglasses	20% savings on unlimited non-prescription sunglasses from any VSP doctor within 12 months of your last Well Vision Exam
Laser Vision Correction	Average 15% off the regular price <b>or</b> 5% of the promotional price discounts only available from contracted facilities

**APPENDIX J:**  
**SCHEDULE OF BENEFITS**  
**AFLAC GROUP HOSPITAL INDEMNITY**

New for 2025, Saginaw Plumbers & Pipefitters Local 85 will be offering BenExtend through AFLAC. This benefit can help protect you when you really need it by providing lump sum cash payments in the event of a critical illness, accident or hospitalization.

**Accident & Injury**

This benefit is designed to help covered members meet out-of-pocket expenses that can follow an accidental injury that happens off the job, whether minor or catastrophic.

<b>Accident Insurance</b>			
<b>Coverage Information</b>	<b>Member</b>	<b>Spouse</b>	<b>Child</b>
Initial Treatment	\$150	\$150	\$150
Ambulance	\$300	\$300	\$300
Major Diagnostic Testing	\$300	\$300	\$300
Lacerations	\$100	\$100	\$100
<b>Fracture Benefit Schedule</b>			
Hip / Thigh	\$2,500	\$2,500	\$2,500
Vertebrae / Sternum	\$2,250	\$2,250	\$2,250
Pelvis	\$2,000	\$2,000	\$2,000
Skull (Depressed)	\$1,875	\$1,875	\$1,875
Leg	\$1,500	\$1,500	\$1,500
Forearm / Hand / Wrist	\$1,250	\$1,250	\$1,250
Foot / Ankle / Kneecap	\$1,250	\$1,250	\$1,250
Shoulder Blade / Collar Bone	\$1,000	\$1,000	\$1,000
Lower Jaw	\$1,000	\$1,000	\$1,000
Skull (Simple)	\$875	\$875	\$875
Upper Arm / Upper Jaw	\$875	\$875	\$875
Facial Bones (Except Teeth)	\$750	\$750	\$750
Vertebral Processes / Sacrum	\$500	\$500	\$500
Coccyx / Rib / Finger / Toe	\$200	\$200	\$200

For a complete list of coverage amounts and restrictions, please refer to the Accident Insurance Certificate

## Critical Illness

AFLAC voluntary critical illness coverage provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with a critical illness.

<b>Critical Illness Insurance</b>	
<b>Coverage Information</b>	
Benefit Amount	\$3,000
<b>Core Covered Conditions</b>	
Cancer	100% of benefit amount
Heart Attack	100% of benefit amount
Major Organ Transplant	100% of benefit amount
End Stage Renal / Kidney Failure	100% of benefit amount
Stroke	100% of benefit amount
Bone Marrow Transplant	100% of benefit amount
Sudden Cardiac Arrest	100% of benefit amount
Non-Invasive Cancer	25% of benefit amount
Coronary Artery Bypass Surgery	25% of benefit amount
Skin Cancer (Once per Benefit Year)	\$250
For a complete list of covered conditions/illnesses and restrictions, please refer to the Critical Illness Insurance Certificate	

## Hospital Indemnity

AFLAC's group voluntary hospital indemnity coverage provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with being in the hospital.

<b>Hospital Indemnity</b>			
<b>Hospital Confinement</b>	<b>Member</b>	<b>Spouse</b>	<b>Child</b>
Days 1-4	\$300	\$300	\$300
Days 5-10	\$225	\$225	\$225
Days 11-31	\$75	\$75	\$75
Maximum of 31 days of confinement per covered accident or covered sickness			
For a complete list of coverage amounts and restrictions, please refer to the Hospital Indemnity Certificate			





