MICHIGAN BAC FRINGE BENEFIT FUNDS

Michigan BAC Health Care Fund
Michigan BAC Pension Fund
Michigan BAC Apprenticeship & Training Fund

Managed for the Trustees' by:
TIC INTERNATIONAL CORPORATION

March 2018

To: **ALL PLAN PARTICIPANTS AND ALTERNATE PAYEES OF THE MICHIGAN BAC HEALTH CARE FUND**

Dear Plan Participant:

We have attached the following Important Notices and Annual Reports for your review. These Notices and Reports are required to be mailed to each Plan Participant annually as provided by the Employee Retirement Income Security Act of 1974 (ERISA):

If you have any questions, please contact your Local Union office or the Fund Office.

Sincerely,

Board of Trustees
Michigan BAC Health Care Fund

6525 Centurion Drive • Lansing, MI 48917-9275
(517) 321-7502 • FAX (517) 321-7508
TOLL FREE (800) 531-2244
www.michiganbac.org

IMPORTANT NOTICE REGARDING HEALTH CARE BENEFITS

TO: All Eligible Participants of the Michigan BAC Health Care Fund

RE: **MICHIGAN BAC HEALTH CARE FUND – ELIGIBILITY MODIFICATIONS**

Dear Plan Participant:

As a reminder, the Michigan BAC Health Care Fund ***does not provide for any coverage for Motor Vehicle related accidents or incidents.*** The Fund totally and completely excludes coverage for any claim arising out of an auto or other vehicular related accident or incident. "Vehicle" includes all usual forms of transportation on public highways such as vans, pickup trucks, motorcycles, etc.

To make certain that you have health care coverage if you have a vehicular accident/incident, you should check with your automobile insurance agent and/or insurance carrier to make sure that you are covered under your automobile policy "first and completely" for any claim arising out of a vehicular related accident or incident. You should make it perfectly clear to your agent or carrier that the Fund excludes such coverage from its Schedule of Benefits. Thus it is imperative that your policy has the proper coverage to protect you and your dependents.

If you have any questions regarding these changes, please do not hesitate to contact the Fund Office.

Sincerely,

Board of Trustees
Michigan BAC Health Care Fund

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice
September 23, 2013

The Michigan BAC Health Care Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

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

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1.
Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

(1) For treatment, payment and health care operations.

(2) Enrollment information can be provided to the Trustees.

(3) Summary health information can be provided to the Trustees for the purposes designated above.

(4) When required by law.

(5) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

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

(7) The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other

activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(8) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

(9) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(10) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(11) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2
Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice.

Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

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

1. a power of attorney for health care purposes;

2. a court order of appointment of the person as the conservator or guardian of the individual; or

3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

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

Section 3
The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI.

The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted on the Plan's website, www.michiganbac.org, you will also receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

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

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4
Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5
Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at: Michigan BAC Health Care Fund, 6525 Centurion Drive, Lansing, Michigan 48917,(800) 531-2244.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

TO: PLAN PARTICIPANTS OF THE MICHIGAN BAC HEALTH CARE FUND

RE: SUMMARY OF MATERIAL MODIFICATIONS

Dear Plan Participant:

This Notice, known as a Summary of Material Modifications ("SMM"), describes changes in the Fund's Plan adopted by the Trustees since the Summary Plan Description ("SPD") was printed. It is an amendment to the SPD that you received previously. You should keep this SMM with the SPD for future reference.

The Board of Trustees as of March 2018 is as follows:

Union Trustees:	Management Trustees:
Nelson McMath, *Chairman* BAC Local No. 2 3321 Remy Drive Lansing, MI 48906	Andy Bracy, *Secretary* Bracy & Jahr, Inc. 828 Quincy Grange Quincy, MI 49082
James Brylowski BAC Local No. 2 3321 Remy Drive Lansing, MI 48906	Scott Fisher AGC of Michigan 2323 North Larch Street Lansing, MI 48906
James Budd BAC Local No. 2 3321 Remy Drive Lansing, MI 48906	Damian Hill AGC of Michigan 2323 North Larch Street Lansing, MI 48906
Chuck Kukawka BAC Local No. 2 21031 Ryan Road Warren, MI 48091	Steve Meyer Schiffer Mason Contractors 2190 Delhi, NE, PO Box 250 Holt, MI 48842-1849
Daryl Nichols BAC Local No. 2 1404 Industrial Park Rd, Ste. 2 Saline, MI 48176	Norm Thomas Spence Brothers 417 McCoskry Saginaw, MI 48601

RE: SUMMARY OF MATERIAL MODIFICATIONS TO ELIGIBILITY RULES, SHORT-HOUR REQUIREMENTS, AND NON-ACTIVE SELF-PAYMENT RATES

Dear Participant:

This is a summary of material changes we've made to the Michigan BAC Health Care Fund's Quarterly Eligibility Requirements, Short-Hour requirements and non-Active Self-Payment rates. We've made these changes after careful review.

These changes go into effect with the August 2016 work month. This means that the Quarterly Eligibility Requirement begins in August 2016, and the Short-Hour and non-Active Self-Payment rates will apply to the October 2016 Short-Hour and non-Active Self-Payments.

1. Quarterly Eligibility Requirements

We've changed the Quarterly Eligibility Requirement.

The Quarterly Eligibility Requirement is currently three hundred (300) hours. ***Effective August 1, 2016,*** the Quarterly Eligibility Requirement will be three hundred and twenty five (325 hours).

Please Note: the Trustees ***did not*** increase the 1,100 hours in a 12 consecutive month requirement. So, you still only need 1,100 hours in a 12 consecutive month period to continue to be eligible for one month.

2. Short-Hour Requirement

The eligibility increase – from 300 to 325 hours – will also impact Short-Hour Self-Pay requirements since you'll have to pay the difference between the hours you worked and 325 hours, instead of 300. This change is effective with the August 2016 work month, ***so the change will apply to your October 2016 Short-Hour Self-Payment if any.***

In addition, you will only be permitted to purchase coverage through the Short Hour self-payment rules if you have been eligible during the most recent twelve (12) month period.

a) Coverage For A Single Participant

If you work and have employer contributions for at least 277 hours in three (3) consecutive months, you can make up the difference (the "Short-Hours") between the hours you worked and the three hundred twenty-five (325) hours required for continued Fund eligibility. (As described above, effective August 1, 2016, three hundred twenty-five (325) hours in three (3) consecutive months is required to maintain Fund eligibility).

b) Coverage For A Participant And One Dependent

If you work and have employer contributions for at least 215 hours in three (3) consecutive months, you can make up the difference (the "Short-Hours")

between the hours you worked and the three hundred twenty-five (325) hours required for continued Fund eligibility.

c) Coverage For A Family

If you work and have employer contributions for at least 193 hours in three (3) consecutive months, you can make up the difference (the "Short-Hours") between the hours you worked and the three hundred twenty-five (325) hours required for continued Fund eligibility.

What You Pay And What You Get In Coverage

To qualify to make "Short-Hours" payments, you must first meet the hours requirement that applies to you -- that is, single participant, participant with one dependent, etc.

Then, you must pay the *current* hourly health care contribution rate multiplied by the number of hours you're "short."

Here's an example: if you're "short" twenty (20) hours, you must pay the Fund $6.57 x twenty (20) hours or $131.40. The $6.57 hourly rate is set forth in your *current* collective bargaining agreement.

We'll monitor your eligibility to make "Short-Hour" payments. But, if you believe that you qualify to make "Short-Hour" payments, please contact the Fund Office immediately at the phone number listed below.

3. Non-Active Self-Payment Rates

The self-payment rates for the non-Active participants will increase as follows ***effective for the August 2016 work-month (i.e., effective for self-payments due in October 2016)*** (the self-payment rates for Active participants ***is not*** changing at this time):

Current Retiree Self-Payment Rates	Retiree Self-Payment Rates Effective 10/1/16	Retired and Non-Active Participants	Current Retiree Self-payment with Dental, Vision & Hearing	Retiree Self-Payment with Dental, Vision & Hearing - Effective 10/1/16
$237.98	$285.58	Single Retiree Coverage	$263.28	$315.94
$290.53	$348.64	Single Retiree Coverage with Prescriptions	$337.81	$405.37
$535.44	$642.53	Two Person Retiree Coverage	$554.20	$665.04
$653.68	$784.42	Two Person Retiree Coverage with Prescriptions	$709.29	$851.15
$612.95	$735.54	Family Coverage	$619.12	$742.94
$784.42	$941.30	Family Coverage with Prescriptions	$793.43	$952.12
$137.04	$164.45	Single Medicare Eligible Retiree	$159.89	$191.87
$371.78	$446.14	One Person with Medicare and One without Medicare	$423.16	$507.79
$612.95	$735.54	Two Persons without Medicare and One with Medicare	$619.12	$742.94

Current Retiree Self-Payment Rates	Retiree Self-Payment Rates Effective 10/1/16	Retired and Non-Active Participants	Current Retiree Self-payment with Dental, Vision & Hearing	Retiree Self-Payment with Dental, Vision & Hearing - Effective 10/1/16
$784.42	$941.30	Family with Prescriptions and One Person with Medicare	$793.43	$952.12
$267.62	$321.14	Two Person Medicare Eligible Retiree Coverage	$319.78	$383.74
$546.66	$655.99	Two Persons with Medicare and One Person without Medicare	$587.83	$705.40
$321.52	$385.82	Single Widow without Medicare	$327.95	$393.54
$653.68	$784.42	Two Person Widow coverage without Medicare	$709.29	$851.14

If you have any questions regarding this information please contact the Fund Office at (800) 531-2244.

Sincerely

Michigan BAC Health Care Fund
Board of Trustees

TO: PLAN PARTICIPANTS OF THE MICHIGAN BAC HEALTH CARE FUND

RE: **SUMMARY ANNUAL REPORT FOR PLAN YEAR ENDED APRIL 30, 2017**

Dear Plan Participant:

This is a summary of the Annual Report for the Michigan BAC Health Care Fund, Employer Number 38-6098425, Plan No. 501, for the period of May 1, 2016 through April 30, 2017. The Annual Report has been filed with the Internal Revenue Services, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees has committed itself to pay certain medical, surgical and other health care claims incurred under the terms of the Plan.

INSURANCE INFORMATION

The Plan has a contract with Blue Cross Blue Shield of Michigan to pay certain claims incurred under the terms of the Plan. The total premiums paid for the Plan Year ending April 30, 2017 were $525,987.

BASIC FINANCIAL STATEMENT

The value of Plan Assets, after subtracting Liabilities of the Plan was $4,164,776 as of April 30, 2017, compared to $2,996,471 as of May 1, 2016. During the Plan Year, the Plan experienced an increase in its Net Assets of $1,168,305. This increase includes unrealized appreciation and depreciation in the value of Plan Assets; that is, the difference between the value of the Plan's Assets at the end of the Year and the value of the Assets at the beginning of the Year or the cost of Assets acquired during the Year. During the current Plan Year, the Plan had Total Income of $8,091,049, including Employer contributions of $6,075,504, Employee contributions of $982,756, realized losses of ($15,148) from the sale of assets, earnings from Investments of $405,174 and other income of $642,763.

Plan Expenses were $6,922,744. These Expenses included $947,726 (see Schedule A) in administrative expenses and $5,975,018 in benefits paid to Participants and Beneficiaries.

YOUR RIGHTS TO ADDITIONAL INFORMATION

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

1. An Accountant's report;
2. Financial information and information on payments to service providers;
3. Assets held for investment;
4. Transactions in excess of 5% of Plan Assets;
5. Insurance information, including sales commissions paid by insurance carriers; and
6. Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the Plan participates.

To obtain a copy of the full Annual Report, or any part thereof, write or call the office of the Board of Trustees, Michigan BAC Health Care Fund, 6525 Centurion Drive, Lansing, Michigan 48917-9275, or at toll free (800) 531-2244 or (517) 321-7502. The charge to cover copying costs will be $5.75 for the full Annual Report or twenty-five cents per page for any part thereof.

You also have the right to receive from the Plan Administrative Manager, on request and at no charge, a Statement of the Assets and Liabilities of the Plan and accompanying notes, or a Statement of Income and Expenses of the Plan and accompanying notes, or both. If you request a copy of the full Annual Report from the Plan Administrative Manager, these two statements and accompanying notes will be included as part of that Report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the Report, because these portions are furnished without charge.

You also have the legally protected right to examine the Annual Report at the main office of the Plan (Board of Trustees, Michigan BAC Health Care Fund, 6525 Centurion Drive, Lansing, MI 48917-9275), at any other location where the Report is available for examination and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: U.S. Department of Labor, Employee Benefits Security Administration, Public Disclosure Room, 200 Constitution Avenue, N.W., Room N-1513, Washington, DC 20210.

Sincerely,

Board of Trustees
Michigan BAC Health Care Fund

SCHEDULE A: Administrative Expenses

Contract fee (Blue Cross)	$596,963	Lockbox and bank service charges	$8,780
Administrative manager's fee*	122,195	Trustee and fiduciary insurance and bonding	6,030
Collection fees	61,933	Trustee meeting & conference expenses	5,183
Legal fees	49,908	Postage	3,622
Investment expense	24,047	Contract monitoring fees	1,950
Printing and miscellaneous	15,055	Participant notices	1,534
Audit fee	14,700	Form 5500 and 990 preparation fee	1,400
Actuarial fee	12,000		
Payroll audit fee	11,748		
Member communications	10,678	Total	$947,726

* Includes rent, equipment, regular postage, staffing, computer services, etc.

Important Notice From the Michigan BAC Health Care Fund About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Michigan BAC Health Care Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan when you are eligible to do so. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Since prescription drug coverage through the Michigan BAC Health Care Fund ends when you become eligible for Medicare, the prescription drug coverage offered by the Fund at that point is, [on average for all Supplement to Medicare plan participants,] **NOT** expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage**. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, because prescription drug coverage is no longer offered by the Michigan BAC Health Care Fund once you are eligible for Medicare. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Michigan BAC Health Care Fund. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you decide to drop your current coverage with the Michigan BAC Health Care Fund, since it is employer/union sponsored group coverage, you may be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Michigan BAC Health Care Fund.

Your prescription drug coverage that is provided by the Michigan BAC Health Care Fund is creditable until you become eligible for Medicare. At that time you will no longer be entitled to any prescription drug coverage through the Michigan BAC Health Care Fund.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the Michigan BAC Health Care Fund will no longer be creditable once you are eligible for Medicare, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Michigan BAC Health Care Fund coverage will not be affected. The Fund will provide Supplement to Medicare coverage if you elect to maintain you coverage with the Fund however, you will not have any prescription drug coverage through the Fund.

If you do decide to join a Medicare drug plan and drop your current Michigan BAC Health Care Fund coverage, be aware that you and your dependents may not be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the Fund Office 1-800-531-2244 for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Blue Cross Blue Shield of Michigan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage… More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

TO: PLAN PARTICIPANTS OF THE MICHIGAN BAC HEALTH CARE FUND

RE: WOMEN'S HEALTH AND CANCER RIGHTS

Dear Plan Participant:

The Trustees of your Health and Welfare Fund are issuing this annual notice in compliance with the Women's Health and Cancer Rights Act of 1998. Your Health Care Plan already provides the benefits required by this law. You have a right to this notice, and the Trustees are providing the notice for your information so that you may be assured that you are treated in accordance with Federal Law if the need arises.

The Federal Law requires that all health care plans that provide medical and surgical benefits for mastectomies provide participants and beneficiaries receiving mastectomy benefits and who elect mastectomy related breast reconstruction with coverage for the following:

- **Reconstruction of the breast on which the mastectomy has been performed;**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance; and**
- **Prostheses and the treatment of physical complications of all stages of mastectomy including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.**

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

Please keep this notice with your Summary Plan Description. If you have any questions regarding these federal requirements, please contact the Fund Office.

Sincerely,

Board of Trustees
Michigan BAC Health Care Fund