2016
SUMMARY PLAN DESCRIPTION
UPPER PENINSULA PLUMBERS & PIPEFITTERS
HEALTH & WELFARE FUND

UPPER PENINSULA
PLUMBERS, PIPEFITTERS & HVAC UA LOCAL 111

UPPER PENINSULA MECHANICAL CONTRACTORS ASSOCIATION

UPPER PENINSULA PLUMBERS & PIPEFITTERS
HEALTH & WELFARE FUND
SUMMARY PLAN DESCRIPTION

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PART 1: INTRODUCTION

A. ABOUT YOUR SUMMARY PLAN DESCRIPTION

The Trustees of the Upper Peninsula Plumbers & Pipefitters Health and Welfare Fund (the "Fund" or the "Plan") are pleased to furnish you with this Summary Plan Description (or "SPD"). While it is not possible for this SPD to include every detail or explain every circumstance that may apply to you, you will find in this SPD a general explanation of the benefits available to you and your dependents, including answers to questions such as:

- How you become eligible to participate;
- What benefits the Fund pays and does not pay for;
- How much your co-insurance and deductibles are;
- How you go about filing a claim or appealing a claim that has been denied.

This is only a summary of your benefits and rights, the legal rules that govern those benefits and rights are contained in the Plan Document. If you wish to view the Plan Document or obtain a copy of it, you can do so by contacting the Fund Office, 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 will be controlling. In addition, you should keep in mind the benefits provided by the Fund are not accrued, guaranteed, or lifetime benefits. The Board of Trustees of the Fund may amend, change, or discontinue benefits at any time. If certain provisions in this SPD are amended or are changed after you have received this SPD, you will receive what is called a Summary of Material Modifications, or SMM, which will explain those changes to you. Throughout this SPD, some key terms that are used are in **bold**. You can find the definition of these terms in the definition section of this SPD.

B. IF YOU HAVE QUESTIONS

Throughout this SPD you will be referred to the Fund Office for questions and assistance. The Fund Office 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**.** A third party administrator operates the Fund Office, which is a company called TIC International. **The Fund Office is located at 6525 Centurion Drive, Lansing, MI 48917. The phone number for the Fund Office is 1-800-342-1730.** Notices, payments, and other documents that you may be required to send will almost always be sent to the Fund Office, so make special note of its address and contact information.

C. NOTICE REGARDING THE PLAN'S STATUS AS A GRANDFATHERED HEALTH PLAN

The Board of Trustees of the Upper Peninsula Plumbers & Pipefitters Health and Welfare Fund believe the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office, TIC International, at 1-800-342-1730. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This

website has a table summarizing which protections do and do not apply to grandfathered health plans.

D. DEFINITIONS AS USED IN THIS SPD

There are certain terms that will be used in this SPD, which have a specific meaning. These terms are defined below, and will be bolded when they appear throughout this SPD.

- **Benefit Year** – means the time period of January 1 through December 31 of each year.
- **Collective Bargaining Agreement** – means an agreement between an Employer and the Union that requires fringe benefit contributions to the Upper Peninsula Plumbers and Pipefitters Fringe Benefit Funds.
- **Contribution Dollars** - means the fringe benefit contributions received by the Fund for hours worked in Covered Employment. Only contributions actually received by the Fund will be deemed Contribution Dollars. This means that hours you have worked that are contributions are due for, but have not yet been paid to the Fund by your Employer, will not be counted as Contribution Dollars towards your eligibility and other requirements.
- **Covered Employment** – there are two basic requirements for work to qualify as Covered Employment. First, your Employer must have signed a collective bargaining agreement with the Union that requires contributions to this Fund, and second, the work you are performing for the Employer must be work that is covered by that Collective Bargaining Agreement, meaning you must be performing work that is covered by the trade jurisdiction of the United Association.
- **Continuing Eligibility** – the requirements for you to continue eligibility for benefits under the Plan after you have met the requirements for Initial Eligibility. Like Initial Eligibility, these requirements vary based upon your status (i.e. Single, Two-Person, Family).
- **Dependent** – Dependents are your spouse and your children. For a "Dependent Child" to be eligible for benefits, that child must be a son, daughter, stepchild, adopted child, child lawfully placed for adoption, or foster child that is less than 26 years of age. A Dependent Child also includes a handicapped child who is incapable of self-sustaining employment because of mental or physical handicap, who is dependent upon you for support and maintenance, and whose disability began prior to reaching age 26.
- **Effective Date** - means the effective date of this SPD, the effective date of a specific benefit, or the date an Employee or Dependent becomes eligible for benefits.
- **Employee** – an Employee is 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 Trust Fund.
- **Employer** – an Employer is any of the following:
    - Any member of an employer association and any other individual, partnership, corporation or business entity which 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 Fund;
    - 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 Fund on behalf of its Employees, including self-employed persons or sole-proprietors;
    - The Union, its affiliated Locals or 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 Fund 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 funds, 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 Fund.

- **Disabled** – this means that you are, as a result of a physical or mental condition that the Board of Trustees finds on the basis of satisfactory medical evidence, unable to engage in any work within the jurisdiction claimed by the United Association (UA) for remuneration or profit. However, you will not be deemed to be Disabled if the disability results from the use of narcotics, or if such disability was contracted, suffered, or incurred while you were engaged in or resulted from your participation in any criminal activity, or comes from a self-inflicted injury that is not the result of a medical condition.
- **Dollar Bank** – a notional account where Contribution Dollars in excess of those needed to meet eligibility requirements are "stored." These dollars can then be used to continue eligibility in months where the Continuing Eligibility requirements are not met by working. You can store an unlimited amount of Contribution Dollars in the Dollar Bank. Only Active Participants are eligible for the Dollar Bank. This account is **not** "vested" meaning this benefit can be reduced or eliminated at any time.
- **Initial Eligibility** – the requirements that you must meet to begin coverage. These requirements are explained later in this SPD, and may vary depending upon your status (Single, Two-Person, Family etc.)
- **Medical Provider** - includes a "physician" who is a doctor of medicine, osteopathy, chiropractor, podiatry or optometry, legally qualified and licensed to practice medicine or perform surgery or provide services at the time and place services are performed. The term "physician" shall also mean 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). It shall also mean 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. This definition includes 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 Fund or its network provider may seek physician verification or audit claims.
- **Medical Reimbursement Account ("MRA")** – a notional account that does not vest that you can use to pay for some expenses not covered by the Plan. Only certain expenses approved by the IRS and the Board of Trustees can be reimbursed. As of September 1, 2015, the maximum balance permitted in the MRA is $10,000.00. The previous maximum balance was $5,000.00.
- **Non-Medical Benefits** – means the Accidental Death & Dismemberment, Loss of Time, and Burial Expense Benefits offered by this Plan.
- **Participant** - means an **Employee** who has met the applicable requirements established by the Board of Trustees to be eligible for benefits under this Plan.
- **Retiree**- a Participant that has retired from Covered Employment and is eligible for benefits as a Retiree under this Plan.
- **Spouse** – means the person to whom you are legally married.

E. SPECIAL NOTICES

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, 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 Fund Office for more information.

Rights under the Newborns' 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 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PART 2: GENERAL INFORMATION

A. PLAN NAME AND OPERATIONS

- The name of the Fund is the Upper Peninsula Plumbers & Pipefitters Health & Welfare Fund.
- The Fund's tax identification number is 38-6111803. The Plan ID Number is 501.
- The provisions of in this SPD are current through September 1, 2015. This is called the "Effective Date." Provisions taking effect in the future are noted in this SPD.
- Records are maintained on a 12-month period of time. This is known as the "Plan Year." The Plan Year begins on July 1st and ends on June 30th.
- Federal laws, in particular the Employee Retirement Income Security Act ("ERISA"), as well as some laws of the State of Michigan, govern the Plan and Trust.
- The Fund's legal counsel is Novara Tesija, P.L.L.C. Their address is 2000 Town Center, Suite 2370, Southfield, Michigan 48075. The firm's phone number is 248-354-0380. The Fund's attorneys are responsible for handling all legal matters that affect the Fund and its operation.
- If you wish to serve legal documents, the documents should be delivered to the Fund Office. You may also deliver these documents to the Fund's legal counsel.
- This Fund provides benefits on a self-funded basis, while other benefits may be provided through insurance companies. The Trustees reserve the right to modify which part of the benefits schedule are provided on a self-funded basis and which parts, if any, are provided through an insurance carrier.
- As a general rule, self-payments for coverage are to be sent to the Fund Office. Self-payments are essentially pre-paid and are due by the 20th of each month. This means, for example, that a self-payment for coverage in October would be due by September 20th.
- Unlike a defined benefit pension plan, federal law does **not** guarantee coverage under this Fund. The Board of Trustees reserves the right to modify the level of coverage this provided, or to terminate this Fund entirely.

B. TRUSTEES OF THIS HEALTH PLAN

As required by federal law, the Fund is operated by a Board of Trustees made up of an equal number of representatives from the sponsoring Union, the **Upper Peninsula Plumbers & Pipefitters Local 111** (**the Union)** and from **Employers** as well as various **Employer** associations who contribute to the Fund as required by a

Collective Bargaining Agreement. The members of the Board of Trustees are known as the "named fiduciaries". The Board of Trustees is responsible for the administration and operation of the Plan, including the resolution of any claim appeals. The Trustees for this Plan are:

Union Trustees	Employer Trustees
Michael Hares	Brad Peterson
Dean Gutzman	Dan Melendy
John Asplund	Greg Suddereth
James Monson	George Cavadeas

PART 3: BECOMING AND STAYING ELIGIBLE FOR BENEFITS

A. ELIGIBILITY IN GENERAL

In order to be become and stay eligible for benefits, you have to meet the conditions summarized below. As you will note, these conditions will be different depending on who you are. For example, if you are retired, your eligibility requirements are different from a person who is still working. Also, you should note the following items when reviewing this eligibility section:

Initial Eligibility is automatically determined. The Fund Office will determine your **Initial Eligibility** automatically. You do not need to take any special step to become a **Participant** other than filling out and returning enrollment forms. However, please note that eligibility for coverage does *not* automatically make you eligible for all benefits offered by the Plan. Some benefits require you, in addition to satisfying the eligibility requirements, to meet certain deductible, co-pay and/or other requirements before you can receive those particular benefits.

Open Enrollment is from December 1 through December 31st of each year. This is the time period where persons who previously declined coverage, or for whom the enrollment or special enrollment period was missed, can once again enroll in coverage.

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 where permitted by this Plan. 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 Fund Office. These rights and obligations are also discussed again in detail in the "Your Rights And Responsibilities" section of this SPD, which begins on Page 32.

Reciprocity for work in other union jurisdictions. The Trustees have entered into reciprocity agreements with other health and welfare funds covering the plumbing, pipefitting and related crafts throughout the country. Pursuant to these reciprocity agreements, contributions made on your behalf may be transferred from one fund to another, upon your request and authorization. The contributions that may be transferred may enable you to meet the **Continuing Eligibility** requirements of the "home fund." This means that if you work in

another jurisdiction and have **Contribution Dollars** made to another fund on your behalf, you may request that such contributions be transferred to this Fund via a reciprocity agreement.

B. IF YOU ARE WORKING IN COVERED EMPLOYMENT

How Do I Become Eligible? As an Active **Employee** (meaning you are working and not retired or disabled), you will establish **Initial Eligibility** for Medical, Prescription Drug, Dental, and **Non-Medical Benefits** (Accidental Death & Dismemberment, Loss of Time, and Burial Expense Benefits) on the first day of the month *following* the month in which $2,000 of **Contribution Dollars** are received by the Fund within a twelve (12) consecutive month period. You should keep in mind that your **Employer** has a one-month "bookkeeping period" in which to remit contributions to the Fund.

The contributions from your **Employer** for the hours you worked must be received by the Fund before those hours will be considered as **Contribution Dollars** for establishing eligibility, and you must also fill out certain enrollment forms prior to coverage beginning. You cannot make a self-payment in order to establish **Initial Eligibility**. Any **Contribution Dollars** received that are in excess of those required to meet the **Initial Eligibility** requirements will be credited to your **MRA** up to the $10,000 maximum, then to the **Dollar Bank**.

An example of how this "bookkeeping" period affects eligibility, along with how **Contribution Dollars** are used to establish **Initial Eligibility** is set forth below.

> **EXAMPLE #1**: In the months of January, February, and March of 2016, Bob works enough hours so that $2,000 of Contribution Dollars is owed on his behalf, with Bob reaching the $2,000 mark in March. Bob needs family coverage, which as of January 1, 2016, costs $1,000 Contribution Dollars per month. The Contribution Dollars for March, which give Bob the necessary $2,000 to become eligible, will be due to the Fund from his Employer by April 15th. As a result, Bob and his family will first become eligible for coverage on May 1st. The $1,000 of excess Contribution Dollars (there is a $1,000 excess because family coverage costs $1,000) will go to fund Bob's MRA. Once Bob's MRA reaches the $10,000 maximum, new Contribution Dollars which are in excess of what he needs to stay eligible each month ($1,000) will go into his Dollar Bank.

How Do I Stay Eligible For Benefits? Unlike the requirements for **Initial Eligibility**, the requirements for **Continuing Eligibility** are different depending on the type of contract/coverage you need. As of January 1, 2016, Single Coverage costs $800 **Contribution Dollars** per month, Two-Person Coverage costs $900 **Contribution Dollars** per month, and Family Coverage costs $1,000 **Contribution Dollars** per month. As discussed below, you can stay eligible by working, by drawing from your **Dollar Bank**, by drawing from your **MRA**, by making self-payments, or by a combination of these methods.

> **EXAMPLE #2**: As noted in Example #1, Bob has already met the requirements for Initial Eligibility. In April of 2016, Bob works enough hours so that $1,800 Contribution Dollars are owed on his behalf. Bob's employer pays the fringe benefit contributions on time (by May 15th) for the hours worked in April, so now Bob has met the requirements to stay eligible in June. The Fund will take the $1,000 of Bob's Contribution Dollars to continue his eligibility, with the excess of $800 going into his MRA. As a result, Bob now has a balance of $1,800 in his MRA.

To further illustrate how **Contribution Dollars** are used for eligibility purposes, please see the chart below.

Hours Worked in the Month of:	Count Towards Eligibility for the Month of:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

How are excess Contribution Dollars divided between the MRA and Dollar Bank? Excess **Contribution Dollars** are used to fund your **MRA** first up to the maximum balance of $10,000.00. Once you reach this maximum, the excess goes to fund the **Dollar Bank**. If there is a balance in your **Dollar Bank** that is equivalent or greater than three (3) or more months of coverage and the balance in your **MRA** drops below the maximum, the balance in your **MRA** will be replenished monthly with funds from your **Dollar Bank**. However, if your **Dollar Bank** balance is *below* three (3) months, funds *cannot* be transferred and your **MRA** can be only funded with new excess **Contribution Dollars**.

> **EXAMPLE #3:** Assume that Bob has continued to work for some time, and he now has a balance of $10,000 in his MRA, and $5,000 in his Dollar Bank. In October of 2017, only $400 Contribution Dollars are paid on Bob's behalf for the work he performed in September. Bob also has a large claim in October, and uses $900 from his MRA. Because Bob has more than three months of coverage built up in his Dollar Bank, at the end of October $900 will be taken from Bob's Dollar Bank to replenish his MRA back to the maximum of $10,000. Then, so that Bob can continue coverage in November, the Fund will take $600 from Bob's Dollar Bank ($400 in Contribution Dollars + $600 from the Dollar Bank = $1,000, which is what Bob needs to continue with family coverage).
>
> **EXAMPLE #4:** Dan has family coverage. He has $2,000 in his Dollar Bank and $8,000 in his MRA. Dan works enough hours to stay eligible, but he needs to use the balance in his MRA to pay for braces for his children, which are $9,000. Dan can use the entire $8,000 in his MRA to pay for the braces, but he cannot transfer an additional $1,000 from the Dollar Bank to pay for the rest of the braces because the balance in the Dollar Bank is below three months of coverage (i.e. for 3 months of family coverage, the balance needs to be $3,000 or more).

What if I do not work enough hours to stay eligible: If you do not work enough hours to meet the requirements for **Continuing Eligibility**, the amount required to stay eligible is first taken from the **Dollar Bank**, then from the **MRA** unless you decide not to use the **MRA** for self-payments. If the balance of one or both of these accounts is still not enough to continue coverage, you can make a partial or full self-payment. There is no limit on the number of self-payments you can make, however, you must remain available for work within the jurisdiction of the **Union** and keep your name on the out-of-work list. If you fail to do so, you will no longer be permitted to make self-payments.

EXAMPLE #5: Bob has a balance of $10,000 in his MRA. He also has a balance of $4,300 in his Dollar Bank. In November of 2017, the Fund receives only $500 of Contribution Dollars for the work he performed in October. In order to continue coverage for December, the Fund will take $500 from Bob's Dollar Bank (since the rate to continue family coverage is $1,000) in order to continue his coverage for the month of December.

EXAMPLE #6: Dan has used the balance in his MRA to pay for braces for his children, and has also used the balance in his Dollar Bank for to continue coverage in June and July of 2016. In July, the Fund received $500 Contribution Dollars for work Dan performed in June. To continue coverage in August, Dan will have to make a self-payment of $500 ($500 of Contribution Dollars + $500 = $1,000, which is the amount needed to continue family coverage).

Do I have to draw from my MRA for self-payments? No. If your **Dollar Bank** is depleted, you can elect *not* to have any shortfall taken from your **MRA**. However, if you do so, you will **not** be able to make self-payments to continue coverage. You will also be afforded the permanently opt out of the **MRA** and waive the right to all future reimbursements. This right is described in more detail in Part 4 of this SPD. If you fail to make a timely self-payment, you will be offered coverage under the COBRA provisions of the Plan. In order to return to the Plan, you will have to reestablish eligibility. Reinstatement of eligibility is discussed later in this SPD on Page 11.

Can I Opt Out For Other Coverage? Yes, but there are requirements if you opt out. If you elect to opt out in favor of other coverage, such as the coverage of your **Spouse**, the Plan will require that you attest in writing that (1) the other coverage is not merely a health reimbursement account or HRA; and (2) that it provides what is known as "minimum value" under the Patient Protection and Affordable Care Act ("PPACA"), often referred to simply as "healthcare reform." If you elect to opt-out, **Contribution Dollars** received on your behalf will be allocated to your **MRA** up to the maximum balance allowed, which is currently $10,000, with any excess being allocated to the **Dollar Bank.** In addition, you must pay a monthly administrative fee of **$200**, unless the balance in your **Dollar Bank and MRA** is less than $3,000, then the fee is **$25**. This fee will be automatically deducted from the **Dollar Bank**. If you do not have a balance in the **Dollar Bank** or it is depleted as a result of making these payments, then you will have to remit the $25 payment to the Fund Office by the 20th of each month.

How do I reinstate coverage after it has terminated? If you lose eligibility (meaning that you have exhausted the balances in both your **Dollar Bank** (and **MRA** if you elected to make self-payments from it) and have failed to make a timely self-payment) then you must meet the requirements for **Continuing Eligibility** at the applicable contract rate (i.e. $1,000 for family coverage) within a twelve-month (12) consecutive period to reinstate coverage. If you do not work enough hours in a month to reinstate coverage, then the **Contribution Dollars** remitted will accumulate until you reach the required level.

EXAMPLE #7: Bob has exhausted the balances in both the Dollar Bank and his **MRA**. In August of 2018, he had $300 Contribution Dollars remitted on his behalf. Bob did not make a self-payment, so his coverage terminated. If Bob returns to work within 12 months of August of 2018, and wants to have family coverage, he only needs to have $700 Contribution Dollars remitted on his behalf (the $300 is "stored" for 12 months, so he only needs $700 to get to $1,000). Also, he does have to accumulate not all $700 Contribution Dollars in one month. For example, if Bob had $200 in September, $200 in October, and

$300 in November, he would eligible again in January of 2019 (there would still be a one-month bookkeeping period before coverage would begin again).

Special Rule (New Contractors Only): Active **Participants** of newly signed **Employers** may establish eligibility for benefits on the first day of the month following the month in which the Fund receives **Contribution Dollars** equal to the monthly premium for **Continuing Eligibility**. Active **Participants** establishing eligibility under this rule will start with a *negative* balance in their **Dollar Bank**.

> **EXAMPLE #8:** Alex works for a newly signed Employer and needs family coverage. He starts work on February 1, 2016 and works hours sufficient to give him $1,000 Contribution Dollars. Adam will have coverage beginning on April 1, 2016. His Dollar Bank balance will now be a *negative* $1,000, because the $1,000 in Contribution Dollars will be applied towards his *negative* Dollar Bank balance. Adam also works enough hours to give him $1,000 Contribution Dollars in March. Adam has how cleared his negative bank balance, and any excess hours earned in future months will start to fund his MRA up to the $10,000 maximum. Once the maximum is reached, he will also begin accumulating a balance in the Dollar Bank.

SUMMARY OF ELIGIBILITY REQUIREMENTS- ACTIVE PARTICIPANTS

Contract Type	Initial Eligibility	Continuing Eligibility THROUGH 12-31-15	Continuing Eligibility EFFECTIVE 1-1-16	Excess Hours
Single	$2,000 in 12 consecutive months	$700 (approximately 95 hours per month)*	$800 (approximately 108 hours per month)*	All excess hours go first to the MRA, then to the Dollar Bank. Effective on 9-1-15, the MRA cap was increased to $10,000.
Two Person		$800 (approximately 108 hours per month)*	$900 (approximately 121 hours per month)*	
Family		$900 (approximately 122 hours per month)*	$1,000 (approximately 135 hours per month)*	

****These rates are subject to change at the discretion of the Board of Trustees. If the rates change, you will receive a notice from the Fund Office.***

C. IF YOU ARE A NON-BARGAINING UNIT EMPLOYEE (OFFICE WORKER OR "NBU")

How Do I Become Eligible? Non-Bargaining Unit **Employees** (such as office staff or working owners of contributing **Employers**) establish **Initial Eligibility** on the first day of the month following the month in which the Fund receives $2,000 of **Contribution Dollars** within a 12-month consecutive period. Non-Bargaining Unit **Employees** must sign a participation agreement in a form approved by the Trustees and the **Employer** must contribute for *all* of its Non-Bargaining Unit Employees. Non-Bargaining Unit **Employees** *are* eligible for Dental Benefits, but are NOT eligible for **Non-Medical Benefits**. If your **Employer** *voluntarily* chooses to send excess **Contribution Dollars,** those dollars will be credited to an **MRA** up to the $10,000 maximum. Non-Bargaining Unit Employees are NOT eligible for a **Dollar Bank**, and any balance in the **MRA** is forfeited to the Plan if you stop working for an **Employer.**

How Do I Stay Eligible? Unlike the requirements for **Initial Eligibility**, the requirements for **Continuing Eligibility** are different depending on the type of contract/coverage you have. As of January 1, 2016, Single Coverage costs $800 **Contribution Dollars** per month, Two-Person Coverage costs $900 **Contribution Dollars** per month, and Family Coverage costs $1,000 **Contribution Dollars** per month. You stay eligible by your **Employer** continuing to remit the required amount of **Contribution Dollars** each month. If your **Employer** fails to remit the required amount of **Contribution Dollars** each month, you will lose coverage. Non-Bargaining

Unit **Employees** are NOT permitted to make self-payments to continue coverage. If your **Employer** *voluntarily* chooses to remit **Contribution Dollars** in *excess* of the amount required to maintain eligibility, those **Contribution Dollars** will be allocated to the **MRA** up to the $10,000 maximum. Remember, Non-Bargaining Unit **Employees** are NOT eligible for a **Dollar Bank** and if you stop working for an **Employer**, you lose the balance in the **MRA**. The monthly requirements to stay eligible for benefits are also summarized at the end of this section.

To further illustrate how **Contribution Dollars** are used for eligibility purposes, please see the chart below:

Hours Worked in the Month of:	Count Towards Eligibility for the Month of:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

Can I Opt-Out For Other Coverage? No. Non-Bargaining Unit Employees may not opt-out of coverage.

How is my coverage reinstated? If your **Employer** fails to timely remit **Contribution Dollars,** coverage will end. Your **Employer** can reinstate coverage by remitting the delinquent **Contribution Dollars** to the Fund, in which case coverage will generally resume on the first day of the month following the month in which the **Contribution Dollars** are received. If the Employer becomes delinquent, Non-Bargaining Unit Employees would be offered coverage under COBRA.

> **EXAMPLE #1**: Sandy's Employer remits $1,000 Contribution Dollars for family coverage in May for the hours she worked in April. This means that Sandy has coverage for the month of June (since April hours count toward eligibility in June). But, her Employer does not make contributions for the work she performs in May. As a result, Sandy's coverage will end on June 30th. If her Employer later makes the delinquent payment, for the work she performed in May and in June, coverage will be reinstated for May and Sandy will also have coverage for July and August. If Sandy made a COBRA payment, the Plan will refund it once the delinquent contributions are received.

SUMMARY OF ELIGIBILITY REQUIREMENTS – OFFICE WORKERS

Contract Type	Initial Eligibility	Continuing Eligibility THROUGH 12-31-15	Continuing Eligibility EFFECTIVE 1-1-16	Excess Hours
Single	$2,000 in 12 consecutive months	$700 (approximately 95 hours per month)*	$800 (approximately 108 hours per month)*	If *voluntarily* sent, excess hours go first to an MRA. Starting on 9-1-15, the MRA cap is increased to $10,000. No Dollar Bank is available for NBUs.
Two Person		$800 (approximately 108 hours per month)*	$900 (approximately 121 hours per month)*	
Family		$900 (approximately 122 hours per month)*	$1,000 (approximately 135 hours per month)*	

****These rates are subject to change at the discretion of the Board of Trustees. If the rates change, you will receive a notice from the Fund Office.***

D. IF YOU ARE AN EARLY RETIREE

How Do I Become Eligible? To qualify for **Initial Eligibility** as an Early **Retiree** (meaning you are *not* working in **Covered Employment** anymore but are not yet eligible for Medicare) you must meet all of the following requirements:

- Be receiving monthly pension benefits from the Upper Peninsula Plumbers and Pipefitters Pension Fund, or the Plumbers and Pipefitters National Pension Fund, or are receiving Social Security Benefits;
- Accrue at least 360 hours of **Employer** contributions in ten (10) of the previous (15) years immediately preceding retirement;
- Be eligible as an Active **Participant** on the date of retirement;
- Make timely self-payments to the Fund Office (generally by the 20th of each month prior to the month for which the payment is being made). An Early **Retiree** may elect to have the self-payment premiums automatically deducted from his or her pension check. Forms for authorizing this deduction are available from the Fund Office.

How Do I Stay Eligible?

- **Medical, Surgical, & Prescription Drug Benefits**. After exhaustion of any balance in your **Dollar Bank**, you will maintain eligibility for yourself and your **Dependents** so long as you make timely self-payments and are not eligible for Medicare. The self-payment amount will be established by the Board of Trustees and may be adjusted from time to time. **You must maintain continuity of coverage, as no reinstatement will be permitted if you fail to timely make a self-payment**.

- **Non-Medical and Dental Benefits**. Early **Retirees** are **not** eligible for Accidental Death & Dismemberment, Loss of Time, and Burial Expense benefits. Early **Retirees are** eligible for a special Loss of Time Benefit, and are also eligible to select Dental Benefits for an additional premium. Self-payment rates that include Dental Benefits are available from the Fund Office and must be selected when you enroll for **Retiree** coverage. **You must maintain continuity of coverage, as no reinstatement will be permitted if you fail to timely make a self-payment**.

What If I Go Back To Work? If you return to work, you must notify the Fund Office in writing and continue to make self-payments until the Plan's **Initial Eligibility** requirements are met. When you stop working, you must again inform the Fund Office. Early **Retirees** returning to work will *not* accumulate a balance in the **Dollar Bank**

or the **MRA**. In addition, **Contribution Dollars** received under reciprocity agreements are not credited for purposes of eligibility. You must continue to make the required self-payments in order to continue coverage.

Can I Choose Not To Cover My Spouse? Yes. You may choose not to cover your **Spouse** if you notify the Fund Office in writing of this election. If your **Spouse** later loses health coverage, you can add your **Spouse** back if you provide proof of the loss of coverage to the Fund Office within thirty-days (30) after coverage has terminated. If you elect not to cover your **Spouse**, you must pay a monthly administrative fee of **$100**, unless the balance in your **Dollar Bank** and **MRA** is less than $3,000, then the fee is **$25**. This fee will be automatically deducted from the **Dollar Bank**. If you do not have a balance in the **Dollar Bank** or it is depleted as a result of making these payments, then you will have to remit the $25 payment to the Fund Office by the 20th of each month. Keep in mind that you, as the Early **Retiree**, may *not* opt-out and come back into the Plan, this option is available only for your **Spouse**.

E. IF YOU ARE RETIRED (AGE 65 AND OVER)

How Do I Become Eligible? To qualify for **Initial Eligibility** as a **Retiree**, a **Participant** must meet all of the following requirements:

- Be receiving monthly pension benefits from the Upper Peninsula Plumbers and Pipefitters Pension Fund, or the Plumbers and Pipefitters National Pension Fund, or are receiving Social Security Benefits;
- Accrue at least 360 hours of **Employer** contributions in ten (10) of the previous fifteen (15) years immediately preceding retirement;
- Be eligible for benefits as an Active **Employee** on the date he or she retires; and
- Make timely self-payments to the Fund Office.

How Do I Stay Eligible? Eligibility requirements are different for Medical, Surgical, and Prescription Drug Benefits then they are for Non-Medical and Dental Benefits. The differences are explained below.

- **Medical, Surgical and Prescription Drug Benefits**. Coverage for **Retirees** is provided through a Medicare Advantage Plan. **Retirees** maintain eligibility for this plan by timely remitting self-payments at the rate established by the Board of Trustees. Self-payments are due on the 20th of each month. A **Retiree** may elect to have his or her self-payments deducted from their monthly pension check from a pension plan sponsored by the **Union**. Forms for automatic deduction are available from the Fund Office. **Retirees** returning to work will not accumulate a balance in the **Dollar Bank** beyond what is needed to maintain eligibility, and credit will not be given for **Contribution Dollars** received that are not sufficient to satisfy the requirements for eligibility. Self-payment rates are available from the Fund Office. **You must maintain continuity of coverage, as no reinstatement will be permitted if you fail to timely make a self-payment**.

- **Non-Medical and Dental Benefits**. **Retirees** are **not** eligible for Accidental Death & Dismemberment benefits. **Retirees** are eligible for Burial Expense Benefits. Retirees are also eligible for Dental Benefits; however, there is an additional premium for this benefit. Self-payment rates that include Dental Benefits are available from the Fund Office. The election for Dental Benefits is made at the time you enroll in **Retiree** coverage. **You must maintain continuity of coverage, as no reinstatement will be permitted if you fail to timely make a self-payment**.

Can I Choose Not To Cover My Spouse? A **Retiree** may choose not to cover his or her **Spouse** under this Plan provided he or she notifies the Fund Office in writing of this election. If the **Spouse** later loses health coverage, the **Spouse** may be added back onto the Plan provided the **Retiree** provides proof of the loss of coverage within

thirty-days (30) after coverage has terminated. If you elect not to cover your **Spouse**, you must pay a monthly administrative fee of **$100**, unless the balance in your **Dollar Bank** and **MRA** is less than $3,000, then the fee is **$25**. This fee will be automatically deducted from the **Dollar Bank**. If you do not have a balance in the **Dollar Bank** or it is depleted as a result of making these payments, then you will have to remit the $25 payment to the Fund Office by the 20th of each month. The **Retiree** may not opt-out and come back into the Plan, this option is available only for the **Spouse** of the **Retiree**.

What If I Go Back To Work? If you return to work, you must notify the Fund Office in writing and continue to make self-payments until the Plan's **Initial Eligibility** requirements are met. When you stop working, you must again inform the Fund Office. **Retirees** returning to work will *not* accumulate a balance in the **Dollar Bank** or the **MRA**, and credit will *not* be given for **Contribution Dollars** received that are not sufficient to satisfy the requirements for eligibility. In addition, **Contribution Dollars** received under reciprocity agreements are not credited for purposes of eligibility. You must continue to make self-payments in order to continue coverage.

What About Medicare? Your coverage with the Fund is a Medicare Advantage Plan. Accordingly, **Retirees** eligible for Medicare will be treated as if they elected both parts A&B and coverage from this Plan will be provided accordingly. Be sure that you elect the right Medicare options, so that you do not end up with gaps in your coverage. You will be notified by the Fund Office of the monthly amount due to maintain your coverage. Self-payments must be made from the date active coverage was lost, and are due the first day of each calendar month. **If you fail to make a timely self-payment, you will lose your coverage and it cannot be reinstated.** Keep in mind that retiree coverage is **not** "vested" and therefore it can be changed or eliminated at any time.

F. IF YOU BECOME DISABLED

How do I become eligible? If you are an Active **Employee** who becomes **Disabled**, you will be eligible for benefits under this Plan provided that you:

- Are **Disabled**;
- Are receiving monthly pension benefits from the Upper Peninsula Plumbers and Pipefitters Pension Fund, or the Plumbers and Pipefitters National Pension Fund, or are receiving Social Security Benefits;
- Were an eligible Active **Participant** under this Plan for three (3) of the five (5) years immediately preceding the time you become **Disabled**;
- Make application for such coverage in the time and manner prescribed by the Trustees;
- Agree to submit to an examination by a **Medical Provider** or clinic selected by the Trustees to establish his initial disability status or to confirm his continued disability status; and
- When necessary, make timely self-payments to the Fund Office (generally by the 20th of each month prior to the month for which the payment is being made);
- Sign a reimbursement agreement in a form acceptable to the Board of Trustees.

What are Disability Credits? Disabled **Participants** will be given credits to remain eligible for up to fifty-two (52) weeks provided you continue to meet the requirements for **Continuing Eligibility** and the period of disability lasts at least two consecutive weeks. Usually, the disability credits will be enough to continue eligibility so a self-payment will not be required. However, sometimes you may need to make some self-payments even while receiving the credits when, for example, you may not have been working full-time prior to the disability occurring.

How Do I Stay Eligible Once My Disability Credits Are Gone? A disabled **Participant** maintains eligibility by timely remitting self-payments to the Fund Office after exhaustion of the balance in the **Dollar Bank,** the **MRA**, or both. The self-payment rate will be established by the Board of Trustees, and is subject to change at any time. As a **Disabled Participant**, you must notify the Fund Office in writing that you want to maintain your eligibility through self-payments within **60 days** of the latter of the following two events: (1) the month in which you were last covered under the Active **Participant** program or (2) the month in which you receive a Social Security Disability award. **Failure to notify the Fund will result in a permanent loss of coverage**. Disabled Participants **must** enroll in Medicare Parts A&B when eligible to do so. Disabled Participants who are drawing a pension from a fund sponsored by the **Union** may elect to have their self-payment premiums deducted from a pension check. Forms for this deduction are available from the Fund Office.

Can I Choose Not To Cover My Spouse? A Disabled **Participant** may choose not to cover his or her **Spouse** under this Plan provided he or she notifies the Fund Office in writing of this election. If the **Spouse** later loses health coverage, the **Spouse** may be added back onto the Plan provided the Disabled **Participant** provides proof of the loss of coverage within thirty-days (30) after coverage has terminated. **A Disabled Participant exercising this opting out must pay a monthly administrative fee of $25**. This fee will be automatically deducted from the **Dollar Bank**. If you do not have a balance in the **Dollar Bank** or it is depleted as a result of making these payments, then you will have to remit the $25 payment to the Fund Office by the 20th of each month. This fee must be paid to the Fund Office by the 20th of each month. The Disabled **Participant** may not opt-out and come back into the Plan, this option is available only for the **Spouse** of the Disabled **Participant**.

G. IF YOU ARE A SURVIVING SPOUSE

How Do I Stay Eligible If My Spouse Passes Away? A Surviving **Spouse** of a deceased **Participant** or **Retiree** is eligible for continued coverage under the Plan, provided both the deceased **Participant** or **Retiree** and the Surviving **Spouse** were covered under the Plan at the time of their death. Self-payments at the rate set by the Board of Trustees will be required from the Surviving **Spouse** on the first day of the month following the month in which the **Dollar Bank** of the deceased **Participant** or **Retiree** is exhausted. Continuity of coverage must be maintained and timely self-payments must be made in order for a Surviving **Spouse** to maintain eligibility. Dental Benefits **are** available to a Surviving **Spouse** for an additional premium. Rates can be obtained by contacting the Fund Office. Surviving **Spouses** and their **Dependents** are **not** eligible for **Non-Medical Benefits**.

How Do I Stay Eligible? The **Spouse** and/or **Dependents** of deceased Active or Retired **Participants** may continue eligibility in the Plan by making full self-payments once the balance in the **Dollar Bank** is exhausted or partial self-payments if the **Dollar Bank** balance is insufficient to maintain eligibility. Self-payment rates for Surviving **Spouses** will be established by the Board of Trustees from time to time, and are subject to change, in the their sole discretion. Remarriage will result in the termination of the Surviving **Spouse's** and his or her **Dependent's** eligibility for benefits under the Plan.

When does coverage end? Coverage will end upon the occurrence of any of the following events, as applicable: (1) the last day of the month in which the **Spouse** remarries; (2) the last day of the month in which the **Spouse** becomes eligible as an employee from the group health plan of his or her employer; (3) the last day of the month for which a timely self-payment was made; (4) for any **Dependent** children of the Surviving **Spouse**, on the last day of the month in which the **Dependent** child turns age 26.

How do I reinstate coverage? Coverage for a Surviving **Spouse** and **Dependents** will not be reinstated. If you fail to make a timely self-payment, coverage will be offered under COBRA.

H. IF YOU ARE A DEPENDENT

How Do I Become Eligible? **Dependents** of an **Employee** are eligible for coverage when the **Employee** meets the applicable **Initial Eligibility** requirements. An eligible **Dependent** includes the following:

- Your **Spouse**;
- Your son, daughter, stepchild, adopted child, child lawfully placed for adoption, or foster child who is less than 26 years of age (coverage will terminate in this instance on the last day of the month in which the **Dependent** Child turns 26);
- Each handicapped child, who is incapable of self-sustaining employment because of mental or physical handicap, and who is dependent on you for support and maintenance. A handicapped child can remain as your **Dependent** and eligible for coverage so long as (1) you remain eligible for benefits as **Participant**, and (2) the incapacity of your child began before the date the child's coverage would otherwise terminate under the Plan (for example, the disability began before the child was already age 26 or older).

How Do I Stay Eligible? **Dependents** remain eligible so long as the **Employee** or Surviving **Spouse** continues to meet the applicable requirements for **Continuing Eligibility**. If you are a **Dependent** of an **Employee** that has passed away, you will have to make self-payments to remain eligible after exhaustion of any balance in the **Dollar Bank** and the **MRA** if used to make self-payments**.**

What about coverage under court orders? The Plan will provide benefits otherwise available in accordance with any valid order of a court, determined by the Trustees to be a Qualified Medical Child Support Order (QMCSO) 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 a **Participant** or beneficiary 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 is specified. The Fund Office 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 child or the child's custodial parent or legal guardian will be made in accordance with applicable law.

I. COVERAGE UNDER THE FAMILY MEDICAL LEAVE ACT

A contributing **Employer** which is a "covered employer" as that term is defined by the Family Medical Leave Act ("FMLA") is required to notify the Fund when an eligible employee has been granted family or medical leave, in accordance with the terms and conditions established by the Trustees. If you have questions about FMLA leave, you should contact your **Employer**.

J. CONTINUATION OF COVERAGE UNDER USERRA

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, the **Contribution Dollars** accrued will be frozen, and you may elect to continue coverage for all benefits under the Plan, except **Non-Medical Benefits**, for a period which is the lesser of:

- The twenty-four (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 will be charged the monthly COBRA premium rate, unless your period of service is less than 31 days, in which case coverage shall be provided at no additional cost.

You must return to **Covered Employment** or register on the **Union's** out-of-work list within ninety (90) days of your discharge under honorable conditions from the services or within twenty-four (24) months of discharge if you are recovering from an illness or injury incurred during or aggravated by your service. Upon return to **Covered Employment** or registration on the **Union's** out-of-work list, your **Dollar Bank**, if any, shall be restored. You shall be eligible for coverage without having to reestablish eligibility. You will also need to submit copies of your induction and discharge papers to the Fund Office.

K. CONTINUATION OF COVERAGE UNDER COBRA

Generally. The Consolidated Omnibus Budget Reconciliation Act ("COBRA") offers **Employees** 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 as the result of a Qualifying Event. Persons who experience a Qualified Event are called "Qualified Beneficiaries" under COBRA, and can elect COBRA coverage provided they comply with the Plan's notice requirements.

Qualifying Events for Participants. If you are an Active **Participant**, you become a Qualified Beneficiary and entitled to elect COBRA coverage if any of the following events occurs and causes you to lose coverage under the Plan:

- Your employment terminates for any reason other than "gross misconduct"; or
- Your experience a reduction in hours of employment.

Qualifying Events for Dependents. The following are Qualifying Events for a **Spouse** and/or **Dependent Child** of a **Participant** if they cause the **Spouse** or **Dependent Child** to lose coverage under the Plan:

- The termination of the **Participant's** employment for reasons other than gross misconduct, or reduction in **Participant's** hours of employment;
- The death of the **Participant**;
- The **Participant's** divorce or legal separation;
- The **Participant's** eligibility for Medicare;
- In some circumstances, upon the filing by the **Participant's Employer** of a Chapter 11 Bankruptcy Reorganization petition; or
- The **Dependent** ceases to be a "**Dependent Child**" under the Plan (e.g. turns age 26).

Notice Requirements. A **Participant** or **Dependent** who has lost coverage due to divorce, separation or loss of dependency status, must notify the Fund Office of the Qualifying Event **within 60 days** of the occurrence of the Qualifying Event to qualify for COBRA continuation coverage. In all other cases, the **Participant's Employer** must notify the Fund Office **within 30 days** of the Qualified Event. Failure to notify the Fund Office within the time specified will result in termination of the **Participant** or **Dependent's** group health care coverage as of the date of the qualifying event.

Extensions of COBRA Coverage. Coverage through COBRA can be extended in two ways; the first is when a person is found to be disabled by the Social Security Administration ("SSA") and the second is when there is a second Qualifying Event during the first 18 months of coverage under COBRA. These two types of extensions, and the duties they place on you to notify the Fund Office about them, are discussed below.

Social Security Disability. If you were an Active **Participant** who lost coverage under the Plan due to termination of your employment for reasons other than gross misconduct or a reduction in hours (this would be your first Qualifying Event), and the Social Security Administration ("SSA") determines that you are disabled, you and your **Dependents** may be able to extend your COBRA coverage for an additional 11 months. The disability must have started sometime before the 61st day of losing coverage due to your termination or a reduction in hours. **Also, in order to be eligible for the extension, you must notify the Fund Office**. The notice must be in writing, and it must be provided within the first 18 months of your COBRA coverage beginning due to your termination or reduction in hours **and** within 60 days of the last of the following events to occur:

1. The date the SSA determined you were disabled;
2. The date 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 **Dependent** Child) would lose coverage as a result of your loss of coverage due your termination or reduction in hours (i.e. the Qualifying Event).

If you fail to timely provide the notice, you will not be eligible for the extension. The notice should include the name of the person receiving the coverage, information about the disability, and a copy of the letter from the SSA.

Loss of Disability Status: If you are awarded Social Security Disability status, but later the SSA determines that you are no longer disabled, you must notify the Fund Office within **30 days** from the date the SSA notifies you that it no longer considers you disabled. The notice should include the name of the person receiving the coverage and a copy of the letter from the SSA notifying you that you are no longer considered disabled.

Second Qualifying Event: If a second Qualifying Event occurs while you and your family are on COBRA due to your termination or reduction in hours (i.e. the first Qualifying Event) your **Spouse** and **Dependents** may be entitled to an additional 18 months of coverage under COBRA if a second Qualifying Event occurs. Second Qualifying Events that would give rise to this extension for your **Spouse** and **Dependents** are (1) your death; (2) your becoming eligible for Medicare; (3) your divorce or legal separation from your **Spouse**; or (4) if a **Dependent** Child no longer qualifies as a dependent under the Plan (e.g. turns age 26). 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 also provide the Fund Office with written notice of the Second Qualifying Event within **60 days** of the later of:

1. The date of the second Qualifying Event; or
2. The date that your **Spouse** or **Dependent** Child would lose coverage under the Plan due to the second Qualifying Event (such as turning age 26).

If you fail to timely provide the notice, you will not be eligible for the extension. The notice should include the name of the person receiving the coverage and information about the second Qualifying Event.

Cost of Continuation Coverage. The cost of COBRA continuation coverage, excluding weekly disability benefits, for eighteen (18) months, shall be determined by the Board of Trustees from time to time, but shall not exceed 102% of the applicable health insurance premium. The Trustees may charge up to 150% of the applicable health insurance premium for COBRA coverage in excess of 18 months for disabled qualified beneficiaries.

SUMMARY OF COBRA QUALIFYING EVENTS			
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 spouse divorce	N/A	36 months	36 months
Your child no longer qualifies as a dependent	N/A	N/A	36 months

L. WHAT IF MY EMPLOYER IS DELINQUENT?

Participants who become ineligible due to an **Employer's** delinquency are not permitted to continue eligibility by making self-payments, but can continue coverage through COBRA. If **Contribution Dollars** are received which would have satisfied the requirements for **Continuing Eligibility**, an appropriate refund of any self-payments will be made. Hours worked for a delinquent **Employer** do not result in the accumulation of **Contribution Dollars** until the contributions are received by the Plan. You will be provided with 30 days advance notice prior to a termination of coverage due to an **Employer's** delinquency.

PART 4: WHAT BENEFITS ARE AVAILABLE UNDER THIS PLAN?

Generally. This Plan provides coverage to **Participants** and their eligible **Dependents** for various benefits, which are summarized here and in the Schedules of Benefits, which are part of the Appendices to this SPD. In general, the Plan provides medical, hospital and surgical benefits, prescription drug coverage, mental health and substance abuse benefits, dental coverage, and other coverage listed in the Appendices and discussed more in this section.

A. MEDICAL, SURGICAL, AND PRESCRIPTION DRUG BENEFITS.

Medical, Surgical, and Prescription Drug Benefits are provided through a PPO network from Blue Cross Blue Shield of Michigan ("BCBSM"). A list of providers within this network will be provided to you by BCBSM. Appendix A contains the Benefits At A Glance or "BAAGs" from BCBSM, which summarizes the coverage available to each class of **Participant**. For some benefits, you must also pay a portion of the expenses, such as co-pays deductibles, and co-insurance. In addition, some benefits may be subject to pre-authorization and step therapy requirements. You can obtain a copy of these requirements from the Fund Office or from BCBSM. Please note that coverage available under this Plan may be modified from time to time. In general, Active **Participants**, Non-Bargaining **Employees**, **Dependents**, Surviving **Spouses**, Early **Retirees**, and Disabled **Participants** receive the same medical, surgical and prescription drug benefits. **Retirees** who are eligible for Medicare and Disabled **Retirees** on Medicare are provided with a different benefits package that is supplemental to Medicare.

In addition to the coverage summarized in Appendix A, the Plan also provides the following benefits:

B. MEDICAL REIMBURSEMENT ACCOUNT

Generally. The **MRA** may be used only for expenses permitted by the Internal Revenue Code and the Board of Trustees. Effective September 1, 2015, the maximum permitted balance in the **MRA** is $10,000. Reimbursements from the **MRA** must be at least $25, and cannot be older than 1 year. If you are an Active

Participant and opt-out, you are not eligible for the **MRA** unless the other coverage is (1) not merely a form of health reimbursement account and (2) provides "minimum value" under the PPACA.

Forfeit of Balance & Use by Dependents. For Active **Participants**, your **Spouse** and/or **Dependents** may continue to use the **MRA** for permitted expenses in the event of your death. You will lose any balance in the **MRA** if there is no activity in twenty-four (24) consecutive months and you are not eligible for any other benefits under this Plan, or if you opt-out of the **MRA**. The **MRA** is not a vested benefit. For Non-Bargaining Unit **Employees**, the **MRA** cannot be transferred. Upon your death, the termination of your coverage under this Plan, or the ending of your employment with an **Employer**, the balance in the **MRA** is forfeited to the Plan.

Opt Out. Once annually, and again upon termination of your eligibility under the Plan if you have not previously opted out, you will be able to permanently opt out of the **MRA** and waive all future reimbursements from your account. If you do so, your will not receive any additional funds on your paycheck. You also cannot use your **MRA** to purchase insurance coverage on a state or federal "Marketplace" where individual insurance policies under the PPACA or "healthcare reform" are sold. You also will not be able to establish an **MRA** balance again unless your eligibility terminates and you again reestablish eligibility. If you wish to opt out, you should contact the Fund Office.

C. DENTAL BENEFITS

Dental Benefits are provided through a network from Delta Dental, and are summarized in Appendix B. Delta Dental will provide a list of providers within the network to you at no cost.

For Active Participants & Non Bargaining Unit Employees: Coverage is automatically provided to you and the cost of the Dental Benefit is included in the rates charged for eligibility. In other words, there is **no** additional premium to pay. Federal law requires that you have the option to decline Dental Benefits, even though they are provided at no additional cost. If you wish to decline Dental Benefits, please contact the Fund Office. Please note, however, that declining Dental Benefits will *not* result in a reduction of the cost to continue eligibility nor any additional funds being placed onto your paycheck from your **Employer**.

For Early Retirees and Retirees: There is an additional cost if you choose to have Dental Benefits. Special self-payment rates are available that include the Dental Benefit.

D. NON-MEDICAL BENEFITS

With the exception of Loss of Time Benefits, which are also available to Early **Retirees** under limited circumstances, **Non-Medical Benefits** are provided to Active **Participants** only. These benefits are summarized below. Please note that if you are an Active **Participant** that has opted out of coverage, you **are** still eligible for these benefits, but **only** if you continue to timely pay the opt-out fee. If you opt out of Health Insurance coverage and fail to pay the opt-out fee, you will **not** be eligible to receive **any Non-Medical Benefits**.

Accidental Death & Dismemberment Coverage. In the event of death or dismemberment due to violent or accidental means, the Plan will provide benefits as follows:

Type of Loss	Benefit Amount
Death	$2,500
One hand and one foot	$2,500
One hand or one foot + vision in one eye	$2,500
Both hands	$2,500
Entire sight of one eye	$1,250
One hand or one foot	$1,250
Entire sight in both eyes	$2,500

A "Loss" with respect to the Accidental Death & Dismemberment Benefit means the following: with reference to the hand or foot means complete severance through or above the wrist or ankle joint. With reference to the eye, "Loss" means the total and permanent or irrecoverable loss of the entire sight beyond remedy by surgical or other means thereof. Payments will be made directly to the eligible **Participant**, if still living and, otherwise, to his Beneficiary. If the person suffers more than one loss in any one accident, **payment shall be made only for that loss for which the largest amount is payable**. The Trustees reserve the right to modify or eliminate this benefit, either prospectively, or retroactively, as they, in their sole discretion, deem appropriate.

Burial Expense Benefits. The Plan will pay the following amounts provided the Fund Office is notified in writing within **one (1) year** of the date of the death, and provided with a true copy of the Certificate of Death:

- Death of **Participant**: $2,500
- Death of a **Retired Participant**: $2,500
- Death of **Spouse**: $2,000
- Death of **Dependent** child: $1,500

Loss of Time Benefits. The Plan will pay up to twenty-six (26) weeks of Loss of Time Benefits in the amount of $450 per week. You must sign a reimbursement agreement in a form acceptable to the Board of Trustees before receiving Loss of Time Benefits. The Trustees may, in their sole discretion, extend Loss of Time Benefits for periods of time in excess of 26 weeks. If you wish to apply for an extension of Loss of Time Benefits, you must contact the Fund Office and submit the appropriate form, which the Fund Office will provide to you. To qualify for Loss of Time Benefits (or an extension of existing benefits), you must:

- Be an eligible Active **Participant** on the date the disability begins;
- Become **Disabled** by a non-occupational accidental bodily injury, sickness, or disease;
- Be under the regular care of a qualified **Medical Provider**.

You will not receive any Loss of Time Benefits for any day during which you perform any work, whether for pay or profit, even if during such period you are still under the care of a **Medical Provider**.

Payment of Loss of Time Benefit. Benefit payments will be made during the period of disability, beginning: (1) with the 1st day of disability due to an accident or injury; or (2) with the 8th 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 provided that your **Medical Provider** provides the Plan with the required medical evidence or a certification of disability. This benefit will be coordinated and offset by other benefits you may receive. Therefore, before you begin to receive the Loss of Time Benefit, you must sign a Reimbursement Agreement with the Plan.

Disability Period. Concurrent disabilities will be treated as one disability. In order for you to qualify for additional Loss of Time Benefits, you must either (1) return to work for an **Employer** for at least 5 consecutive days; or (2) receive certification from your **Medical Provider** that you are able to return to employment.

Return to Active Employment. Once you return to work, you must notify the Fund Office on that date. If benefits are paid to you when you have returned to work and you failed to notify the Fund Office, you will be required to refund those payments to the Plan within ten (10) days.

Limitations. There are some circumstances where Loss of Time Benefits will not be paid. These exclusions are listed below.

- For any period of disability during which you are not under the care of a **Medical Provider**;
- For disability due to accidental bodily injuries arising out of and in the course of your employment;
- For 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 disabilities resulting from alcoholism or drug abuse;
- For any disability caused by or related to engaging in a criminal act;
- For cosmetic procedures, except where the procedure is needed as a result of an injury during an otherwise covered accident or event;
- For time lost due to an experimental procedures or surgery;
- Surgery to correct vision deficiency in lieu of corrective lenses or contacts;
- For time lost due to injuries incurred during military service;
- For dental procedures, unless related to an otherwise covered accident; or
- For time lost due to self-inflicted injuries; or
- For time lost as a result of any other exclusion under the Plan. See pages 27-28 for additional exclusions.

Benefits Taxable. Loss of Time Benefits **are** taxable. Your benefit will be reduced by the amount of tax applicable. At the end of a year in which you received Loss of Time Benefits, you will receive documentation detailing the amount of tax withheld.

Benefit Coordinated. This benefit will be coordinated and offset by other benefits you may receive. Therefore, before you begin to receive Loss of Time Benefits, you must sign a Reimbursement Agreement with the Plan.

Early Retiree Loss of Time Benefits. **Retirees** who meet the following criteria will be afforded a $450 weekly benefit for a period of one year. This Board of Trustees may, in their sole discretion, extend this benefit beyond one year. In addition to obtaining Board of Trustee approval, Early **Retirees** seeking to extend Loss of Time Benefits must apply for Social Security Disability and sign a Reimbursement Agreement in a form approved by the Board of Trustees. To apply for an extension, contact the Fund Office. To qualify for the Loss of Time Benefit, you must meet the following conditions:

- Be suffering from a physical or mental condition that has rendered you **Disabled**;
- Be under the regular care of a qualified **Medical Provider**;
- Were an eligible Active **Participant** at the time the disability arose; and
- Make timely self-payments to the Plan and have applied for benefits from the Social Security Administration.

Payment of Loss of Time Benefit. Benefit payments will be made during the period of disability, beginning: (1) with the 1st day of disability due to an accident or injury; or (2) with the 8th 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 provided that your **Medical Provider** provides the Plan with the required medical evidence or a certification of disability. This benefit will be coordinated and offset by other benefits you may receive. Therefore, before you begin to receive the Loss of Time Benefit, you must sign a Reimbursement Agreement with the Plan.

Disability Period. Concurrent disabilities will be treated as one disability. In order for you to qualify for additional Loss of Time Benefits, you must either (1) return to work for an **Employer** for at least 5 consecutive days; or (2) receive certification from your **Medical Provider** that you are able to return to employment.

Return to Active Employment. If you return to work, you must notify the Fund Office on that date. If benefits are paid to you when you have returned to work and you failed to notify the Fund Office, you will be required to refund those payments to the Plan within 10 days.

Limitations. There are some circumstances where Loss of Time Benefits will not be paid. These exclusions are listed below.

- For any period of disability during which you are not under the care of a **Medical Provider**;
- For disability due to accidental bodily injuries arising out of and in the course of your employment;
- For 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 disabilities resulting from alcoholism or drug abuse;
- For any disability caused by or related to engaging in a criminal act;
- For cosmetic procedures, except where the procedure is needed as a result of an injury during an otherwise covered accident or event;
- For time lost due to an experimental procedures or surgery;
- Surgery to correct vision deficiency in lieu of corrective lenses or contacts;
- For time lost due to injuries incurred during military service;
- For dental procedures, unless related to an otherwise covered accident; or
- For time lost due to self-inflicted injuries.

Benefits Taxable. Loss of Time Benefits are taxable. Your benefit will be reduced by the amount of tax applicable. At the end of a year in which you received Loss of Time Benefits, you will receive documentation detailing the amount of tax withheld.

Benefit Coordinated. This benefit will be coordinated and offset by other benefits you may receive. Therefore, before you begin to receive Loss of Time Benefits, you must sign a Reimbursement Agreement.

PART 5: WHAT RESTRICTIONS APPLY TO MY COVERAGE?

A. COORDINATION OF BENEFITS

Generally. Coordination of benefits (COB) sets out rules for order of payment of covered charges when two or more plans (other than a motor vehicle accident policy) cover the same individual. The COB rules apply generally to all benefits payable from this Plan other than **Non-Medical Benefits**. When any person is covered

by this Plan and another plan, this Plan will coordinate benefits when a benefit is received. 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 100% of the allowable expenses. Any person eligible for benefits under another plan that is primary over this Plan must comply with that plan's requirements. Only after full compliance and denial by another plan will this Plan provide benefits.

Employment. COB rules are in effect whenever any individual has coverage under this Plan and any other group insurance program, health and welfare fund, Medicare, or other health care plan. If any employer, who provides a health care plan other than this Plan, employs any person receiving benefits under this Plan (such as a spouse or child) then that employer's health insurance program will become the primary insurance carrier.

"Birthday Rule" for Dependents. If you and your **Spouse** are both entitled to benefits from separate insurance programs, and both plans cover your children, then the insurance plan that covers the **Spouse** with the earliest birthday in the year will be considered the primary insurance carrier. So, if your birthday is in June, but your spouse's is in April, then your spouse's insurance plan will be primary. If the birthdays of the two policyholders are on the same date, the policy of plan that has been in effect for the longer time will be primary. This Plan will provide coverage as set forth in this SPD if it is considered to be primary. Otherwise, the other plan will be required to pay the benefits up to the maximum amount payable in accordance with its schedule of benefits and this Plan will then pay any remaining amounts not covered by such other plan up to, and in accordance with, the coverage this Plan provides so that, in the aggregate, no more than 100% of the "covered charges" will be paid.

Car Accidents. In the case of a car accident, you should keep in mind that **this Plan does not pay for any claims related to a car accident**. Where the coordination of benefits clauses between this Plan and any policy of automotive insurance conflict, this Plan directly disavows coverage and shifts the burden to the automotive insurance carrier. **You should be review your auto insurance policy with your insurance agent or carrier of insurance to ensure you have selected the proper coverage options for your policy.**

COVERAGE TYPE	PRIMARY	SECONDARY
Policy that has no coordination provisions	Plan *without* coordination provision	Plan *with* coordination provision
Employer Provided Coverage	Plan covering person as employee	Plan covering person as spouse/dependent
Coverage for a Child	Plan covering parent whose birthday is earlier in the year	Plan covering parent whose birthday is later in the year
Coverage for a Child with Divorced Parents	Unless provided otherwise by court order, the plan covering parent with physical custody. In case of remarriage, stepparent with custody.	Unless provided otherwise by court order, the plan covering parent without physical custody.

Coordination of Benefits - Medicare. This Plan generally provides coverage secondary to Medicare. However, if you continue to work in **Covered Employment** past the age of 65, certain coordination of benefits rules must be followed. When coverage under this is coordinated with Medicare, the Plan follows the coordination of benefit rules proscribed by law. These rules are summarized below.

COVERAGE	PRIMARY	SECONDARY
At least one **Contributing Employer** has 20 or more **Employees,** and the **Participant** or **Spouse** of a **Participant** is 65 or older	This Plan	Medicare
No **Contributing Employer** has 20 or more **Employees,** and the **Participant** or **Spouse** of a **Participant** is 65 or older	Medicare	This Plan
Retired Participant or **Spouse** of a **Retired Participant**, who is 65 or older	Medicare	This Plan
At least one **Contributing Employer** has 100 or more **Employees,** and the **Dependent** or **Participant** is **Disabled**	This Plan	Medicare
No **Contributing Employer** has 100 or more **Employees,** and the **Dependent** or **Participant** is **Disabled**	Medicare	This Plan
Participant or **Dependent** with End-Stage Renal Disease (ESRD)	This Plan for the first 30 months of Medicare Eligibility. After 30 months, Medicare will become Primary.	Medicare for the first 30 months of Medicare Eligibility. After 30 months, this Plan will become Secondary.

B. THIS FUND'S RIGHT OF SUBROGATION

The Plan has subrogation rights, which means that it 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 also is 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. For more information about subrogation rights, contact the Fund Office, or consult the Plan Document.

C. EXCLUSIONS

There are some services that this Plan generally does not cover or only covers under certain conditions. Some of these exclusions are listed below, but this is not a complete list. If you are uncertain whether a particular condition or service is covered, you should contact the Fund Office.

- For treatment or procedures that are not medically necessary;
- For loss or expense from sickness, or disease, or as a result of any accidental bodily injury which arises out of or in the course of employment, which entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law;
- For services that would not be charged if there were no insurance;

- For pre-employment or insurance exams;
- For any period of hospital confinement that occurs before the effective date of eligibility, upon becoming eligible however, the Plan will assume coverage;
- For sterilization reversals;
- For payment of surcharge or nonresident tax levied by community hospitals;
- For installation of air conditioning units, humidifiers for environmental controls, whirlpools, air filters, bathroom rails, special toilet seats, commodes, chair lifts, or other non-essential home-installed conveniences even when prescribed by a physician, including ergometers and exercycles, bicycles, etc.;
- For elective surgery, including cosmetic surgeries that are not necessary by reason of sickness, injury or disease or for the protection of the health of the individual;
- For treatment of injuries sustained in an automobile, motorcycle or other motor vehicle accident or complications resulting from such injuries or accident.
- For television, telephone, guest trays or other non-essential personal items and services including take-home prescription drugs and supplies;
- Any deductible required by the plan or reimbursement of deductibles under the plan or prescription deductible, if any;
- For expense incurred (or from complications resulting from) for cosmetic surgery (other than medically necessary breast reconstruction) or experimental surgery, except as otherwise noted in coverage documents from BCBSM;
- For the use of a private room. If used, the average semi-private room rate of that hospital will be paid, except private room accommodations required by the hospital for treatment in quarantine purposes and not for the comfort of the patient;
- For hospitalization for dental care unless the dental condition adversely affects a medical condition and treatment of the dental condition is expected to improve the medical condition;
- For radial keratotomies (and/or for Lasik);
- For purchase of sun lamps required for any cause;
- For experimental procedures, supplies and devices;
- For temporomandibular joint (TMJ) services, except surgery to the jaw joint, x-rays (including MRI) and injection procedures.
- For custodial care;
- For weight loss drugs, and
- For donor expenses.

PART 6: HOW DO I FILE A CLAIM?

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 must first obtain the appropriate claim form(s) from the Fund Office, network administrator, or insurer. For Medical, Surgical, and Prescription Drug Benefits, the network administrator is Blue Cross Blue Shield of Michigan (BCBSM). For Dental Benefit claims, the insurer is Delta Dental. For more information, please contact the Fund Office.

Medical, Surgical, and Prescription Drug claims are submitted directly to BCBSM. Delta Dental will process claims under the Dental Benefit, and will be handled directly by Delta Dental. Claims for Non-Medical Benefits are filed with the Fund Office. With respect to your **MRA**, if you wish to be reimbursed by the Plan for a

covered expense, you must fill out a claim form and attached an **ORGINAL** copy of the bill (make a photocopy for your records) for which you are seeking to be reimbursed. You must then mail the claim form and the copies of the bills to the Fund Office. You may obtain a claim form by contacting the Fund Office at the number provided to you in this SPD. The bill that you submit along with your claim form must contain the following information:

- Name of plan;
- Employee's name;
- Employee's social security number;
- Name of patient;
- Name, address and telephone number of the provider of care;
- Diagnosis;
- Type of services rendered, with diagnosis and/or procedure codes; and
- Date of services; and charges.

All claims must be presented within **one year** of the date charges for the services were incurred. Claims filed later than that date may be declined/reduced. If you were unable to submit a claim within the one-year deadline, you may request a waiver by contacting the Fund Office. Each request for waiver of the one-year deadline will be reviewed on a case-by-case basis. Waivers, if able to be granted under law and/or any applicable contractual restrictions, will only be granted upon a showing of unique and extraordinary circumstances.

A. CLAIM TYPES & DECISION TIMEFRAMES

Claims for payment for services rendered to you are categorized, usually by the urgency of the claim. The types of claims and the rules that apply to each are summarized below. These definitions are summaries only. For the legal definitions of the various types of claims, you should consult the Plan Document.

Urgent Care Claims. These are emergency claims, claims that could jeopardize the health of the patient, or those that would cause the patient to be in severe pain without the care or treatment needed. Urgent care claims will be decided within 72 hours. If more information is needed to decide an urgent care claim, you will be notified within 24 hours of the receipt of the claim. You will then have at least 48 hours to provide the information needed. You will then be notified of the decision within 48 hours of the receipt of the information, or within the 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 3 days of the oral notification.

Concurrent Care Decisions. These are claims for an ongoing course of treatment to be provided over a period of time that was approved in advance. If the length of treatment approved is reduced, you will be provided with written notice within a sufficient amount of time for you to appeal that decision. If you request to extend a course of treatment approved, you will be notified within 24 hours of the receipt of your request for that extension, if you requested the extension at least 24 hours prior to the expiration of the approved length of treatment.

Pre-Service Claims. These are claims for care that are approved in advance. If enough information is available, Pre-Service claims will be decided within 15 days of the receipt of the claim. If more time is needed, this period may be extended by 15 days. You will be notified prior to the expiration of the initial 15-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 45 days

to provide that information. The claim will then be decided within 15 days of you supplying the information, or by the end of the 45-day period you had to supply that information, whichever time period expires first.

Post-Service Claims. These are claims submitted after you have obtained the treatment. If enough information is available, Post-Service claims will be decided within 30 days of the receipt of the claim. If more time is needed, this period can be extended by 30 days. You will be notified prior to the expiration of the initial 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 45 days to provide that information. The claim will then be decided within 15 days of you supplying the information, or by the end of the 45-day period you had to supply that information, whichever time period expires first.

Disability Claims. Disability claims will generally be decided within 45 days after the receipt of the claim. If more time is needed to decide your claim, this period can be extended period by 30 days. This period may be extended again for an additional 30 days. If this occurs, you will be given notice of this second extension prior to the end of the first 30-day period. The notice 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 45 days to provide that information. The claim will then be decided within 30 days of you supplying the information, or by the end of the 45-day period you had to supply that information, whichever time period expires first.

B. WHEN YOUR CLAIM IS DENIED

In the event your claim is denied, you will receive a notice that will explain the reasons for denying your claim and it will reference the section of the Plan Document or Schedule of Benefits upon which the denial is based. It will also explain your rights to file a civil action under ERISA, which is the federal law that regulates employee benefit plans. If applicable, the notice will also advise you of any additional information which is needed to make a further determination of your claim. The notice will also explain to you the process for filing an expedited appeal if the claim is of an urgent nature.

Internal Appeals. The appeals process is divided into two steps. For the first step, BCBSM will review your claim. Delta Dental will review claims for Dental Benefits. For the second step (i.e. appealing a denial of your claim) your appeal will be sent to the Board of Trustees. The procedures for each step are outlined below.

Step 1 Appeal. You have **180 days** from the mailing date of your claim denial to make your appeal. You may submit your appeal yourself, or you may have an authorized representative submit the appeal on your behalf. In addition, 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.
- 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 (A) was relied upon in making the benefit determination, (B) was submitted, considered or generated in the course of making the benefit decision, or (C) 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.

In addition, when considering your appeal, the reviewer:

- Will take into account 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 benefit determination by the Plan;
- Will not afford deference to the initial adverse benefit determination/denial of your claim;
- Will ensure a different person than the individual who initially denied your claim considers your appeal. Moreover, the individual considering your appeal will not be subordinate of the person who initially issued the denial;
- Will 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, investigational, or not medically necessary or appropriate. The entity that decides your claims (i.e. BCBSM, Delta Dental, etc.) will provide you the identity of this individual even if their opinion is not relied upon when considering your appeal.
- You will be notified of a decision from a Step 1 Appeal within the following timeframes:

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

If a Step 1 appeal is denied, you will once again receive a notice detailing the reasons for the denial, informing you of your right to appeal to the Board of Trustees, the rights and time limits under which you may bring a civil action, and also describing your other rights under the Plan and ERISA. The notice will also discuss procedures if your claim is of an urgent nature.

Step 2 Appeals. Following the denial of your first appeal, you will have **180 days** after your first appeal was denied to submit your claim to the Board of Trustees. The written notice only needs to state the claimant's name, address, and the fact that the claimant is appealing from an adverse decision and giving the date of the decision appealed from. The Board of Trustees will follow the same guidelines listed above for Step 1 appeals. The decision of the Board of Trustees is final; there is no further right to an appeal after the Board of Trustees has denied your claim. In the event of a denial by the Board of Trustees, you will receive a notice explaining the reason for the decision, and advising you of your rights relative to their decision under ERISA. You will also be notified if your claim is approved. You will receive notice of the Board of Trustees' decision generally within the following time frames:

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

PART 7: YOUR RIGHTS AND RESPONSIBILITIES

A. YOUR RIGHTS UNDER ERISA

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, also called "ERISA." ERISA provides that all plan participants are entitled to:

- Examine, without charge, all plan documents, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated

summary plan description and insurance contracts 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 Fund Office's office and at other specified locations such as the work site or the union hall.

- Obtain, upon written request to the Fund Office, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Fund Office may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Fund Office is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your **Dependents** may have to pay for such coverage.
- 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 plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The Board of Trustees, who operates this Plan, are "fiduciaries" of this Plan. This means they have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No person or company, 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 30 days, you may file a suit in a federal court. In such a case, the court may require the Fund Office to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Office.
- 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 it should happen that the Plan's fiduciaries misuse the Plan's money, or 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 a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision concerning a QDRO or Medical Child Support Order, you may file suit in federal court. 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 Fund Office 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.

B. HIPAA, HITECH, AND GINA PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and The Health Information Technology for Economic and Clinical Health (HITECH) Act, 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 Fund Office. If you have questions about the privacy of your health information please contact the Fund's legal counsel, set forth above. If you wish to file a complaint under HIPAA, please contact the Fund Office. In addition, under the Genetic Information Non-Discrimination Act (GINA), the Plan will not discriminate on the basis of and cannot request genetic information when making determinations regarding your eligibility for coverage.

C. NOTIFYING THE FUND OF CHANGES, SPECIAL ENROLLMENT EVENTS

Under some circumstances, you will be required to notify the Fund Office of certain events. Your failure to do so may affect your coverage. Some of these events also qualify as "special enrollment" events that allow you to add persons to coverage outside of the normal enrollment period. Accordingly, the Fund Office must be notified of any changes regarding the following:

- **Marriage** - To add a spouse and any eligible stepchildren to coverage, the marriage must be reported within 30 days. A copy of the certificate of marriage must be filed with the Fund Office. The **Spouse** and any eligible stepchildren will then be covered from the moment of marriage.
- **New Children** - To add a child to coverage, the birth must be reported within 30 days by providing the Fund Office with a copy of. A copy of the birth certificate must be filed with the Fund Office. The child will then be covered from the moment of birth.
- **Adoptions** - Adoption or placement of a child must be reported within 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 Fund Office. Coverage will then be effective as of the date of the adoption or placement for adoptions.
- **Change of Address** - Any change of address must be reported within 30 days.
- **Name Change** - Any name change must be reported within 30 days.
- **Deaths** - Deaths should 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 Fund Office. A former **Spouse** is no longer eligible for benefits as of the date of the divorce, except as provided under COBRA. Eligible **Dependent** Children will continue to be covered if they continue to qualify as **Dependent** children under this Plan.

- **Change of Employment Status**. If you or your **Spouse** switches employers, returns from a leave of absence, moves to full or part-time employment, then you must notify the Fund Office within 30 days.

PART 8: WHAT HAPPENS WHEN CIRCUMSTANCES CHANGE?

A. AMENDMENT & TERMINATION

If changes are made to the provisions of this Plan or the coverage it provides, you will receive a notice from the Fund Office. These notice are typically referred to as a "Summary of Material Modifications" or "SMM" for short. While the Board of Trustees has broad authority to make changes, it may not amend the Plan in a way that would: (1) 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 (2) cause any part of the Plan's assets to revert to the contributing **Employers**. The Plan may also be terminated, in whole or in part, merged, or combined with another plan. The Board may also terminate the Plan when a **Collective Bargaining Agreement** requiring **Employer Contributions** no longer exits.