

**FLINT PLUMBING
AND
PIPEFITTING INDUSTRY
HEALTH CARE FUND**

**SUMMARY PLAN DESCRIPTION
2021**



PREFACE

The Board of Trustees of the Flint Plumbing and Pipefitting Industry Health Care Fund (the Trustees) describe the benefits provided by the Flint Plumbing and Pipefitting Industry Health Care Fund (the Fund) by a plan document titled “Flint Plumbing and Pipefitting Industry Health Care Fund Plan” (Plan). It is intended that the Plan shall conform to the requirements found in the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time. If any portion of the Plan does now, or in the future, conflict with ERISA or applicable federal regulations, ERISA and/or such regulations will govern.

Although the Trustees expect to continue the Fund indefinitely, they reserve the right to change or terminate the Fund at any time and for any reason, for any group or class of Participants or Dependents, as well as for all such groups. Correspondingly, the Trustees may change the level of benefits provided, or eliminate an entire category of benefits, at any time and/or for any reason. There are no vested benefits under the Plan for Active Employees or Retirees.

The Fund is subject to all terms, provisions and limitations stated in the Plan which are described in this summary plan description (“SPD”). **If there is any conflict between the terms of this SPD and the Plan, the Plan controls.**

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ARTICLE 1 – DEFINITIONS

Active Employee means a Journeyman, Apprentice, Serviceman, Union Employee, Apprenticeship Fund Employee, or other person on whose account an Employer makes Contributions to the Fund based upon current employment.

Apprentice means a person learning the trade and designated as an Apprentice under the Collective Bargaining Agreement.

Apprenticeship Fund Employee means an instructor or other employee of the Local 370 Apprentice and Journeymen Training Fund (Apprenticeship Fund) on whose behalf the Apprenticeship Fund makes Contributions to the Fund.

Association means Flint Association of Plumbing & Mechanical Contractors, Inc.

Children or Child means:

- (a) Any person up until the first of the month following the month in which he/she turns age 26 and either:
 - (1) is a Participant's natural child or adopted child; or
 - (2) has been placed with a Participant for adoption; or
 - (3) is a Participant's stepchild, which means he/she is the child of his/her Spouse; or
- (b) A person who would qualify as a "child" under paragraph (a) but for the age limitations, who by reason of mental or physical handicap is incapable of sustaining employment and the Participant has submitted proof of such acceptable to the Trustees to the Fund Office within 31 days of the date upon which he/she attains 26 years of age; or
- (c) An alternate recipient under a Qualified Medical Child Support Order of a Participant.

Collective Bargaining Agreement means any contract entered into between the Union and the Association or any Employer under which the Employer has agreed to contribute to the Fund.

Contributions or Employer Contributions mean contributions received by the Fund by an Employer as required under a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act. Contributions become vested plan assets at the time they become due and owing.

Covered Employment is employment covered by the Collective Bargaining Agreement, or employment for which Contributions have been or are required to be made to the Fund on behalf of a Participant.

Covered Person means the Participant or Dependent who is eligible for a particular benefit.

Dependent means a Participant's Spouse or Child.

Employer means:

- (a) a member of the Association who is bound by the terms of a Collective Bargaining Agreement between the Union and the Association to make Contributions to the Fund;
- (b) any other employer engaged in work coming within the jurisdiction of the Union who is obliged, by a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act, to make Contributions to the Fund;

- (c) the Union to the extent, and solely to the extent, that it acts in the capacity of an employer of its business representatives or other employees on whose behalf it makes Contributions to the Fund; and
- (d) the Apprenticeship Fund, to the extent and solely to the extent that it acts in the capacity of an employer of employees on whose behalf Contributions are made to the Fund.

Fund means the Flint Plumbing & Pipefitting Industry Health Care Fund.

Fund Office or Plan Office means Flint Plumbing & Pipefitting Industry Health Care Fund, 6525 Centurion Drive, Lansing, MI 48917, (517) 321-7502 or (888) 797-5862.

Illness means a bodily disorder, disease, physical sickness, or mental disorder, including pregnancy, childbirth, miscarriage, or complications of pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Participant means an Active Employee, Retiree, or Surviving Spouse.

Plan means this document, i.e. the Flint Plumbing and Pipefitting Industry Health Care Fund Plan.

Plan Year means the fiscal year August 1 through July 31 of the following year.

Retiree means an individual who:

1. Has at least 8,700 hours in Contributions remitted to the Plan in the 10 years immediately preceding his retirement; and
2. Is eligible in this Plan at the time of his retirement as an Active Employee and immediately upon retirement elects to continue coverage as a Retiree;
3. Is receiving an Early, Normal or Disability Pension Benefit from the Flint Plumbing & Pipefitting Industry Pension Fund; and
4. Is and remains a member in good standing with the Union.

Short Term Disability means a Participant is unable to perform Covered Employment.

Spouse means the Active Employee's or Retiree's legal spouse.

Surviving Spouse means the person who was married to an Active Employee or Retiree on the date of the Participant's death.

Totally Disabled means a Covered Person has a current Social Security Disability Award.

Trustees mean the Trustees of the Fund as appointed by the Flint Plumbing & Pipefitting Industry Health Care Fund Trust Agreement.

Union means UA Local 370 Plumbers, Pipefitters and Service Trades.

ARTICLE 2 – ELIGIBILITY RULES

2.1 Active Employees

(a) Initial Eligibility

The Participant will become initially eligible on the first of the second month following the month in which the participant has been credited with at least \$3,850 of employer contributions within a 12-month period, as set forth below:

If credited with at least \$3,850 (in a 12-month period) as of:	Then will establish initial eligibility as 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

Amounts received on behalf of a Participant from the Funded Market Recovery Program (FMRP) shall be treated the same as employer contributions, for the purpose of establishing eligibility only. Amounts paid by the FMRP represent an interest free loan to the Fund made from time to time to establish eligibility for a Participant. When and if FMRP contributions will be contributed is determined in the sole and exclusive discretion of the FMRP.

- (b) **Continuing Eligibility/Dollar Bank.** Any Employer Contributions received in excess of the initial eligibility requirement are added to the Active Employee's Dollar Bank. Each month, a monthly dollar requirement necessary to remain eligible (Monthly Requirement) is deducted from the Active Employee's Dollar Bank to maintain eligibility. The Monthly Requirement is set from time to time in the sole discretion of the Trustees. As of August 1, 2017, the Monthly Requirement is \$1,040 per month.

An Active Employee can bank a maximum of \$16,000 in his/her Dollar Bank. (If Participants had \$16,200 in their Banks as of 3/1/14, their Banks can remain at \$16,200, but no further credit will be given until such Banks fall below \$16,000 and thereafter may not exceed \$16,000.)

Notwithstanding anything in this section to the contrary, where a Participant's initial eligibility has been paid via contributions from the Funded Market Recovery Program, any employer contributions received each month on behalf of such Participant in excess of the Monthly Requirement shall be remitted to the FMRP until it has been reimbursed the amount expended to provide such initial eligibility.

Employer Contributions are credited to an Active Employee's Dollar Bank as follows:

Work Month:	Contributions Received for This Work Month Credited to Dollar Bank in the Following Month:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

The above schedule allows for one bookkeeping month. Notwithstanding, if an Active Employee submits proof that he/she has other comprehensive medical coverage that will be cancelled once eligibility in the Fund is established, the bookkeeping month will be waived and coverage may commence the first of the month following the month in which he has met Initial or Continuing Eligibility requirements.

A Participant's Dollar Bank is forfeited if he/she works for a noncontributing employer in the plumbing and pipefitting industry in the jurisdiction of the Union.

- (c) **Self-Payments.** If an Active Employee's Dollar Bank has less than the Monthly Requirement, he/she can continue to be eligible by paying the difference between the amount in his/her Dollar Bank and the Monthly Requirement. This is the "self-pay rate." The self-pay rate can change at any time in the sole discretion of the Trustees.

In the event an Active Employee has less than one month's reserve in his/her Dollar Bank and elects not to self-pay to continue coverage, such balance will be frozen and used in the event he/she re-establishes eligibility within 18 months.

The Fund Office will send monthly self-pay notices and payment is due to the Fund Office within 10 days of the date of this self-pay notice. Once an Active Employee fails to timely make a self-payment, he/she will be offered COBRA coverage.

To be entitled to self-pay, an Active Employee must be available for work for a contributing Employer, on the Union's out of work list, and not working for a noncontributing employer in the plumbing and pipefitting industry in the jurisdiction of the Union. Where there is no balance in the dollar bank, an employee must pay the entire Monthly Requirement, known as a "full self-payment." No individual can make full self-payments for longer than 18 consecutive months, unless they can provide proof, acceptable in the sole discretion of the trustees, that they have met these requirements for such 18 months and continue to do so.

An Active Employee who is not eligible for self-pay will be offered COBRA coverage and all months for which self-payments were previously made will be counted towards his/her maximum allowable time on COBRA.

- (d) **Reinstatement of Eligibility for Active.** An Active Employee whose eligibility has terminated will be reinstated when sufficient funds are credited to his/her Dollar Bank to meet the Monthly Requirement. Notwithstanding, if an individual has been ineligible for more than 18 months, he/she must again satisfy the initial eligibility requirements of section 2.1(a) to be reinstated.
- (e) **Supplemental Benefit.** Funds in the Dollar Bank can be used for the Supplemental Benefit, as set forth in Article 6.
- (f) **Work for Noncontributing Employer.** Notwithstanding any term of this Plan to the contrary, all coverage will terminate for an Active Employee who works for a noncontributing employer in the plumbing and pipefitting industry in the jurisdiction of the Union and he/she will be offered COBRA coverage.

2.2 Short Term Disability Coverage for Active Employees

When an Active Employee has a Short-Term Disability, continued eligibility is provided via his/her Dollar Bank as set forth in this section.

An Active Employee's Dollar Bank will be credited each weekday he/she has a Short-Term Disability in an amount equal to the Monthly Requirement divided by 20, but not to exceed the Monthly Requirement per month. This is referred to as the "Short Term Disability Credit." If necessary to maintain eligibility, an Active Employee may self-pay the difference in Short Term Disability Credit and the Monthly Requirement. Short Term Disability Credit begins the date of injury or one week following the onset of Illness.

Short Term Disability Credit is only available if an Active Employee:

- (1) submits proof sufficient, in the sole discretion of the Trustees, that he/she is unable to perform Covered Employment, and
- (2) either:
 - (A) he/she is eligible for payment of Weekly Disability (Loss of Time) Benefits under the Plan, or
 - (B) is eligible for weekly worker's compensation benefits as a result of a disability incurred while working in Covered Employment within the jurisdiction of Local Union 370.

To be eligible for Short Term Disability Credit, an Active Employee and his physician must complete and submit a form provided by the Fund, and the information provided must be acceptable, in the sole discretion

of the Trustees, to establish a Short-Term Disability. The Trustees have the right to have an Active Employee medically examined by a physician chosen by the Trustees, at the Fund's expense, to assist in their determination as to whether an Active Employee has a Short-Term Disability.

Short Term Disability Credit is provided for a maximum of 26 weeks for any single period of disability. All Short-Term Disability absences will be considered a single period of disability, regardless of whether the disabilities are related, until a Participant returns to Covered Employment and the number of hours worked upon such return multiplied by the applicable contribution rate equals the Monthly Requirement.

Once eligibility is exhausted under this section, an Active Employee may continue coverage via the remaining credit in his/her Dollar Bank or by self-payments.

2.3 Active Employee Absence Due to Military Service

- Coverage for an Active Employee or Dependent under the Plan will terminate upon entry into military service. Military service means that service covered under the Uniformed Services Employment and Reemployment Act, 38 USC §4303.
- If coverage under the Plan is terminating due to military service, a Covered Person may elect to continue the health coverage under the Plan for up to 24 months after the absence begins, or for the period of military service, if shorter. The Covered Person must notify the Plan Office as soon as he volunteers for or is called to active duty. The maximum premium that will be charged is 102% of the full premium for the coverage. However, if the military service is for 30 or fewer days, the maximum premium will be the self-payment amount.
- Upon termination for military duty, a Participant's eligibility shall be frozen, with reinstatement under that same status upon his/her discharge from the military. Exclusions and waiting periods will not be imposed upon re-employment provided coverage would have been afforded had the person not been absent for military service, unless there are disabilities that the Veterans Administration determines to be service related. For these benefits to apply, however, the period of service must be less than five years and a Participant must return to Covered Employment within 90 days after completion of the service.

2.4 Retiree Coverage

- (a) **General.** Upon meeting the definition of Retiree, a Retiree and his/her Dependents become eligible for Retiree coverage. If an otherwise eligible individual does not elect to continue coverage as a Retiree immediately upon retirement, he/she will not be allowed to participate at a later date.
- (b) **Required Medicare Enrollment.** All Medicare eligible Retirees and Dependents are required to enroll in Medicare Parts A and B (but not Part D Prescription Drug coverage) as soon as he/she becomes eligible for Medicare coverage and must immediately forward a copy of his/her Medicare card to the Fund Office. Failure to do so will result in the individual becoming responsible for the costs of medical expenses that otherwise would have been covered by Medicare.
- (c) **Self-Payments.** Retirees are required to make monthly self-payments to maintain coverage. The self-payment amount is established from time to time in the sole discretion of the Trustees. Failure to timely make a self-payment will result in the loss of coverage which cannot be reinstated. Notwithstanding, if the Trustees determine, in their sole discretion, that an former Participant who never had Retiree coverage and who is receiving a disability pension from the Flint Plumbing & Pipefitting Industry Pension Fund, had a lapse in coverage because he/she was incapacitated from making self-payments on his/her own behalf, then on a one time only basis this former Participant may

be allowed to retroactively elect Retiree coverage to the date coverage lapsed, not to exceed one year retroactive reinstatement, upon payment of any and all missed self-payments. The Fund Office will send monthly self-pay notices and payment is due to the Fund Office within 10 days of the date of this self-pay notice.

The extent to which Retiree self-payments do not cover the full cost of coverage is the Retiree Subsidy. The Retiree Subsidy for pre-Medicare Retirees is the difference between the Active Monthly Requirement (see section 2.1(b)) and the pre-Medicare Retiree self-payment rate established by the Trustees. The Retiree Subsidy for Medicare Retirees is the difference between the premium for coverage under the Medicare Policy (see section 5.2) and the Medicare Retiree self-payment rate established by the Trustees. The amount of the Retiree Subsidy is determined in the sole discretion of the Trustees and can be changed or eliminated at any time.

- (d) **Return to Work.** A Retiree who returns to work will be covered as a Retiree until sufficient funds are credited to his/her Dollar Bank to meet the Monthly Requirement as an Active Employee. Notwithstanding, if an individual has not been an Active Employee for more than 18 months, he/she must again satisfy the initial eligibility requirements of section 2.1(a) to be reinstated as an Active Employee.

A Retiree who engages in non-bargaining unit work in the plumbing and pipefitting industry (for example, sales, estimating, project manager, and safety) will not receive the Retiree Subsidy as set forth in Section 2.4(c) and must pay the full cost of coverage as determined in the sole discretion of the Trustees. A Retiree has an obligation to notify the Fund Office before he returns to work, or if that is not feasible as soon as possible. Such an individual will be eligible for the Retiree Subsidy again the first month following written notice to the Fund Office that he is no longer working, provided there has been no lapse in his Retiree coverage under the Fund (in which case coverage would permanently terminate).

2.5 Termination of Coverage for an Active Employee or Retiree

Notwithstanding any term of this Plan to the contrary, coverage for an Active Employee or Retiree terminates the earliest of the following:

- (1) Failure to meet the requirements for continuing eligibility, including a failure to make any self-payment in a timely manner; or
- (2) Plan amendment which results in the termination of coverage; or
- (3) Termination of the Plan.

2.6 Dependents

- (a) **In General.** Dependents are eligible for coverage under this Plan when the Participant upon whom they are dependent is eligible. Notwithstanding any term of the Plan to the contrary, Dependent coverage terminates when such individual no longer meets the definition of Dependent.

A new Dependent should be enrolled within 30 days of marriage, birth, adoption, or placement for adoption and if so enrolled a Spouse will become eligible for coverage as of first day of the first month following the date of marriage and a Child's coverage will be effective the date of birth, adoption, or placement for adoption. If a Dependent is enrolled after these 30 days, retroactive coverage cannot be guaranteed, and any retroactive coverage will be limited to that allowed by BCBSM policies and procedures.

- (b) **Dependent Coverage upon Death of the Participant.** Notwithstanding the above, if an Active Employee or Retired Participant dies, his/her surviving Dependents will continue coverage, without self-payment, so long as they continue to meet the definition of Dependent and until the later of:

- (1) The normal eligibility termination date based on the Participant's Dollar Bank as if death had not occurred; or
- (2) The last day of the third calendar month following the month in which the Participant died.

Thereafter, coverage may continue so long as self-payments, established from time to time in the sole discretion of the Trustees, are timely made for individuals who continue to meet the definition of Dependent.

- (c) **Termination of Dependent Coverage.** Notwithstanding any term of the Plan of the Plan to the contrary, Dependent coverage terminates upon the first of the following:

- (1) Failure to make timely self-payments;
- (2) Failure to meet requirements for continuing coverage, including failure to meet the definition of Dependent;
- (3) Remarriage of Dependent Spouse;
- (4) Termination of coverage of the Participant upon whom coverage is based; or
- (5) Termination of the Plan.

2.7 Opt Out.

- (a) **Opting Out of Full Plan Coverage.** One time per year upon receipt by the Fund Office of a written request acceptable to the Trustees, an Active Employee may opt out of the benefits provided by the Fund if:

- (1) He/she is actually enrolled in a group health plan that does not consist solely of excepted benefits (e.g., can be a spouse's plan) (Other Coverage); and
- (2) The Other Coverage meets the Affordable Care Act minimum value standard.

Medicare is not "Other Coverage" for purposes of this provision.

- (b) **Freezing of Dollar Bank.** Upon opting out, an Active Employee's Dollar Bank will be frozen. "Freezing" the Dollar Bank means:

- (1) Eligibility for the Active Employee and his/her Dependents will terminate the first of the month following the receipt of the request to opt out, except the Active Employee will remain eligible for life insurance and the Supplemental Benefit provided under Article 4;
- (2) The Active Employee's Dollar Bank will continue to be credited with ½ of the Employer Contributions received while the Dollar Bank is frozen less the cost of life insurance, up to the maximum Dollar Bank limit set forth in Section 2.1(b); and
- (3) Active Employee's will maintain their "frozen" bank until there have been no contributions made on the Active Employee's behalf for 18 months. After there have been no contributions for 18 months, the remaining balance in the Active Employee's dollar bank will be forfeited, and there will be no further eligibility under (a) or credit given under (b), above.

If any contributions are received on behalf of the Active Employee thereafter, eligibility must be re-established per the Initial Eligibility Provisions of the Plan.

(c) Reinstatement of Full Coverage

- (1) One Year After Effective Date of Opt Out.** An Active Employee may reinstate full coverage no sooner than one year after the effective date of his/her opt out by forwarding a written request for reinstatement to the Fund Office acceptable to the Trustees.
- (2) Within One Year of Effective Date of Opt Out.** An Active Employee may reinstate full coverage within one year of the effective date of opting out only under the following conditions:
 - (A)** Acquisition of a new Dependent as a result of marriage, birth, adoption, or placement for adoption, if a request to re-enroll for full coverage is made within 30 days of such event. An election change for marriage shall be effective the first day of the first month following the requested change. An election change for birth, adoption, or placement for adoption shall be effective the date of birth, adoption, or placement for adoption.
 - (B)** If each of the following conditions are met:
 - (i)** The Active Employee was covered under a group health plan or had health insurance coverage ("Other Coverage") at the time he made his election to opt out;
 - (ii)** The Participant executed an Acknowledgment at the time of his election for Opt Out coverage verifying he/she had Other Coverage;
 - (iii)** The Participant's Other Coverage:
 - (a)** was COBRA coverage and which has been exhausted; or
 - (b)** was non-COBRA coverage which has been terminated as a result of:
 - (I)** loss of eligibility due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of the plan for similarly situated individuals, or cessation of Dependent status; or
 - (II)** employer contributions toward such coverage were terminated; and
 - (iv)** The Participant requests re-enrollment in full coverage within 30 days of the termination of the Other Coverage.

An election change for the reasons set forth above shall be effective the first day of the first month following the requested change.

- (C)** An Active Employee taking leave under the Family Medical Leave Act may change his election for the period of time he/she is on such leave.
- (D)** The Active Employee loses eligibility for Medicaid or State Children's Health Insurance Program ("CHIP") coverage, or becomes eligible to participate in a premium assistance program under Medicaid or CHIP. In both instances, the employee must request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

- (3) **Dollar Bank Upon Reinstatement.** Upon reinstatement, the Active Employee's Dollar Bank will be "unfrozen" and coverage reinstated the first day of the month following the request to re-enroll, provided the Active Employee has returned to Covered Employment in the jurisdiction of the Union and the amount in the Dollar Bank is sufficient to cover the Monthly Requirement in effect as of the date of the request for reinstatement.

2.8 Reciprocity

The Trustees have entered into reciprocal agreements with the Trustees of similar UA health and welfare funds. Under these agreements, contributions for hours worked in the jurisdiction of another UA local may be transferred to this Fund for use in continuing eligibility.

The amounts to be transferred and the way those transfers are credited to Participants are governed by the Reciprocity Agreements and by the administrative procedures adopted by the Trustees, in their sole discretion, from time to time.

2.9 Trustee Discretion

The Trustees, in their discretion, have the authority to change any term or condition of this Plan at any time, including but not limited to the provisions regarding eligibility.

2.10 Notification to Fund Office

Each Participant and adult Dependent has an obligation to keep the Fund Office informed of changes in address, marital status, beneficiary, and dependents.

2.11 Nonbargaining Unit (NBU) Participation

The Trustees may enter into participation agreements to allow coverage under the Fund for NBU participants under the following conditions:

- (1) The Employer must sign a participation agreement provided by the Trustees.
- (2) The Employer must:
 - (a) Have an office in the jurisdiction of Local 370;
 - (b) Have a current CBA with Local 370;
 - (c) Currently employ, and continue to employ as a condition of participation, bargaining unit employees; and
 - (d) Be current in contributions to all Local 370 funds for bargaining unit employees, and current in contributions to this Fund for NBU participants.

Failure to meet these conditions will be considered a fraud on the Fund, in which event the Employer shall be liable to reimburse the Fund for the costs of all claims incurred for the period of time for which any such condition was not met.

- (3) NBU participants must be employees of the Employer.
- (4) NBU participants have no Bank (and thus no Supplemental Benefit).
- (5) Contributions for each NBU participant must be made at the journeyman rate under the Local 370 CBA for 40 hours per week, 52 weeks per year. No self-payments are allowed to maintain coverage if contributions are not timely received. Eligibility will be terminated where contributions are not timely received and will not be reinstated. No COBRA coverage will be offered if eligibility is terminated due to the Employer's failure to timely pay contributions. Contributions are due for each NBU participant 15 days prior to the month of coverage.

- (6) NBU participants and their Dependents are eligible for medical, prescription drugs, and dental coverage under Article 5. Life insurance coverage will be available only if such coverage is approved by the life insurance carrier.
- (7) NBU participants are not entitled to Weekly Disability Benefits, nor extended eligibility for disability.
- (8) No Dependent coverage is available upon the death of the NBU participant. Dependents will be offered COBRA.
- (9) No retiree coverage is available for NBU participants.
- (10) The Employer is responsible for determining which of its employees will participate. The Employer agrees it is the Employer's responsibility to ensure the benefits it provides to its employees are provided on a nondiscriminatory basis and agrees to indemnify and hold harmless the Fund for any costs or expenses incurred if the Employer fails to do so.
- (11) The Fund will not accept any NBU participation if the total number of NBU participants reaches the 10% limitation applicable to VEBAs under IRC §501(c)(9).
- (12) The Trustees retain the right to change or eliminate the benefits or participation of NBU participants. An election to participate can only be made once per year by an Employer, and if elected the Employer is bound to make contributions for entire year for each of its NBU participants. If the employment of any such NBU participant with the Employer terminates, he/she will be offered COBRA pursuant to the terms of Article 8.

This section 2.11 does not apply to the Union or Apprenticeship Fund.

ARTICLE 3 – WEEKLY DISABILITY BENEFITS (LOSS OF TIME) – ACTIVE EMPLOYEES ONLY

An Active Employee who as the result of a non-occupational accidental bodily Injury or Illness is unable to perform Covered Employment is eligible for a Weekly Disability Benefit in the amount of \$200 per week. An Active Employee must complete an application, supported by a physician statement, on a form provided by the Fund Office. If requested, the applicant must submit to an independent medical examination with a physician selected by the Fund. No benefits are payable under this benefit provision for any period or day of disability for which the Employee is not under the regular care and attendance of a physician. A Chiropractor is not considered a physician for the purposes of disability benefits.

Weekly Disability Benefits are provided for a maximum of 26 weeks for any single period of disability. All disabilities will be considered a single period of disability, regardless of whether the disabilities are related, until a Participant returns to Covered Employment and the number of hours worked upon such return multiplied by the applicable contribution rate equals the Monthly Requirement.

Weekly Disability Benefits begin the date of Injury or one week following the onset of Illness. No Weekly Disability Benefits are payable on or after the date an Employee retires. Weekly Disability Benefits are not assignable. Weekly Accident Disability Benefits are also subject to all General Plan Exclusions and Limitations.

ARTICLE 4 – LIFE INSURANCE

4.1 Insured Basic Life and Accidental Death and Dismemberment Benefits – Active Employees

Active Employees are eligible for coverage under a fully insured life insurance policy purchased by the Fund. The amount of coverage is \$30,000 basic life and \$10,000 accidental death and dismemberment. Further information, including limitations and exclusions to coverage, are set forth in the life insurance policy. **If there is any conflict between the terms of the Plan, this SPD or the terms of the life insurance policy, the terms of the life insurance policy control.**

4.2 Retirees

Retirees are eligible for \$9,000 basic life coverage. A Retiree may continue life insurance even if he/she ceases all other coverage under the Fund if he/she continuously makes a monthly self-payment for this coverage. The amount of such self-payment shall be determined from time to time in the sole discretion of the Trustees.

4.3 Beneficiary Designation

You must file a written designation of Beneficiary with the Fund Office on a properly completed form. If you have not made an irrevocable designation of Beneficiary, you may name a new Beneficiary without your prior Beneficiary's consent, by filing a new form with the Fund Office. The change of Beneficiary will be effective on the date received by the Fund Office and prior to your death, regardless of the date you sign the form. If you do not designate a Beneficiary or if your Beneficiary does not outlive you, then Beneficiary shall mean the following who survive you in the following order: (1) Spouse; (2) Children, including legally adopted children; (3) Parents; (4) Brothers and sisters; or (5) Estate. If two or more persons are entitled to the benefit as Beneficiaries, they will share equally.

4.4 Claims and Appeals/Conflicts

All claims and appeals regarding insured life insurance benefits shall be determined by the procedures set forth in the applicable life insurance policies and not pursuant to Article 7. **In the event of any conflict between the provisions of this Plan and the insurance policy, including the proper determination of the beneficiary, the terms of the insurance policy and the determination by the insurance company controls.**

ARTICLE 5 – MEDICAL/PRESCRIPTION DRUG/DENTAL BENEFITS

5.1 Medical/Prescription Drug Benefits – Non-Medicare Eligible Covered Persons

Self-insured medical and prescription drug benefits for non-Medicare eligible Participants and Dependents are administered by Blue Cross Blue Shield of Michigan (BCBSM). Please refer to the applicable BCBSM Benefits Guide for a description of the benefits available under each plan, available at www.bcbsm.com. The coverage provided under each respective BCBSM program is subject to the exclusions and restrictions set forth in the BCBSM Benefits Guides and in this document.

5.2 Medical/Prescription Drug Benefits – Medicare Eligible Covered Persons

Medicare eligible Participants and Dependents are provided medical and prescription drug coverage via a fully insured Medicare coordinated policy. The terms and conditions of such coverage are set forth in the Medicare Policy. Non-Medicare eligible dependents of Medicare eligible Participants are covered under the Fund's self-insured medical and prescription drug plan.

Coverage under the Medicare Policy may be limited if such person has not timely applied for and obtained Medicare. It is the Participant's or Dependent's responsibility to timely obtain Medicare coverage (i.e. as soon as eligible to do so). This obligation applies whether Medicare eligibility is based on age, disability, or end stage renal disease. If a Participant or Dependent does not timely obtain Medicare coverage, he/she is directly responsible for the medical and prescription drug costs that otherwise would have been covered by Medicare or the Medicare Policy.

All Medicare eligible Participants and Dependents will automatically be enrolled in the Medicare Policy at the earliest enrollment opportunity after Medicare eligibility is obtained.

If a Participant has other coverage under a Spouse's plan or any other type of medical plan (Other Coverage), he/she must contact the Fund Office so benefits can be properly coordinated. If he/she does not do so, he/she

may be responsible for the costs of medical expenses that otherwise would have been paid by the Other Coverage.

5.3 Dental Benefits

Self-insured dental benefits for eligible Active Employees, Retirees, and their Dependents are administered by Blue Cross Blue Shield of Michigan (BCBSM). Please refer to the applicable BCBSM Benefits Guide for a description of the benefits available under each plan, available at www.bcbsm.com. The coverage provided under each respective BCBSM program is subject to the exclusions and restrictions set forth in the BCBSM Benefits Guides and in this document.

5.4 Coordination of Benefits

(a) Application

This provision shall apply in determining the benefits for an allowable expense if the sum of:

- (1) the benefits that would be payable under the Plan in the absence of this provision; and
- (2) the benefits that would be payable under any other plan in the absence of a coordination of benefits provision, would exceed the allowable expense payable under this Plan.

Benefits payable under another plan include the benefits that would have been payable had the claim been duly filed under that plan.

Notwithstanding anything in this section to the contrary, a Participant or Dependent will never receive less if covered by two or more plans than he would receive if covered by this Plan alone; provided, however, that this Plan will pay no more than an amount which would bring total coverage up to the amount which would have been provided under this Plan.

(b) Coordination

Plan rules regarding coordination:

- (1) Another plan without a coordinating provision shall always be deemed to be the primary Plan.
- (2) If another plan has a provision that makes this Plan primary, then:
 - (A) The plan covering the patient directly rather than as a dependent is primary and the other is secondary.
 - (B) If a child is covered under both parents' plans, the plan that covers the parent whose birthday occurs earlier in the calendar year shall be considered the primary plan.
 - (C) If neither (A) nor (B) applies, the plan covering the patient longest is primary.
- (3) With respect to dependents of divorced parents, the following rule applies:
 - (A) if there is a court decree, the plan that covers the dependent of the parent with responsibility to do so pursuant to such decree shall be primary;
 - (B) if (A) does not apply:
 - (i) the plan covering the parent with custody of the dependent shall be considered the primary plan;

- (ii) the plan covering the spouse, if any, of the parent with custody of the dependent will be secondarily liable; then
 - (iii) the plan covering the parent without custody shall be liable; then
 - (iv) the plan covering the spouse, if any, of the parent without custody of the dependent will be liable last;
- (C) if neither (A) nor (B) apply, the “Birthday Rule” will be used to determine liability in the order set forth in (B)(i)-(iv).
- (4) Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) Rules when applicable.

The following addresses specific situations where MSP Rules are applicable:

- (A) **Coordination with Coverage by Virtue of Current Employment Status:** In the event a Medicare-eligible Covered Person is eligible under one plan as a dependent (for example, a dependent of an actively employed spouse) and another plan other than as a dependent (for example, a Retiree under this Plan), and as a result of the Medicare Secondary Payer Rules, Medicare is
 - (i) Secondary to the plan covering the Covered Person as a dependent; and
 - (ii) Primary to the plan covering the Covered Person other than as a dependent.

Then benefits of the plan covering the Covered Person as a dependent are primary to those of the plan covering the Covered Person other than as a dependent. For example, if a Pensioner is covered as a dependent under a plan covering his/her Spouse as an active employee, then the benefits of the Spouse’s plan are primary to the benefits provided by this Plan.
- (B) **End Stage Renal Disease:** After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Participant or Dependent receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e., will provide benefits) only to the extent required by Medicare’s Secondary Payer rules.
- (5) With respect to a Participant or Dependent on COBRA Continuation of Coverage from any other plan, this Plan will be secondary.
- (6) This Plan is primary when Medicaid is involved as the other carrier.

5.5 Benchmark

The Plan adopts the Michigan benchmark plan for purposes of defining essential health benefits.

ARTICLE 6 – SUPPLEMENTAL BENEFIT

6.1 Supplemental Benefit

Amounts in an Active Participant’s Dollar Bank can be used for a Supplemental Benefit (SB), subject to the terms and conditions of this Article. The SB, like all other Fund benefits, it is not a vested benefit. The Trustees may eliminate the SB at any time.

6.2 Eligible Expenses

The following expenses, not otherwise covered by this Fund or any other health care plan or insurance, are eligible for reimbursement as a SB:

- Reimbursement of self-payments made to maintain coverage in the Fund,
- hearing aids,
- vision care expenses, including laser eye surgery,
- dental benefits, including orthodontics, and
- deductibles and co-insurance on BCBSM administered benefits.

Participants receive a “Benny” debit card that can also be used to access the medical reimbursement portion of the Supplemental Benefit.

Unless auto substantiated, a Participant must submit file an itemized claim and upload substantiation documentation via the Consumer Portal provided by Wex Health at: <https://tici.lh1ondemand.com/Login.aspx>

All receipts or documentation must include the following information: bill from the provider that reflects name and address of the provider, detailed description of the service, the date of service, patient’s name, amount charged, and amount paid by the Participant.

6.3 Annual Benefit Amount/Minimum Balance

The maximum SB allowed per calendar year is \$5,000 for claims incurred on or after 8/1/13. However, when the balance equals or is less than the Monthly Requirement, the remaining amount can only be used for Fund self-payments.

6.4 Supplemental Benefit After Retirement

An eligible Retiree may continue to utilize the balance in his/her Dollar Bank upon retirement for the SB. If prior to retirement the Retiree had frozen his/her Dollar Bank under Section 2.7(b), such Dollar Bank shall be reactivated upon his/her retirement. When an eligible Retiree’s Dollar Bank balance equals or is less than the Monthly Requirement, the remaining amount can only be used for Fund self-payments.

ARTICLE 7 – CLAIMS REVIEW AND APPEAL PROCEDURES

For benefits provided under the fully insured policies, and the Medicare Policy referenced in section 5.2, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits, and not by the provisions of Article 7 and 7A.

The Plan will disregard the period from March 1, 2020, until the earlier of: (1) 1 year from the date a Participant or Beneficiary becomes eligible for an extended deadline or (2): 60 days after the announced end of the National Emergency or such other date announced by the applicable federal agency (the “Outbreak Period”) for all participants and dependents in determining the following periods and dates:

- (1) Relating to election periods under Section 2.7:
The 30-day period (or 60-day period, if applicable) to request special enrollment.
- (2) Relating to COBRA Coverage under Article 8:

- a. The 60-day election period for COBRA continuation coverage,
 - b. The date for making COBRA premium payments,
 - c. The date for individuals to notify the plan of a qualifying event or determination of disability, and
 - d. The date for the Plan to provide a COBRA election notice.
- (3) Relating to submission of claims under Section 7.2 and claims and appeal procedures under Articles 7 and 7A:
- a. The date within which individuals may file a benefit claim,
 - b. The date within which claimants may file an appeal of an adverse benefit determination,
 - c. The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination, and
 - d. The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

7.1 Types of Claims Covered

For purposes of the procedures set forth below, the following terms are used to define health claims:

- **Urgent Health Claims:** claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;
- **Pre-Service Health Claims:** for example, pre-certification of a hospital stay or predetermination of dental coverage;
- **Post-Service Health Claims:** for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician; and
- **Concurrent Claims:** claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by Plan amendment or Plan termination.
- **Rescission of Coverage:** retroactive cancellation of coverage.
- **Disability Claims:** initial claims for disability benefits or any rescission of coverage of a disability benefit.

7.2 Initial Submission of Claims

Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, medical, dental, and prescription drug claims should be submitted to Blue Cross Blue Shield of Michigan, and all other claims for benefits (including eligibility claims) should be submitted to the Fund Office.

7.3 Notice That Additional Information is Needed to Claim

After the claim is submitted, the Fund deadline to provide notice to Claimant that the claim is incomplete (with explanation of additional information is necessary to process claim) is:

- For Urgent Health Claims – 24 hours after receiving improper claim.
- For Pre-Service health claims – 5 days after receiving improper claim.

After receipt of notice from the Fund that the claim is incomplete, the Claimant's deadline to supply the Fund the information requested to complete claim is:

- For Urgent Health Claims – 48 hours after receiving notice.
- For Pre-Service Health Claims – 45 days after receiving notice.

- For Post-Service Health Claims – 45 days after receiving notice.
- For Disability Claims – 45 days after receiving notice.

7.4 Avoiding Conflicts of Interest

The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

7.5 Initial Decision on A Claim

(a) Additional Evidence

- (1) The Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), below, to give the Claimant a reasonable opportunity to respond prior to that date; and
- (2) Before the Fund can issue an initial benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), to give the claimant a reasonable opportunity to respond prior to that date.

(b) The Fund deadline for making an initial decision on a claim is:

- For Urgent Health Claims – As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim; or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier.
- For Pre-Service Health Claims – 15 days after receiving the initial claim. A 15-day extension is permitted if the Plan needs more information and it has provided notice of same to the Claimant during the initial 15 day period. Fund deadline for responding is tolled while awaiting requested information from the Claimant.
- For Post-Service Health Claims – 30 days after receiving the initial claim. A 15-day extension is permitted if the Plan needs more information and has provided notice of same to the Claimant during the initial 30-day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.
- For Disability Claims – 45 days after receiving the initial claim. A 30-day extension is permitted if the Plan needs more information and has provided proper notice of same to the Claimant. An additional 30-day extension is permitted if the Plan needs more information and has provided notice of same to the Claimant during the first 30-day extension. Fund deadline for responding is tolled while awaiting additional information from Claimant.

7.6 Adverse Benefit Determination

Notice of an adverse benefit determination will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rule or similar guideline does not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable));
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of available internal appeal process and how to initiate the external review process for an adverse benefit determination which involves a medical condition of the claimant for which the timeframe for completion of the internal appeal would jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function;
- if applicable, a statement of the Claimant's right to bring a civil action after further denial on appeal or external appeal; and
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272, or the Michigan Office of Financial and Insurance Regulation, MiCHAP, P.O. Box 30220, Lansing, Michigan 48909, (877) 999-6442.

With respect to an adverse benefit determination involving disability benefits, the adverse benefit determination must also include the following:

- An explanation of the basis for disagreeing with any of the following:
 - The health care professionals that treated the Claimant;
 - The advice of the health professional obtained by the Plan; or
 - A disability determination from the Social Security Administration.
- A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.
- The adverse benefit determination must be in a culturally and linguistically appropriate manner.

7.7 Internal Appeals

(a) Adverse Benefit Determinations

A Claimant may appeal any Adverse Benefit Determination received under Section 7.6. An Adverse Benefit Determination means any of the following:

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan;
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
- failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate;
- rescission of coverage; or

- A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a disability benefit or any rescission of coverage of a disability benefit.

(b) Submission of Internal Appeals

An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the Claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal appeal.

The Plan will continue to provide coverage for an ongoing course of treatment pending the outcome of an internal appeal.

The review on appeal shall 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. Appeals should be submitted as follows:

Appeals Regarding Benefits Administered by Blue Cross Blue Shield of Michigan:

- For those claims administered by BCBSM, submit an initial appeal of a benefit denial to the address set forth on the BCBSM denial. If BCBSM denies this appeal, you may submit a second appeal to the Plan Office.

Appeals Regarding Benefits Not Administered by Blue Cross Blue Shield of Michigan:

- For those claims not administered by BCBSM, submit appeals to the Plan Office.

(c) Time for Submitting Internal Appeals

A Claimant must appeal a benefit denial within the following time limits:

- For Urgent Health Claims – 180 days after receiving denial.
- For Pre-Service Health Claims – 180 days after receiving denial.
- For Post-Service Health Claims – 180 days after receiving denial. In addition, for those claims administered by BCBSM, the second appeal to Trustees must be made within 30 days of the BCBSM appeal denial.
- For Concurrent Claims – Claimant must be given enough time to appeal decision before termination effective.
- For Disability Claims – 180 days after receiving denial.

ALL APPEALS MUST BE TIMELY SUBMITTED. A CLAIMANT WHO DOES NOT TIMELY SUBMIT AN APPEAL WAIVES HIS/HER RIGHT TO HAVE THE BENEFIT CLAIM SUBSEQUENTLY REVIEWED ON INTERNAL APPEAL, ON EXTERNAL REVIEW, OR IN A COURT OF LAW.

(d) Notice of Decision on Internal Appeal

The notice of a decision on appeal will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rules or guidelines do not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of the external review process, including information regarding how to initiate the external review process;
- a statement of the Claimant's right to bring a civil action under ERISA §502(a);
- A statement describing any contractual limitation period that applies to the Claimant's right to bring an action under ERISA §502(a) and the calendar date on which such contractual limitation expires;
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272, or the Michigan Office of Financial and Insurance Regulation, MiCHAP, P.O. Box 30220, Lansing, Michigan 48909, (877) 999-6442; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Fund can a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

In addition to the above, a notice of decision on appeal pertaining to a claim for disability benefits will include the following:

- An explanation of the basis for disagreeing with any of the following:
 - The health care professionals that treated the Claimant;
 - The advice of the health professional obtained by the Plan; or
 - A disability determination from the Social Security Administration.

- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.
- The benefit denial must be in a culturally and linguistically appropriate manner.

The Fund deadline for deciding an appeal of a benefit denial and notifying the Claimant of its decision is:

- For Urgent Health Claims – 72 hours after receiving appeal.
- For Pre-Service Health Claims:
 - Benefits administered by BCBSM – BCBSM shall decide the initial appeal and inform the Claimant of its decision 15 days after receiving appeal. A second appeal to the Trustees must be filed within 30 days of receipt of the BCBSM appeal denial. The Trustees shall decide this appeal within 15 days.
 - Benefits not administered by BCBSM – The Trustees shall decide the appeal 30 days after receiving the appeal.
- For Post-Service Health Claims:
 - Benefits administered by BCBSM – BCBSM shall decide the initial appeal and inform the Claimant of its decision 30 days after receiving appeal. A second appeal to the Trustees must be filed within 30 days of receipt of the BCBSM appeal denial. The Trustees shall decide this appeal at a Board Meeting. *
 - Benefits not administered by BCBSM – The Trustees shall decide the appeal at a Board Meeting. *
- For Concurrent Claims – Prior to termination of previously approved course of treatment.
- For Disability Claims – The Trustees shall decide the appeal at a Board Meeting. *

*Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third Board Meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees decision on appeal no later than five days after the decision is made.

7.8 Deemed Exhaustion of Internal Claims and Appeals Processes

If the Plan fails to adhere to all the requirements in this Article 7 with respect to any claim for benefits, the Claimant is deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Article 7A.

The Claimant is also entitled to pursue any available remedies under Section 502(a) of ERISA, or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

In addition to the above, if the Plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the Claimant chooses to pursue available remedies under ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees.

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

7.9 Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

7.10 Limitations of Actions

For adverse benefit denials not subject to external review, no action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal. For adverse benefit denials subject to external review, a request for external review must be made within the time limitations provided in Section 7A.2. In the event a Claimant does not abide by these time limitations, he/she waives his/her right to any further review of an adverse determination, including waiving his/her right to have the determination reviewed in a court of law.

7.11 Avoiding Conflicts of Interest

The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

ARTICLE 7A – EXTERNAL REVIEW PROCESS

7A.1 Eligibility for External Review

The external review process applies to any final internal adverse benefit determination that involves: (1) medical judgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or legal interpretation without any use of medical judgment), or (2) a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time). Weekly disability benefits are not subject to external review.

A denial, reduction, or termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

7A.2 Request for External Review

A Claimant must file a request for an external review with the Fund within four months after receipt of a notice of the final internal appeal. If he/she fails to do so, he/she waives the right to an external review or review in a court of law.

The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an external review.

7A.3 Preliminary Review

Within five business days following the receipt of the external review request, the Fund must complete a preliminary review of the request to determine whether:

- (a) The Claimant is or was covered under the Plan at the time the health care item or service was requested or provided;
- (b) The final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;
- (c) The Claimant has exhausted the Plan's internal appeal process; and
- (d) The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Fund must issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-ESBS (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete and the Fund must allow a Claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

7A.4 Referral to Independent Review Organization

- (a) The Fund must assign an independent review organization (IRO) to conduct the external review.
- (b) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the IRO within ten business days additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Fund. Upon receipt of such information, the Fund may reconsider its final internal decision on appeal, but such reconsideration will not delay the external review. If the Fund decides to provide coverage, within one business day after such decision the Fund must provide written notice of same to the Claimant and the IRO and the IRO must then terminate the external review.

- (c) Within five business days after the date of assignment, the Fund will provide to the IRO documents and any information considered in making the final decision on internal appeal, but failure to do so

will not delay the conduct of the external review. If the Fund fails to timely provide this information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination and notice of such decision will be provided by the IRO to the Claimant and Fund within one business day.

- (d) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - 1) The Claimant's medical records;
 - 2) The attending health care professional's recommendation;
 - 3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;
 - 4) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - 5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - 6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - 7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- (e) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and deliver its decision to the Claimant and the Fund.
- (f) The IRO's decision notice will contain:
 - 1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - 2) the date the IRO received the assignment and the date of the IRO decision;
 - 3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - 4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - 5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
 - 6) A statement that judicial review may be available to the Claimant; and
 - 7) Current contact information, including phone number, for any applicable state office of health insurance consumer assistance or ombudsman established under PHS Act §2793.
- (g) The external reviewer's decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law. The Plan must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

- (h) The IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, Fund, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

7A.5 Expedited External Review

A Claimant can make a request for an expedited external review at the time the Claimant receives

- (a) An adverse benefit determination which involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or
- (b) A final internal appeal denial which involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund must take the steps for Preliminary Review outlined above under the standard external review procedures and immediately send the notification of such review to the claimant.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO as outlined in Section 7.3A, above. The Plan must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The Plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation to the Claimant and the Fund.

7A.6 Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret Plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

7A.7 Limitations of Actions

No action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on External Review. In the event a Claimant does not bring an action within such 180 days, he/she waives his/her right to any further review of an adverse determination in a court of law.

ARTICLE 8 – COBRA CONTINUATION COVERAGE

8.1 Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to participants and their dependents when they would otherwise lose group health coverage.

8.2 Nature of COBRA Continuation Coverage

- (a) COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A Participant, his Spouse, and dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.
- (b) A Participant will become a qualified beneficiary if coverage is lost under the Plan because either one of the following qualifying events happens:
 - (1) Hours of employment are reduced such that hours are insufficient to maintain eligibility,
Or
 - (2) Employment ends for any reason other than gross misconduct.
- (c) The Spouse of a Participant will become a qualified beneficiary if coverage is lost under the Plan because any of the following qualifying events happens:
 - (1) Death of spouse;
 - (2) Spouse’s hours of employment are reduced such that hours are insufficient to maintain eligibility;
 - (3) Spouse’s employment ends for any reason other than his or her gross misconduct;
 - (4) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
 - (5) Divorce or legal separation from the participant.
- (d) Dependent Children become qualified beneficiaries if coverage is lost under the Plan because any of the following qualifying events happens:
 - (1) The parent-Participant dies;
 - (2) The parent-Participant’s hours of employment are reduced such that hours in the hour bank are insufficient to maintain eligibility;
 - (3) The parent-Participant’s employment ends for any reason other than his or her gross misconduct;
 - (4) The parent-Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
 - (5) The parents become divorced or legally separated; or
 - (6) The Child stops being eligible for coverage under the plan as a “Dependent Child.”

8.3 When COBRA Coverage Is Available

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the Participant, the Employer must notify the Plan Administrator of this qualifying event within 30 days of the death. The Plan Administrator will monitor whether a qualifying event has occurred due to reduction in hours, termination of employment, or Medicare eligibility.

8.4 Participant/Spouse Obligation to Give Notice to Plan of Certain Qualifying Events

In the event of divorce, legal separation, or a dependent Child loses eligibility for coverage as a dependent Child or if after COBRA coverage is elected a qualified beneficiary becomes covered under another group health plan, the Participant and his Spouse both have an obligation to notify the Plan Administrator of such event within 60 after this qualifying event occurs. This notice must include: the name of the Participant, the social security number of the Participant, the name of the qualified beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the qualifying event (for example, the date of a divorce), and the date on which the qualifying event occurred. If timely notice is not provided, the right to COBRA coverage is forfeited.

Further, failure to timely notify the Plan of a divorce, legal separation, or a Child losing eligibility gives the Plan the right to hold the participant and his/her Spouse separately and fully liable for any benefits paid by the Plan which would not have been paid had the Plan received timely notification of such event. At its sole election, the Plan may suspend the payment of future benefits until such amount has been recovered.

8.5 How COBRA Coverage Is Provided

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Participants may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. The COBRA notice will contain information regarding the premium that must be paid for COBRA coverage, which is 102% of the cost to the Plan for such coverage. If the period of COBRA coverage is extended due to disability, discussed below, the premium is 150% of the cost to the Plan.

Coverage under the Plan will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium. See section 8.7 below regarding the election period for COBRA coverage.

8.6 Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage, as follows:

- (1) When the qualifying event is the death of the Participant, the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce, legal separation, or a dependent Child's losing eligibility as a dependent Child, COBRA continuation coverage lasts for up to a total of 36 months.
- (2) When the qualifying event is the end of employment or reduction of the Participant's hours of employment, and the Participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement.

- For example, if a Participant becomes entitled to Medicare eight months before the date on which his eligibility terminates, COBRA continuation coverage for his Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).
- (3) In all other events, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

(A) Disability Extension

If the qualified beneficiary or anyone in his family covered under the Plan is determined by the Social Security Administration to be disabled and notifies the Plan Administrator in a timely fashion, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

(B) Second Qualifying Event Extension

If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered Spouse and dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent Children receiving continuation coverage if the participant or former Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, legally separated, or if the dependent Child stops being eligible under the Plan as a dependent Child, but only if such event would have caused the Spouse or dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

The Plan Administrator must be notified of this second qualifying event within 60 days of such event.

- (4) Notwithstanding the foregoing, months on self-payment will count towards allowable months of COBRA coverage allowed pursuant to the terms of section 2.1(c).

8.7 The Election Period for COBRA Continuation

Qualified beneficiaries have 60 days after receipt of the Election Notice, which will be sent to each qualified beneficiaries' last known address, to elect COBRA continuation coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

8.8 Premium Payment for COBRA Coverage

Following an election, a qualified beneficiary has 45 days to pay the initial COBRA premium. If this is not timely paid, coverage will not be reinstated and the qualified beneficiary will not be given a second chance to reinstate coverage.

Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. If payments are not made within this period, coverage will terminate and the qualified beneficiary will not be given an opportunity to reinstate coverage.

If, for whatever reason, the Plan pays medical benefits for a month in which the premium was not timely paid, the qualified beneficiary will be required to reimburse the Plan for such benefits.

The premium equals the cost to the Plan of providing coverage plus a 2% administration fee. In the event of extended coverage as a result of a disability for the 19th – 29th months of coverage, the Plan will charge 150% of the cost of providing coverage.

8.9 Scope of Coverage

COBRA coverage only pertains to health benefits available under the Plan. Coverage for such benefits under COBRA is the same as those the qualified beneficiary had the day before coverage initially terminated. Coverage may change while on COBRA coverage due to Plan amendments that effect all Participants in the Plan. A qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated active employees.

8.10 Enrollment of Dependents During Period of COBRA Coverage and Coverage Options

A Child born to, adopted by, or placed for adoption with a Participant during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the Participant has elected continuation coverage for himself/herself. If a Participant desires to add such a Child to COBRA coverage, he must notify the Plan Office within 30 days of the adoption, placement for adoption, or birth. During the COBRA coverage period, a Participant may add an eligible dependent who initially declined COBRA coverage because of alternative coverage and later lost such coverage due to certain qualifying reasons. If a Participant desires to add such a Child to COBRA coverage, he must notify the Plan Office within 30 days of the loss of coverage.

8.11 Qualified Medical Child Support Orders

If a Child is enrolled in the Plan pursuant to a qualified medical child support order while the Participant was an active employee under the Plan, he is entitled to the same rights under COBRA as any dependent Child.

8.12 Termination of COBRA Coverage

COBRA continuation coverage terminates the earliest of the last day of the maximum coverage period, the first day timely payment (including payment for the full amount due) is not made, the date upon which the Plan terminates, the date after election of COBRA that a qualified beneficiary becomes covered under any other group health plan, or the date after election if a qualified beneficiary becomes entitled to Medicare benefits and such entitlement would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred.

In the case of a qualified beneficiary entitled to a disability extension, COBRA continuation coverage terminates the later of: (a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination from Social Security that the qualified beneficiary is no longer disabled, whichever is earlier; or (b) the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

8.13 Keep the Plan Informed of Address Changes

A participant or his spouse must keep the Plan Administrator informed of any changes in the addresses of family members and is advised to keep a copy of any notices sent to the Plan Administrator.

ARTICLE 9 – QUALIFIED MEDICAL CHILD SUPPORT ORDER

In accordance with §609 of ERISA, the Fund shall provide benefits as required by a Qualified Medical Support Order (“QMCSO”). In general, a QMCSO is a medical child support order which creates or recognizes the right of an alternate recipient (i.e. a child of the Participant) to receive benefits under a group health plan. A QMCSO must meet certain requirements and cannot require a Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of 42 USC § 1396g-1. Procedures for determining the qualified status of medical support orders are available, without charge, from the Plan Office.

ARTICLE 10 – FAMILY AND MEDICAL LEAVE

Certain Employers are required to continue to make contributions to the Fund on behalf of an employee while such employee is on a medical leave of absence pursuant to the federal Family and Medical Leave Act (“FMLA”). Details concerning FMLA leave are available from the Participant’s Employer. Requests for FMLA leave must be directed to such Employer; the Plan cannot determine whether or not a person qualifies for FMLA leave. If a dispute arises between a Participant and his Employer concerning eligibility for FMLA leave, the Participant may continue health coverage by making COBRA payments. If the dispute is resolved in the Participant’s favor, the Plan will refund COBRA payments made by the Participant upon receipt of the FMLA-required contributions from the Employer. If the Employer continues a Participant’s coverage during an FMLA leave and the Participant fails to return to work, he may be required to repay the Employer for all contributions paid to the Plan for such coverage during the leave. The Fund will not return any contributions to the Employer. Failure to return to work at the end of a FMLA Leave may constitute a Qualifying Event under COBRA.

ARTICLE 11 – THIRD PARTY LIABILITY

11.1 Subrogation

(a) In General

Subrogation means the Fund has the right to recover from a Covered Person those amounts paid by the Fund for medical care or other expenses due to an injury caused by a third party (for example, another person or company). For purposes of this Article 11, the term “injury” also includes an illness caused by a third party.

To the extent benefits are paid by the Fund to a Covered Person for medical, dental, Weekly Disability, or other expenses arising out of an injury, the Plan is subrogated to any claims the Covered Person may have against the third party who caused the injury. In other words, the Participant or Dependent must repay to the Plan the benefits paid on his or her behalf out of any recovery received from a third party and/or any applicable insurer.

The Fund’s right of subrogation applies to any amounts recovered, whether or not designated as reimbursement for medical expenses or any other benefit provided by the Fund. The right of subrogation applies regardless of the method of recovery, i.e., whether by legal action, settlement or otherwise.

The Fund's right to subrogation applies regardless of whether the injured Participant or Dependent has been fully compensated, or made whole, for his or her losses and/or expenses by the third party or insurer, as the Fund's right to subrogation applies to any full or partial recovery. This provision is intended to make it clear that this provision shall apply in lieu of the "make whole" doctrine. The Fund has first priority to any funds recovered by the injured Covered Person from the third party or insurer.

Further, the Plan does not have any responsibility for the injured Participant or Dependent's attorneys' fees, i.e. the common fund doctrine will not be applied.

The Fund also has a lien on any amounts recovered by a Participant or Dependent due to an injury caused by a third party, and such lien will remain in effect until the Fund is repaid in full for benefits paid because of the injury.

(b) Conditions to Payment of Benefits

If a Covered Person sustains an injury caused by a third party, the Fund will pay benefits related to such injury (provided such benefits are otherwise properly payable under the terms and conditions of the Plan), provided all the following conditions are met:

- (1) As soon as reasonably possible, the Covered Person must notify the Plan Office that he or she has an injury caused by a third party.
- (2) Prior to the receipt of benefits for such injury, the injured Covered Person must assign to the Fund his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the injury. If such assignment is not made before the receipt of benefits, then the receipt of benefits automatically assigns to the Fund any rights the Participant or Dependent may have to recover payments from any third party or insurer. (If the recovery so assigned exceeds the benefits paid by the Fund, such excess shall be delivered to the Covered Person or other person as required by law.)
- (3) The Covered Person does not take any action that would prejudice the Fund's subrogation rights.
- (4) The Covered Person cooperates in doing what is necessary to assist the Fund in any recovery, which includes but is not limited to executing and delivering all necessary instruments and papers.

(c) Right to Pursue Claim. The Fund's subrogation rights allows the Fund to directly pursue any claims the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim.

(d) Enforcement. If it becomes necessary for the Plan to enforce this provision by initiating any action against the Covered Person, the Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome. The Plan shall be entitled to enforce this provision by way of an equitable restitution, constructive trust, or any other equitable remedy.

At the Fund's option, it may enforce this section 11.1 by deducting amounts owed from future benefits.

11.2 Workers' Compensation

The Fund does not pay any claims covered by workers' compensation. If a Participant or Dependent receives any benefits that are properly payable by workers' compensation, then this Fund must be indemnified by the Participant or Dependent for the amount paid for such benefits. The Fund shall be indemnified out of the proceeds received from the Participant or Dependent in settlement of any workers' compensation claim. The Participant must complete any forms required by the Fund to preserve its rights under this section. At the

Fund's option, it may enforce this provision by deducting amounts owed from future benefits. If the Fund authorizes the payment of benefits pending resolution of a contested workers' compensation claim, eligibility for and payment of such benefits remains subject to all other terms and conditions set forth in this Plan.

11.3 Fund's Rights

Failure of a Covered Person to notify the Fund that an injury is due to the action of a third party is considered a fraud on the Fund. Notwithstanding any term of this Article 11, and in addition to the rights of the Fund set forth in this Article 11, where an injury is due to the actions of a third party, or results in a claim compensable by workers compensation, the Trustees have the right to require a Covered Person to repay any benefits paid by the Fund for such injury. Where a Covered Person accepts a settlement or receive an award, future medical expenses for any injury caused by the responsible third party, including workers' compensation, are not eligible expenses under this Plan.

ARTICLE 12 - HIPAA PLAN SPONSOR PROVISIONS

12.1 Protected Health Information ("PHI"), as defined in the Health Insurance Portability and Accountability Act (HIPAA), will only be disclosed to the Plan Sponsor when and if necessary to carry out the Fund's payment and health care operations. In particular, it is anticipated that such disclosures may be necessary to verify eligibility or to make a decision on appeal. All such disclosures will be made in accordance with HIPAA and its corresponding regulations. The Fund otherwise complies with the terms of HIPAA.

12.2 The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to HIPAA. The Plan Sponsor shall, among other things, implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan.

ARTICLE 13 – MISCELLANEOUS PROVISIONS

- **Interpretation of Plan Documents.** The Trustees have full discretionary authority to determine eligibility for benefits, interpret Plan documents and procedures, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.
- **Changes to or Termination of Coverage.** The Trustees reserve the right to amend, alter, or terminate any or all coverages under the Plan, for any or all classes of Participants or Dependents, including Retirees, at any time. The Trustees also have the right to change required self-payment amounts for any benefit or class of Participants or Dependents, including the right to impose self-payment for coverage that previously had been provided without requiring such self-payments.
- **Rescission of Coverage.** Rescission means the retroactive cancellation of coverage. Where coverage was provided as a result of fraud or an intentional misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan will rescind coverage. A 30-day notice of rescission will be provided, but termination of coverage will be retroactive to the date coverage should or would have been terminated if the fraud or intentional misrepresentation had not occurred (Date of Rescission). The intent of this provision is to rescind coverage to the full extent allowed by federal law.

Providing false information to maintain or obtain coverage, or knowingly cooperating in any actions designed to provide false information to maintain or obtain coverage, is an example of a fraud or intentional misrepresentation of material fact. Examples of fraud or intentional misrepresentation of material fact also include, but are not limited to, failing to inform the Fund Office of: (1) a divorce, (2) a Dependent no longer meeting the definition of dependent, or (3) any other event which makes a Participant or Dependent ineligible for coverage.

In the event coverage is rescinded, in addition to any legal and equitable means of recovery available, the Plan has the right to pursue the Participant or Dependent, jointly, and severally, for the full amount paid for such coverage from the date of cancellation, including all costs and attorney's fees, expended in collecting the amount owed. At the Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered. Nothing in this section limits the rights of the Plan to prospectively terminate coverage where such coverage was previously provided as a result of a mistake, intentional misrepresentation, or fraud. Further, nothing in this section limits the right of the Plan to cancel coverage retroactively for failure of a Participant or Dependent to make a self-payment, where there has been a reasonable delay in terminating coverage due to administrative recordkeeping.

ARTICLE 14 – REQUIRED PROVISIONS

A. Type of Administration/Plan Administrator/Plan Sponsor

The Board of Trustees of the Flint Plumbing and Pipefitting Industry Health Care Fund is the Plan Administrator and Plan Sponsor. As such, the Trustees are responsible for overall Plan administration. There are three Trustees appointed by the Union and three Trustees appointed by the Association. The current Trustees are:

Union Trustees

Harold T. Harrington, Chairman
Local Union 370
2151 W. Thompson Road
Fenton, MI 48430

Todd Collins
9252 Pine Needle Trail
Flushing, MI 48433

Daniel Gaudet
9141 West Carpenter Road
Flushing, MI 48433

Employer Trustees

Dominic Goyette, Secretary
Goyette Mechanical Company
382 Gorey Ave.
Flint, MI 48506

Kristine Menzing
Dickerson Mechanical
P.O. Box 250
Davison, MI 48428

David Hendershot
Ecker Mechanical Contractors, Inc.
P.O. Box 19099
Burton, MI 48529

Legal Counsel for the Plan

Michael J. Asher
Jacqueline A. Kelly
AsherKelly
25800 Northwestern Highway, Suite 1100
Southfield, MI 48075
(248) 746-2748

The Trustees have delegated the day-to-day responsibilities for Plan administration to TIC International Corporation, 6525 Centurion Dr., Lansing, MI 48917-9275, telephone number (517) 321-7502.

- B. Effective Date of Plan/Fiscal Year:** The effective date of the Plan is January 1, 1954. The Plan's fiscal year ends July 31st.
- C. Agent for Service of Legal Process:** Service of process should be made upon TIC International Corporation, 6525 Centurion Dr., Lansing, MI 48917-9275, telephone number (517) 321-7502. Service of legal process may also be made upon any Plan Trustee.
- D. Type of Plan/Employer Identification Number/Plan Number:** The Plan is a welfare benefit plan hospitalization, medical, prescription drugs, dental, vision, disability and death benefits. The employer identification number assigned by the IRS is 38-6208007. The Plan Number is 501.
- E. Collective Bargaining Agreements:** The Plan is maintained pursuant to collective bargaining agreements. Copies of such agreements may be obtained upon written request to the Plan Administration Office or are available for examination by participants and beneficiaries at the Plan Administration Office. Alternatively, within 10 days of a written request, such agreements will be made available at the Union Hall or at any employer establishment where at least 50 or more participants are customarily working. The Plan may impose a reasonable charge for such copies.
- F. Source of Plan Contributions:** The primary source of financing for the benefits provided under the Plan and for the expenses of the Plan operations are employer contributions. The rate of contribution is set forth in the Collective Bargaining Agreement. Additionally, under certain circumstances pursuant to the terms of the Plan, a Participant may make self-payments to retain eligibility. A portion of Plan assets are invested, and this also produces additional Plan income. A complete list of the employers contributing to the Plan may be obtained upon written request to the Plan Administration Office and may be examined at the Plan Administration Office.
- G. Welfare Trust Assets and Reserves:** The Board of Trustees holds all assets in trust for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses.
- H. Compliance with Federal Laws.** The extent applicable, the Plan will comply with the following laws:
- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) was enacted to provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. 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).
 - The Women's Health and Cancer Rights Act of 1998 (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans and health insurance issuers that provide coverage for medical and surgical benefits with respect to mastectomies must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema).
 - The Patient Protection and Affordable Care Act of 2010, and the Health Care and Education Reconciliation Act (collectively known as Healthcare Reform) was enacted to provide various protections, including but not limited to the provision of minimum essential health benefits and certain preventative services without cost sharing.
- I. Copies of Schedule of Benefits or Benefit Booklet/List of Network Providers.** A copy of any schedule of benefits or benefits booklet referred to in this SPD is available without cost to any participant or beneficiary

under the Plan upon request to the Plan Office. Additionally, a list of network providers is also available without cost upon request to the Plan Office.

- J. Statement of ERISA Rights:** As a participant in the Flint Plumbing and Pipefitting Industry Health Care Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Administration Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of 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 Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage: 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan: You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in subsequent coverage. The procedure for requesting a certificate of creditable coverage is as follows:

- a. A covered person may contact the Plan Office, TIC International Corporation, 6525 Centurion Drive, Lansing, MI 48917-9275, in writing to request a certificate of creditable coverage, or by phone (517) 321-7502 by phone (ask for a representative of the Flint Plumbing and Pipefitting Industry Health Care Fund Plan).
- b. The requested certificate shall be provided by the earliest date that the Plan Administrator, and the Plan's third-party administrator, TIC International Corporation, acting in a reasonable and prompt fashion, can provide the certificate. In that regard, the parties shall use best and reasonable efforts to process and mail (first class, postage paid) the requested certificate of creditable coverage to the requesting party within five business days of receipt by TIC International Corporation.
- c. The above applies to requests for certificates made by a covered person before losing coverage or within 24 months after losing coverage.
- d. This procedure is in addition to the automatic issuance of certificates of creditable coverage to covered persons upon termination of coverage.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who

operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights: If your claim for a welfare benefit is denied or ignored, 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, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan 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, for example, if it finds your claim is frivolous.

Assistance with Your Questions: If you have any questions about your plan you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

- K. Termination of the Plan:** The Trustees reserve the right to amend, alter, or terminate any or all coverages hereunder, for any or all classes of Participants or Dependents, at any time. The Trustees also have the right to change required self-payment amounts for any benefit or class of Participants or Dependents, including the right to impose self-payment for coverage that previously had been provided without requiring such self-payments. If the Plan is terminated, plan assets shall be used to pay eligible claims and expenses incurred prior to termination and expenses incident to the termination. The Trustees will, in their discretion, allocate any remaining assets in a manner which best effectuates the purposes of the Trust. In no event will plan assets revert to or inure to the benefit of contributing employers or the Association.

This Summary Plan Description is not intended to cover every detail of the Plan or every situation that might occur. The complete Plan is available for inspection at any time at the Plan Office. If there is any conflict between this summary and the Plan, the Plan controls. For a more detailed statement of your rights and obligations, consult the Plan document.

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