KALAMAZOO PLUMBERS STEAMFITTERS AND PIPEFITTERS
LOCAL UNION NO. 357
HEALTH & WELFARE INSURANCE PLAN

2018 SUMMARY PLAN DESCRIPTION

MECHANICAL CONTRACTORS ASSOCIATION OF SOUTHWEST MICHIGAN

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GENERAL INFORMATION

1.1 Why am I receiving this Summary Plan Description?

Federal law requires that you be provided with an SPD at least once every five years. Due to some recent changes made to the benefits this Plan provides, the Trustees have updated the SPD. **This SPD will supersede and replace the SPD you received in 2016. It will also supersede the Summaries of Material Modification that you received since that time. This SPD is effective as of April 1, 2018.**

1.2 What is this SPD for?

The SPD will explain what benefits you have, how you become eligible, how you stay eligible, how you file a claim for benefits, as well as how you appeal if your benefits are denied. It will also provide you with some general information about the Fund. You should keep this SPD for your records.

1.3 Defined terms used in this SPD.

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

- → Active Participant- means a Participant that is working in Covered Employment.
- → Apprentice- means a person who is duly sworn in as a member of the Union and who is a registered apprentice with the Kalamazoo Plumbers, Steamfitters & Pipefitters Local 357 Apprenticeship Program.
- → Benefit Year – means the time period of January 1 through December 31 of each year.
- → Collective Bargaining Agreement – means an agreement between an Employer and the Union that requires fringe benefit contributions.
- → Covered Employment – there are two basic requirements for work to qualify as Covered Employment. First, your Employer must have signed a collective bargaining agreement with the Union that requires contributions to this Plan, and second, the work you are performing for the Employer must be work that is covered by that Collective Bargaining Agreement.
- → Continuing Eligibility – the requirements for you to continue eligibility for benefits under the Plan after you have met the requirements for Initial Eligibility.
- → Dependent – Dependent spouses and children. For a "Dependent Child" to be eligible for benefits, that child must be a son, daughter, stepchild, adopted child, foster child, or child lawfully placed for adoption that is less than 26 years of age. A Dependent Child also includes a handicapped child who is over age 26 but who became Permanently and Totally Disabled **before** reaching age 26 (special rules apply to this situation which are discussed later in this SPD).
- → Effective Date - means the effective date of this SPD, the effective date of a specific benefit, or the date an Employee or Dependent becomes eligible for benefits.
- → Employee – an Employee is any person who is or has been employed by an Employer in Covered Employment, or such other employment for which the Employer is obligated by a Collective Bargaining Agreement, or any other written agreement, to contribute to the Fund.
- → Employer – an Employer is any of the following:
    - Any member of an employer association and any other individual, partnership, corporation or business entity which is employing the services of individuals performing work that is within the trade jurisdiction of the Union and which has a collective bargaining agreement or any other written agreement in effect, requiring contributions to the Fund;

- Any other Employer engaged in work coming within the trade, craft and geographical jurisdiction of the Union, who is obligated by a collective bargaining agreement, or such other written agreement, to make contributions to this Fund on behalf of its Employees, including self-employed persons or sole-proprietors;
- The Union, its affiliated Locals or related International bodies, solely to the extent that it acts in the capacity of an Employer of its business representative or its Employees, provided it agrees to make contributions to the Fund on behalf of such Employees;
- Any training or other similar program operated in whole or in part by the Union, or with its approval, or in which the Union participates;
- Any board of trustees, committee or other agency established to administer or be responsible for fringe benefit funds, educational or other programs established through collective bargaining by the Union, the members of which maintain a collective bargaining relationship with the Union or one of its constituent Locals;
- Any council, committee, or other body composed of representatives of one or more labor organizations of which the Union or one of its constituent Locals is a member and agrees in writing to participate herein; or
- Any sponsoring employer association, whose members maintain a collective bargaining relationship with the Union, solely in its capacity as an Employer of Employees, on whose behalf it has agreed in writing to make contributions to this Fund.

→ Employer Contributions – means the fringe benefit contributions received by the Fund for each hour worked in Covered Employment by Active Participants. Only contributions actually received by the Fund will be counted as Employer Contributions. This means that hours you have worked that contributions are due for but have not yet been paid to the Fund by your Employer, will not be counted as Employer Contributions towards eligibility and other requirements.

→ Initial Eligibility – means the requirements to begin coverage. These requirements are explained later in this SPD.

→ Medical Provider - includes a "Physician" who is a doctor of medicine, osteopathy, chiropractor, podiatry or optometry, legally qualified and licensed to practice medicine or perform surgery or provide services at the time and place services are performed. The term "Physician" shall also mean a person who is licensed or certified as a psychologist (but not including a person acting within the scope of a partial or limited license or certification). It shall also mean a person who is a Member or Fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where such person renders service. This definition includes a physician's assistant, nurse or person of a similar position working under the direction of the treating Physician. The Plan will provide coverage for services administered by a Physician's Assistant or an otherwise qualified person working under a Physician, however, the Plan or its network provider may seek Physician verification or audit claims.

→ Medical Reimbursement Account ("MRA") – the MRA is a notional account that does not vest that can be used to pay for some expenses not covered by the Plan. Only certain expenses approved by the IRS and the Board of Trustees can be reimbursed.

→ Participant - means an Employee who has met the applicable requirements established by the Trustees to be eligible for benefits under this Plan.

→ Permanently and Totally Disabled – means that a person is, in the opinion of an independent medical examiner appointed by Board of Trustees, permanently and totally prevented from engaging in any gainful activity (except for purposes of rehabilitation as may be determined by the Board of Trustees) for remuneration or profit due to a physical or mental condition arising as a result of bodily injury or disease (either occupational or non-occupational in cause) that is expected to last for a period of at least 12 or more months or that is expected to result in death. However, a person will not be deemed to be Permanently and Totally Disabled if the disability results from the use of narcotics, or if such disability was contracted, suffered, or incurred while you were engaged in or resulted from your participation in any criminal activity, or comes from a self-inflicted injury that is not the result of a medical condition.

- → Pension Plan – means the Kalamazoo Plumbers, Steamfitters & Pipefitters Local 357 Pension Plan.
- → Retiree – means a Participant who has met the requirements of the Plan to continue coverage upon retirement from Covered Employment.
- → Spouse – means the person to whom you are legally married.
- → Union – means the Kalamazoo Plumbers, Steamfitters and Pipefitters Local Union No. 357, or any successor thereto.

1.4 General Information about the Fund

The Kalamazoo Plumbers, Steamfitters and Pipefitters Local Union No. 357 Health & Welfare Insurance Fund (referred to as the "Fund" or the "Plan" throughout this document) was created as a result of collective bargaining between the Employers that pay into the Fund and the Union. This Fund is a health and welfare plan, and is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Federal law requires that a joint Board of Trustees operate this Fund. The Sponsoring Employer Association – the Southwest Michigan Mechanical Contractors Association – appoints half of the Trustees and the other half of the Trustees are elected by the Union. The Board of Trustees has complete discretionary authority to operate the Fund and to make benefit determinations. In some instances, it delegates that authority to third parties, such as the Plan Administrator. For more information on the authority and powers of the Board of Trustees, please consult the Plan Document and the Declaration of Trust (you can obtain information on how to view these documents by contacting the Plan Administrator).

If you are a Participant working in the field, for each hour that you work your Employer is required to pay the amount under the CBA negotiated on your behalf by the Union to the Fund. Once your Employer has paid in enough hours on your behalf, you become eligible for benefits unless you qualify for expedited eligibility, which is discussed later in this SPD. If you wish to obtain a copy of the CBA, you can request it from the Plan Administrator. You can also obtain from the Plan Administrator a list of Employers and employer organizations that sponsor this Fund.

A third-party administrator administers the Fund on the Trustees' behalf. For example, the Plan Administrator receives Employer Contributions from the Employers, determines eligibility, in some instances pays claims, and in general is responsible for the day-to-day operation of the Fund. The current administrator is TIC International Corporation. The phone number where you can reach the Plan Administrator is (248) 645-6550 or Toll Free (888) 281-3461 and the address is 30700 Telegraph Rd, Bingham Farms, Michigan 48025.

The Plan's federal identification number is 38-6156571. The Plan ID Number is 501.

1.5 Are the benefits this Fund provides guaranteed to me?

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

1.6 Who are the members of the Board of Trustees?

Union Trustees

Michael Corliss
Kalamazoo Plumbers, Steamfitters & Pipefitters Local 357
11847 Shaver Rd.
Schoolcraft, Michigan 49087

Ken Willcutt
Kalamazoo Plumbers, Steamfitters & Pipefitters Local 357
11847 Shaver Rd.
Schoolcraft, Michigan 49087

Frank Nykamp
Kalamazoo Plumbers, Steamfitters & Pipefitters Local 357
11847 Shaver Rd.
Schoolcraft, Michigan 49087

Employer Trustees

Tom Calvey
C.L. Mahoney Company
438 Forest St.
Kalamazoo, Michigan 49003

Derek Rowe
Mall City Mechanical
7184 Douglas
Kalamazoo, Michigan 49007

Mark McKnight
D.A. Dodd Mechanical Contractors
14 E. Michigan St, P.O. Box 430
Rolling Prairie, Indiana 46371

Kevin Waterstradt
W. Soule Company
7125 Sprinkle Rd.
Kalamazoo, Michigan 49003

1.7 Who is the Fund's legal counsel?

The Fund's legal counsel is Novara Tesija, P.L.L.C. Their address is 2000 Town Center, Suite 2370, Southfield, Michigan 48075. The firm's phone number is 248-354-0380. The Fund's attorneys are responsible for handling all legal matters that affect the Plan and its operation.

1.8 How are legal papers served on the Fund?

Legal papers can be served on the Plan Administrator, or the Fund's legal counsel.

1.9 How are the benefits this Fund provides paid for?

The benefits are self-funded, meaning that the Fund pays claims out of its assets. The assets of the Fund come from Employer Contributions, which are made for each hour worked by Active Participants, along with investment earnings on these contributions. However, the Board of Trustees may choose to provide some or all of the Fund's benefits on an insured basis.

1.10 Special notices required by law

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

Rights under the Women's Health and Cancer Rights Act. The Fund, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For additional information, please contact the Plan Administrator.

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

Non-Discrimination. The Fund complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Fund further provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats), and provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. If you need these services, contact the Plan Administrator. If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

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

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

1.11 Special Enrollment Rights

Even if you become eligible for benefits from the Fund, you may elect to decline coverage. If you do so, you will **not** receive money back on your check. However, if the other coverage you have is lost, you can enroll in coverage again from the Fund (special enrollment). **If that happens, you must request reenrollment in the Plan within 30 of losing the other coverage.**

Special enrollment also allows you to add a new Dependent (new Spouse or child) as a result of marriage, birth, adoption, or placement for adoption. **Newborns are automatically covered from the moment of birth. However, you do need to provide a copy of the new baby's birth certificate to the Plan Administrator within 30 days of the birth.**

If you are adding a new Spouse, child, stepchild, or adopted child that is not a newborn, you need to notify the Plan Administrator within 30 days of the event (the marriage, date of adoption, etc.). You will also need to provide evidence of the relationship (copy of the marriage license, court order for adoption, etc.). If you have questions or need more information, please contact the Plan Administrator. These rights and obligations are also discussed again in detail Part 11 of this SPD.

1.12 Open Enrollment

Open Enrollment is from December 1st through December 31st of each year. Open enrollment is different than Special Enrollment. Special Enrollment lets you or a Dependent come back onto the Plan at any time during the year and is triggered by a specific event (loss of other health coverage, for example). Open Enrollment happens only during December, and does not require any specific event to occur. An example of when someone would use Open Enrollment would be if that person knew that starting the next year and wanted to drop other coverage and restart coverage with this Fund. Another example would be if a person experienced a Special Enrollment event but missed the thirty-day (30) window to request enrollment or provide the required information, such as a marriage license.

1.13 Reciprocity for work in other Union jurisdictions.

The Trustees have entered into reciprocity agreements with other health and welfare funds covering the plumbing, pipefitting and related crafts throughout the country. Pursuant to these reciprocity agreements, contributions made on your behalf may be transferred from one fund to another, upon your request and authorization. The contributions that may be transferred may enable you to meet the Continuing Eligibility requirements of this Fund (the "home fund"). These agreements require that an Employer in another jurisdiction pay at least the minimum hourly rate for this Fund. If, however, you are working in a jurisdiction where the contribution rate is higher, the excess will go to fund your MRA.

1.14 A reminder about self-payments or "short hours" payments.

Throughout the eligibility sections that follow, you will see references to making self-payments. A self-payment is made when you have not worked enough hours to remain eligible. These payments are often informally called "short-hours" payments. When this occurs, you will be offered the option of making a self-payment or going on to COBRA. Self-payments may be "full" meaning you pay the full premium set by the Trustees, or "partial" meaning you pay a portion of that rate offset by Employer Contributions for hours worked or funds from your MRA. If a self-payment is needed to continue coverage, you will receive a notice from the Plan Administrator. **Self-payments are due to the Plan Administrator by the 25th day of each month**. If you elect COBRA coverage, you will also receive certain notices required by law.

PART TWO:
ELIGIBILITY FOR ACTIVE PARTICIPANTS

2.1 A reminder about how your hours are counted

Your Employer is given a one-month bookkeeping period in order to remit the contributions which are due on your behalf for the hours that you worked. Employer Contributions are considered delinquent if they are not paid to the Fund Administrator by the 15th day of the month following the month in which you performed the work. This means that contributions for work you perform in January are due by February 15. As a result, the hours you work in January are counting toward your eligibility for the month of March. This system is necessary to leave time for processing of payments and records. It is more fully explained in the chart below.

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

2.2 What are the requirements for Initial Eligibility?

You become eligible for benefits on the first day of the month following the month in which the Fund receives at least 200 hours of Employer Contributions in any consecutive two-month period.

Example: Assume that Alex starts work in February. He works 110 hours in February, and 120 hours in March. Alex will be covered under the Plan starting on May 1.

The Plan Administrator will determine your eligibility automatically. Once you become eligible you will receive a packet of information from the Plan Administrator. You should read it carefully and return any forms that you are requested to complete. A failure to return these forms could delay payment of your claims, as many of the forms contain information necessary to process your claims for benefits.

2.3 What are the monthly requirements to stay eligible?

Continuing Eligibility is determined by looking back at the number of hours you worked for a period of 1 to 12 months. To stay eligible each month by working (meaning you will not have to make a self-payment) you have to work either: (1) 120 hours every month; or (2) 360 hours in 3 consecutive months; or (3) have worked 1,200 hours in the past 12 consecutive months**. Remember, only hours actually paid by your Employer count toward eligibility.** If your Employer

fails to pay on time, you will have to continue eligibility by using any reserve hours that you have accumulated or by making a self-payment.

2.4 How do I stay eligible if I don't work enough hours or if my employer is delinquent?

As noted in Section 2.3 above, when you work excess hours you build up a reserve that will let you stay eligible in a month when you work less, or do not work at all. If your reserve hours run out, or you do not have enough hours to stay eligible, you can still continue coverage by making a self-payment, by drawing from your MRA, or a combination of these methods. However, keep in mind that you cannot make more than twelve (12) consecutive self-payments.

In addition, in order to be allowed to make a self-payment to continue coverage, you must be available for Covered Employment from the Employers that contribute to this Fund. If you are not working in Covered Employment and fail to register on the Union's out of work list or allow your registration to lapse, it shall create a rebuttable presumption that you are no longer available for work. If you are an Apprentice, you must remain an Apprentice in order to be eligible to make self-payments. In addition, if you refuse an offer of Covered Employment more than three (3) times, you will no longer be permitted to make self-payments, your coverage will be terminated, and coverage will be offered (if you qualify) under COBRA.

2.5 What happens to hours that I work that exceed the requirements for eligibility?

Hours that you work each month (and that are paid by your Employer) that exceed 120 are considered as part of the look back for Continuing Eligibility, which is described in Section 2.3, above.

2.6 Is there a "quick" eligibility option?

If you are a newly organized Employee that has an offer of employment from an Employer or you are a newly sworn in Apprentice, you can opt to become eligible immediately. However, if you do so you will begin coverage with a negative hour balance equivalent to the 200 hours that are ordinarily required to become initially eligible. This negative hour balance will be made up through hours you work in excess of what is required to stay eligible (discussed in Section 2.4 below). If you want to avail yourself of this option, you must notify the Plan Administrator within **10 days** of starting Covered Employment so that the Plan Administrator can activate your coverage.

Example: Ed is newly organized and receives an offer of employment from ABC Company in June of 2018. Ed works 140 hours in June, 160 hours in July, and 160 hours in August. In those 3 months, Ed has worked 100 more hours than the 120 required each month to continue coverage, so Ed's negative hour balance is now only 100 hours. Once Ed clears his negative hour balance, he will begin to accumulate reserve hours to use towards the look-back period described in Section 2.3, above. If Ed is laid off from ABC Company or otherwise stops working for an Employer, he will have to make self-payments, if eligible to do so, in order to continue coverage.

Example: James is sworn in as an Apprentice in September 2018. James is eligible for coverage as of the date he is sworn in. If James drops out of the Apprenticeship Program, he is no longer eligible to make self-payments. If eligible to do so, he can only elect COBRA in order to continue coverage in this situation.

2.7 How can my coverage terminate, and if it does, how can I reinstate it?

Your coverage can terminate if you fail to make a self-payment on time, or if you reach the maximum number of consecutive self-payments permitted. Eligibility will be reinstated on the first day of the following the month that the Fund receives at least 420 hours of Employer Contributions on your behalf within a period of three 3 months.

Example: Joe makes short hours payments in February and March to continue coverage, but does not make a payment in April. He returns to work in June. In June, July, and August he works 150 hours, 140 hours, and 150 hours respectively. Joe's coverage will be reinstated on October 1.

PART THREE:
ELIGIBILITY WHEN YOU RETIRE EARLY FROM COVERED EMPLOYMENT

3.1 What are the requirements for eligibility as an early retiree?

If you retire from Covered Employment before reaching age 65, in order to qualify for coverage as an Early Retiree you must meet **all** of the following requirements:

1. Be under the age of 65;
2. Be eligible for benefits as an Active Participant on the date of your retirement;
3. Be retired from Covered Employment;
4. Be receiving pension benefits from the Pension Plan;
5. For the five (5) calendar years that immediately precede your retirement, the Fund must have received, at least 720 hours of Employer Contributions annually; and,
6. If within the twenty (20) years preceding your retirement, you have **more** than 5 consecutive years of service where less than 720 hours of Employer Contributions were received, you must have an equivalent number of consecutive years of service where at least 720 hours of Employer Contributions were received annually by the Plan.

Example: Bob retired on January 1, 2018 at age 60. From 2012 to 2018, the Plan received at least 720 hours of Employer Contributions per year for Bob, and Bob was eligible on the date of his retirement. But, during 2002-2008 the Plan only received 510, 604, 710, 564, 677 and 514 hours of Employer Contributions. Because Bob had a six-year period where the Plan received less than 720 hours of Employer Contributions per year, he needs to have at least one six-year consecutive period –at any point in his career- where the Plan received 720 or more hours of Employer Contributions. So, if from 1997 to 2003 the Plan received 720 or more hours of Employer Contributions, Bob would be eligible for coverage.

3.2 How do I stay eligible?

Coverage is maintained by timely remitting the required self-payment premium each month. The self-payment amount is subject to change by the Board of Trustees. You will be notified by the Plan Administrator of the monthly amount due to maintain your coverage. **Self-payments are due by the 25th of each month. If you fail to make a timely self-payment, you will lose your coverage and it cannot be reinstated. Remember that retiree coverage is not a vested or guaranteed benefit. It can be changed or eliminated at any time.**

When you make self-payments, the monthly self-payment amount will be deducted from your pension check if your monthly pension benefit is greater than the monthly self-payment amount. However, if you do not wish to have the monthly self-payment taken from your pension check, you may setup an online payment from your bank account. You may still pay by sending in a paper check, however, paper checks require a $25 processing fee that must be paid in addition to the monthly self-payment amount. For more information, please contact the Plan Administrator.

If your monthly pension amount is smaller than your monthly pension benefit, you have two options: (1) you may setup an online payment from your bank account; or (2) you may still pay by sending in a paper check, however, paper checks require a $25 processing fee that must be paid in addition to the monthly self-payment amount. For more information, please contact the Plan Administrator.

3.3 What if I temporarily go back to work?

If you return to Covered Employment, the amount of Employer Contributions received by the Fund will be used to offset your monthly self-payment. If you work enough hours in a particular month you will not be required to make a self-payment for that month. However, any excess Employer Contributions will **not** be refunded to you. Retirees who return to work will not be eligible for Short-Term Disability Benefits or the Life Insurance Benefit. Please also keep in mind that if you return to Covered Employment while receiving your pension benefits, your benefit may be temporarily suspended. Please contact the Plan Administrator for additional information.

3.4 What if I decide to come out of retirement, and want to be an Active Participant again?

You have one year from the date you retire to change your mind. If you do change your mind within one year, and return to Covered Employment, you will not have to re-qualify for retiree coverage when you chose to retire again. However, this option is only available if you decide **not** to take a lump sum pension payment when you first retire. If you take a lump sum pension payment and later wish to come out of retirement, you will have to start over with respect to meeting the eligibility requirements in Section 3.1.

*Example: Adam retires on June 1, 2018. He does **not** elect to take the partial lump sum benefit from the Pension Plan. In January of 2019, he decides that he wants to return to Covered Employment. Because Adam did not take the lump sum when he first retired, and because he returned to work within 1 year, when he retires again he would not have start over with respect to the eligibility requirements listed in 3.1.*

*Example: Joe is 55, and also retires on June 1, 2018. However, Joe **does** take the partial lump sum benefit of $50,000.00 from the Pension Plan. If Joe returns to Covered Employment and later wants to retire a second time before reaching age 65, he will have to meet the eligibility requirements of 3.1 again. This is because under the rule, the measuring period for working at least 720 hours in the 5 years prior to retirement **starts over**. As a result, he will have to work at least another 5 years in order to qualify for coverage.*

PART FOUR:
ELIGIBILITY WHEN YOU RETIRE FROM COVERED EMPLOYMENT

4.1 What are the requirements to qualify for coverage if I retire at age 65 or older?

If you retire from Covered Employment before at or after reaching age 65, in order to qualify for coverage as an Early Retiree you must meet **all** of the following requirements:

1. Be age 65 or older;
2. Be retired from Covered Employment;
3. Be receiving pension benefits from the Local 357 Pension Plan; and
4. Be eligible for coverage under this Fund as an Active Participant on the date you retire.

4.2 How do I stay eligible?

Covered is maintained by timely remitting the required self-payment premium each month. The self-payment amount is subject to change by the Board of Trustees. You will be notified by the Plan Administrator of the monthly amount due to maintain your coverage. **Self-payments are due by the 25th of each month. If you fail to make a timely self-payment, you will lose your coverage and it cannot be reinstated. You should also remember that retiree coverage is not a vested or guaranteed benefit. It can be changed or eliminated at any time.**

When you make self-payments, the monthly self-payment amount will be deducted from your pension check if your monthly pension benefit is greater than the monthly self-payment amount. However, if you do not wish to have the monthly self-payment taken from your pension check, you may setup an online payment from your bank account. You may still pay by sending in a paper check, however, paper checks require a $25 processing fee that must be paid in addition to the monthly self-payment amount. For more information, please contact the Plan Administrator.

If your monthly pension benefit is smaller than your monthly self-payment amount, you have two options: (1) you may setup an online payment from your bank account; or (2) you may still pay by sending in a paper check, however, paper checks require a $25 processing fee that must be paid in addition to the monthly self-payment amount. For more information, please contact the Plan Administrator.

Retiree coverage for those over age 65 is supplemental to Medicare. The Plan will treat you as if you have elected both Parts A and B. You should ensure you have properly enrolled in order to avoid any gaps in coverage.

4.3 What if I temporarily back to work?

If you return to Covered Employment, the amount of Employer Contributions received by the Fund will be used to offset your monthly self-payment. If you work enough hours in a particular month you will not be required to make a self-payment for that month. However, any excess Employer Contributions will **not** be refunded to you. Retirees who return to work will not be eligible for Short-Term Disability Benefits or the Life Insurance Benefit.

4.4 What happens to excess hours I have accumulated when I retire?

Excess hours used to maintain eligibility are forfeited upon retirement. For example, if you worked 460 hours in 3 consecutive months, and you retire, you will lose the excess 100 hours of Employer Contributions. As a result, you will then be required to make self-payments.

PART FIVE:
ELIGIBILITY FOR DISABLED PARTICIPANTS, SURVIVING SPOUSES & DEPENDENTS

5.1 What happens if I become disabled?

Active Participants that are Permanently and Totally Disabled will receive an automatic credit for 6 months of coverage. No self-payments will be required to be made during this initial 6-month period.

If you decide to retire during, prior to, or at the end of the initial six-month period: provided that you meet the eligibility requirements for Early Retiree or Retiree coverage, you will receive an additional six-month disability credit. After the expiration of this 6-month period, you maintain eligibility by timely remitting the required monthly self-payment.

Example: Charles is injured, and is Permanently and Totally Disabled on June 1, 2018. Charles will receive coverage for 6 months. Charles decides to retire in August of 2018. He will receive an additional 6 months of coverage, which will give him coverage through June of 2019. If Charles wishes to continue coverage for July of 2019 and beyond, he must make timely self-payments to the Plan Administrator.

If you do not retire by the end of the initial six-month period, but you also do not return to Covered Employment: you can remain on the Plan for additional 12 months provided that you (1) apply for a determination of Social Security Disability from the United States Social Security Administration; and (2) timely make self-payments at the rates set by the Board of Trustees.

5.2 What coverage is available to a surviving Spouse?

A surviving Spouse of a deceased Participant or Retiree is eligible to continue coverage provided both the deceased Participant or Retiree and the surviving Spouse were covered by this Fund at the time of the Participant's or Retiree's death.

To continue coverage, surviving Spouses must make timely self-payments. If a balance remains in the deceased Participant's or Retiree's MRA, it will automatically be used to make in whole, or in part, the monthly self-payment amount. Once any balance in the MRA is exhausted, full self-payment at the prevailing rate must be made. **Self-payments are due by the 25th of each month. If you fail to make a timely self-payment, you will lose your coverage and it cannot be reinstated.**

Coverage for surviving Spouses will terminate when the surviving Spouse either (1) becomes eligible for coverage as an employee through his or her employment; or (2) upon remarriage. **If you are a surviving Spouse, you must notify the Plan Administrator in writing within 30 days of your eligibility for employer provided health coverage or your remarriage.**

5.3 What coverage is available to dependent children?

The Plan provides coverage for the Dependent children of Active Participants, Retirees, and surviving Spouses. Under this Plan, a Dependent is defined as a son, daughter, stepchild, adopted child, child lawfully placed for adoption, or foster child that is lawfully placed who is **under** 26 years of age.

All coverage under this Plan for a dependent child will terminate on the last day of the month in which the child turns age 26. The Board of Trustees reserves the right to require verification that the child meets the Plan's definition of Dependent.

5.4 What coverage is available to disabled dependent children who are over age 26?

Generally, coverage for Dependent children ends on the last day of the month in which the Dependent child turns age 26. However, if a Dependent child becomes Totally and Permanently Disabled **before** reaching 26 the child can remain on the Plan for an additional period of time under certain conditions. The disabled child (or someone on their behalf) must apply for a determination of Social Security Disability ("SSD") from the United States Social Security Administration within 90 days of the child's 26th birthday. **If the application for SSD is timely submitted, and proof of the application is provided to the Plan Administrator, the child can remain on the Plan for a period of two years from the expiration of the 90-day period.**

At all times, the Board of Trustees retains the right to require an independent medical examination to verify both the initial, and ongoing disability status of the child. **Failure to timely submit the application for SSD will result in the termination of the child's coverage. In addition, the person through whom the child claims coverage (the parent) must remain eligible for coverage from this Plan.**

Example: Daniel is a disabled child. He turns age 26 on June 20, 2018. Daniel's application must be filed and a copy delivered to the Plan Administrator on or before September 18, 2018. Daniel timely applies for SSD, submitting his application on September 1, 2018. Daniel may remain on the Plan until September 1, 2020 even if his application for SSD is denied.

If the SSD application is approved the child may remain on the Plan for an additional two years from the date the determination of SSD is effective.

Example: Daniel receives his SSD award effective March 1, 2020. Daniel may now remain on the Plan until March 1, 2022.

IF YOU ALREADY HAVE A DISABLED CHILD OVER AGE 26 THAT IS CURRENTLY RECEIVING COVERAGE FROM THIS PLAN, THE CHILD'S SSD APPLICATION MUST BE SUBMITTED 90 DAYS FROM APRIL 1, 2018.

PART SIX:
CONTINUATION OF COVERAGE THROUGH SUPPORT ORDERS, FMLA & USERRA

6.1 Continuing coverage through a medical support order

The Plan will provide benefits otherwise available in accordance with any valid order of a court, determined by the Board of Trustees to be a qualified medical child support order (QMCSO) under applicable law, which creates or recognizes the right of an alternate recipient to benefits as an eligible Dependent under the Plan.

A QMCSO must create or recognize an alternative recipient's right to receive benefits for which a Participant or Beneficiary is eligible to receive under this Plan. It must also provide a reasonable description of the benefits of this Plan is required to provide, and the time period to which the QMCSO applies.

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

6.2 Coverage under the Family Medical Leave Act

A Contributing Employer which is a "covered employer" as that term is defined by the Family Medical Leave Act ("FMLA") is required to notify the Fund when an eligible employee has been granted family or medical leave, in accordance with the terms and conditions established by the Trustees. In general, employers will be covered by FMLA if they employ fifty or more employees.

Both the Employer and the Participant are required to provide the notices, information and documentation as may be required by the Trustees and by law. The Fund will continue coverage during the period of any leave for which a Participant is eligible under the provisions of the FMLA provided the Employer remits the required contributions and fully complies with all requirements established by the Trustees. If you have questions about FMLA, contact the Plan Administrator.

6.3 Coverage under the Uniformed Services Employment and Reemployment Rights Act ("USERRA")

If you leave Covered Employment to enter service in the armed forces, or other uniformed services of the United States, the Employer Contributions accrued in your hour bank will be frozen, and you may elect to continue coverage for all benefits under the Plan, except death benefits, accidental death and dismemberment benefits, and accident and sickness or loss of time benefits, for a period which is the lesser of: (1) the 24-month period beginning on the last day of Covered Employment; or (2) the day the Participant fails to apply for or return to Covered Employment.

If you elect to continue coverage, you will be charged the monthly COBRA premium rate, as described in the next section of this SPD, unless your period of service is less than 31 days, in which case coverage shall be provided at no additional cost.

You must return to Covered Employment or register on the Union's out-of-work list within 90 days of your discharge under honorable conditions from the services or within 24 months of discharge if you are recovering from an illness or injury incurred during or aggravated by your service. Upon return to Covered Employment or registration on the Union's out-of-

work list, your reserve hours accumulated by working excess hours, if any, shall be restored. You will also be eligible for coverage without having to reestablish eligibility. However, if the period of military service exceeds 5 years, you must again establish Initial Eligibility before coverage will be reinstated. You will also need to submit copies of your induction and discharge papers to the Plan Administrator.

PART SEVEN:
CONTINUATION OF COVERAGE UNDER THE PLAN THROUGH COBRA

7.1 General information about COBRA

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") offers Participants and their Dependents the opportunity to temporarily extend their health care coverage under the Plan under certain circumstances after coverage under the Plan would normally end. To be eligible for coverage under COBRA, you must experience a "Qualified Event" which in turn makes you a "Qualified Beneficiary" under COBRA.

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

7.2 What are the Qualifying Events for Active Participants?

If you are working in Covered Employment, you become a Qualified Beneficiary and are entitled to elect COBRA coverage if any of the following events occurs and causes you to lose coverage under the Plan:

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

7.3 What are the Qualifying Events for Dependents?

The following are Qualifying Events for a Spouse or the Dependent child if their occurrence causes loss of coverage under the Plan:

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

7.4 How long does COBRA coverage last?

The length of coverage depends on the type of Qualifying Event. The table below summarizes the coverage available based on the type of Qualifying Event. It is also possible to experience a second Qualifying Event, which can extend the length of time you can remain covered. Initial and secondary Qualifying Events are discussed in the ensuring sections of this SPD.

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

7.5 What are the notice requirements if I experience a Qualifying Event?

When you experience a Qualifying Event, written notice to the Plan Administrator is required. **The type of Qualifying Event dictates whether you or your Employer has to provide the notice**. The type of Qualified Event also dictates when the notice has to be provided. In addition, if you experience a second Qualifying Event an additional notice will have to be provided. These requirements are discussed in detail below.

If the Qualifying Event is divorce, marital separation or a loss of status as a Dependent child: you must notify the Plan Administrator of the Qualifying Event within **60 days** of the occurrence of the Qualifying Event to qualify for COBRA continuation coverage.

Example: A judgment of divorce for Adam and Claire is entered on June 1. Claire wishes to continue coverage under the Plan. Claire must notify the Plan Administrator of her divorce within 60 days of June 1. If Claire fails to do so, her coverage will be automatically terminated under the Plan as of June 1.

Example: Tom is the stepchild of James. James and Tom's mother are divorced, with the judgment of divorce being entered on August 15. Tom and his mother must provide written notice to the Plan Administrator within 60 days of August 15 since there are two events that occur in this example to different persons: Tom losing status as Dependent and his mother is getting a divorce.

For all other Qualifying Events: In all other cases, the Participant's Employer must notify the Plan Administrator within **30 days** of the Qualified Event. Failure to notify the Plan Administrator within the time specified will result in termination of the Participant or Dependent's group health care coverage as of the date of the Qualifying Event.

7.6 Are there additional notice requirements if I become disabled?

Yes. If you become disabled, you have to notify the Plan Administrator. These requirements are discussed below.

Social Security Disability. If you are actively working and lose coverage under the Plan due to termination of your employment for reasons other than gross misconduct or because of a reduction in hours (this would be your first Qualifying Event), and the Social Security Administration ("SSA") later determines that you are disabled (this would be the second Qualifying Event) you and your Dependents may be able to extend COBRA coverage for an additional 11 months. In order to extend coverage under COBRA, the disability must have started sometime **before** the 61st day of losing coverage due to the termination or reduction in hours.

In addition, in order to be eligible for the extension, you must notify the Plan Administrator. If you fail to timely provide the notice, you will not be eligible for the extension. The notice must be in writing, include the name of the person receiving the coverage, include information about the disability, and include a copy of the disability determination letter from the SSA. The notice must also be provided within the first 18 months of your initial COBRA coverage beginning and **within 60 days** of the last of the following events to occur:

1. The date the SSA determined you were disabled;
2. The date which coverage was lost due to a reduction in hours or termination of employment (i.e. the Qualifying Event);
3. The date on which a Qualified Beneficiary (such as your Spouse or Dependent child) would lose coverage as a result of your loss of coverage due your termination or reduction in hours (i.e. the Qualifying Event).

Example: John is laid off on February 1, 2018 but does not make a self-payment and elects COBRA. He is injured in a fall on March 15, 2018 and applies for Social Security Disability. John is determined to be disabled by the SSA on May 1, 2019. John provides notice to the Plan Administrator within 60 days of May 1, 2019. John is eligible for the extension because: (1) the disability began before the 61st day of losing coverage due to his layoff (the fall occurred on March 15) and (2) the notice of his disability was provided within the first 18 months of COBRA coverage (i.e. before August 1, 2019) and within 60 days of the SSA determining that John was disabled.

7.7 Is notification required if Social Security Disability status is lost?

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

7.8 What if there is a second Qualifying Event during the time period I am receiving coverage under COBRA for the first Qualifying Event?

If a second Qualifying Event occurs while you and any of your Dependents are on COBRA due to your termination or reduction in hours (i.e. the first Qualifying Event) your Spouse and Dependents may be entitled to an additional 18 months of coverage under COBRA if a second Qualifying Event occurs. Second Qualifying Events that would give rise to this extension are (1) your death; (2) you becoming eligible for Medicare; (3) your divorce or legal separation from your Spouse; or (4) if your child no longer qualifies as a Dependent under the Plan (for example, turns age 26). The Second Qualifying Event must cause a loss of coverage as if the first Qualifying Event had not occurred in order for the extension to be offered. You must also provide the Plan Administrator with written notice of the Second Qualifying Event **60 days** of the latter of:

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

Example: Matt, his wife, and son are receiving coverage through COBRA due to Matt being laid off. Prior to the end of the initial 18 months of coverage under COBRA ending, Matt and his wife divorce. The judgment of divorce is entered on June 1. Matt's wife must provide notice within 60 days of June 1.

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

7.9 How much does COBRA coverage cost?

The cost of COBRA continuation coverage, excluding Loss of Time Benefits provided by this Fund, for 18 months, shall be determined by the Board of Trustees from time to time, but shall not exceed 102% of the applicable health insurance premium. The Trustees may charge up to 150% of the applicable health insurance premium for COBRA coverage in excess of 18 months for disabled qualified beneficiaries.

PART EIGHT

WHAT BENEFITS ARE AVAILABLE UNDER THIS PLAN?

8.1. Medical, Surgical and Prescription Drug Benefits

While the claims for these benefits are paid out of the Fund's assets, the Fund has a contract with the United Health Choice Plus Network of doctors and hospitals. For the Schedule of Benefits for Active Participants, Surviving Spouses, and their Dependents please refer to **Appendix A**. For the Schedule of Benefits for Early Retirees and Retirees on Medicare, please refer to **Appendix B**.

With respect to prescription drugs, the list of specific drugs that the Fund will provide coverage for is referred to as the "formulary." All providers of prescription drug coverage have a formulary. The formulary is the list of preferred drugs. To create the Fund's formulary, the Fund has retained Optum Rx as its pharmacy benefit manager, or "PBM." The job of the PBM is to look at what drugs are most commonly used by doctors, evaluate how much these drugs cost, and then determine whether or not the drugs do what they are supposed to do. The drugs that result in the best outcomes for you (the patient) at the best price are placed on the formulary. The PBM will periodically repeat this process to ensure that the formulary is kept up to date. If at any time the formulary is updated in a way that affects a drug that you are taking, you will receive a notice from the PBM. A copy of the formulary is being mailed to you. You can also request a copy of it from the Plan Administrator, or access it online through www.optum.com.

8.2 How do I obtain a list of the doctors and hospitals that available to me?

A list of the UMR doctors and hospitals is available to you at no charge. Please refer to your insurance card for information on contacting UMR, or you may contact the Plan Administrator. Prior to April 1, 2018, you will receive a new insurance card from UMR. This card will also have the information on it regarding your prescription drug coverage through Optum Rx. To check if your doctor or hospital is within the United Health Care Choice Plus Network, or to obtain a list of providers and hospitals in this network, please visit www.uhc.com or contact UMR by calling the number on the back of your insurance card.

8.3 Are there any restrictions on my benefits?

For some benefits you must also pay a portion of the expenses, such as co-pays deductibles, and co-insurance. Please note that the benefits may be modified from time to time. In addition, certain procedures and drugs are subject to disease management programs. There are several of these programs in place, and each is described in more detail below.

Prior Authorization. This is a process where specific procedures your doctor orders are reviewed to ensure they are safe and appropriate for your condition. Generally, the following categories of services require Prior Authorization: (1) Human organ transplant services; (2) In-lab sleep studies; (3) Inpatient and outpatient lumbar spinal infusion surgery; (4) Inpatient acute care hospitalization; (5) Interventional pain management (injections/implants into the spine); (6) Inpatient hospitalization for mental health and substance treatment; (7) Radiation therapy; (8) Radiology; (9) Inpatient rehabilitation services; (10) Skilled nursing facility services; (11) Maternity stays beyond 48 hours for vaginal delivery and 96 hours for cesarean sections; (11) Residential treatment; (12) Infusion therapy. For further information regarding services subject to Prior Authorization, please visit the following website: www.uhc.com or by contacting UMR by calling the number of the back of your insurance card.

Step Therapy. This applies to prescription drugs. Step Therapy can be thought of like the rungs on a ladder, with each "rung" representing a class or type of drugs. At the bottom are drugs that have a long history and track record for safety, and usually less expensive. As you go up the "rungs" the drugs are generally newer, more expensive, and sometimes

more experimental in nature. When treating your condition, you may have to try the more established and less expensive drugs at the bottom of the ladder before moving up to a newer, more expensive drug. For example, you might be required to try a generic version of a drug before moving to a brand name, or moving to what are often called specialty drugs or biologics (i.e. Humira). For details on the Fund's Step Therapy program, please visit www.optum.com or contact Optum Rx by calling the number on the back of your insurance card.

Quantity Limits & Mail-Order Program. Certain medications will only be dispensed in quantity limits that are set by the drug's manufacturer, the FDA, or Optum Rx. In addition, certain medications may be required to be filled through the Fund's mail-order pharmacy. To obtain a list of drugs subject to these limitations and the associated requirements please visit www.optum.com or contact Optum Rx by calling the number on the back of your insurance card.

Case Management. In selected cases involving high-risk, complicated, or high-cost treatment, professional advisers from UMR will offer, on a voluntary basis, counsel and education regarding alternative treatment options and methods to improve clinical outcomes. Information on the Fund's Case Management Program is available at www.uhc.com or by contacting UMR by calling the number on the back of your insurance card.

Utilization Review. Utilization review is a process to make sure that the care you receive is medically necessary, delivered in the most appropriate location, and follows common medical practice. Information on the Fund's U/R Program is available at www.uhc.com or by contacting UMR by calling the number on the back of your insurance card.

Other Programs. The Fund may also implement additional disease management and wellness programs that are necessary to ensure that Participants are provided with an appropriate medical care and to help control costs. If such additional programs are adopted, you will receive a notice and supplement to this Summary Plan Description.

8.4 Is there a maximum amount of cost sharing under this Plan?

Yes. The Maximum Out-of Pocket Limit (called a "MOOP Limit") is the total maximum amount you or your family can be required to pay during the Benefit Year. **This amount includes of deductibles, copayments and coinsurance, but it only counts for covered services rendered in-network only. The MOOP Limit does not include premiums, amounts balance billed, amounts paid for non-covered services, or amounts paid for any services rendered out-of-network**. Once the maximum limit is reached for the Benefit Year, the Plan begins to pay 100% of the approved amount for in-network covered services. For the year beginning January 1, 2018 and ending December 31, 2018, the MOOP Limit is $7,350 for self-only coverage, and $14,700 for family coverage. The federal government, not the Board of Trustees, sets these limits.

8.5 Are there any services that are not covered?

Yes. The Fund will only provide coverage for procedures, services, and prescription drugs that are medically necessary. Elective procedures or those that are purely for cosmetic purposes are not covered. In addition, the following services are not covered:

1. For loss or expense from Medical Condition, or disease, or as a result of any accidental bodily injury which arises out of or in the course of employment, which entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law.
2. For services which are not medically necessary.
3. Acupuncture.
4. Marriage counseling.
5. For service-related injuries or illness due to a Participant's service in the armed forces of the United States.

6. For any hospital confinement, surgery, treatment, service or supply for which the Participant or Dependent is not legally obligated to pay.
7. For any services that occur before the Effective Date of eligibility, upon becoming eligible however, the Plan will assume coverage.
8. For any services that occur after a Participant's eligibility for benefits under the Plan has been terminated.
9. For educational or self-help therapy, other than an initial diabetic self-management therapy following a diabetes diagnosis.
10. For expense incurred for any type of family planning or contraceptive management except as otherwise covered by the Plan or as required to be covered under the Patient Protection and Affordable Care Act (PPACA).
11. For treatment of obesity, except as provided for in the Plan's Schedule of Benefits or as required under the PPACA.
12. For sterilization reversals.
13. For installation of air conditioning units, humidifiers for environmental controls, whirlpools, air filters, bathroom rails, special toilet seats, commodes, chair lifts, or other non-essential home-installed conveniences or personal hygiene items even when prescribed by a Medical Provider including ergometers and exercycles, bicycles, etc.
14. For inpatient personal convenience items such as telephones, televisions, cosmetics, guest trays, magazines or beds and cots for guests that are not determined to be medically necessary.
15. For elective surgeries, other than those required to be covered under the PPACA.
16. For television, telephone, guest trays or other non-essential personal items and services including take-home prescription drugs and supplies.
17. For expense incurred if the person is engaged in any unlawful acts.
18. For expense incurred (or from complications resulting from) for cosmetic surgery or experimental surgery, unless such surgery is medically necessary or required to be covered under the PPACA, or other applicable law.
19. For court ordered hospital confinements and treatment required by court orders, which is the result of an order of any court of law to any eligible Participant or any of his eligible Dependents, even when prescribed by a Medical Provider.
20. For the use of a private room. If used, the average semi-private room rate of that hospital will be paid, except private room accommodations required by the hospital for treatment in quarantine purposes and not for the comfort of the patient.
21. For radial keratotomies (and/or for Lasik), except to the extent covered under the Vision Benefit.
22. For purchase of sun lamps required for any cause.
23. For experimental procedures, supplies and devices, and clinical trials unless otherwise required to be covered under the PPACA or other applicable law.
24. For custodial care.
25. For hospitalization for dental unless concurrent hazardous medical condition requires hospitalization. In such instance, only the hospitalization will be covered, the dental procedures are not covered.
26. Infertility treatments (IUI, IVF etc.) unless otherwise required to be covered under the PPACA.
27. Experimental or other investigative treatments, unless otherwise required to be covered under the PPACA.
28. TENS Units.
29. Cosmetic hair removal.
30. Travel and lodging, except under limited circumstances related organ transplants.
31. For automobile accidents.
32. Coverage for motorcycle accidents is limited as provided in this SPD.

8.6 Dental and Vision Benefits

Yes. Dental benefits are provided through Delta Dental. The Schedule of Benefits for Dental is included as **Appendix C**. Vision benefits are provided through VSP. The Schedule of Benefits for the Vision Benefit is included as **Appendix D**.

Also, while they are included at **no additional cost to you**, federal law requires that the Plan provide you with the option of declining Dental and Vision benefits. If you decline the benefits, you will **not** receive any additional funds on your paycheck. In addition, the requirements with respect to eligibility in this Plan will not change.

8.7 Loss of Time Benefits

The Plan will pay up to 26 weeks of Loss of Time Benefits in the amount of $300 per week if you suffer an injury or experience an illness that renders you unable to perform Covered Employment – meaning you cannot work in the trade. The Trustees may, in their sole discretion, extend these benefits for periods of time in excess of this period. If you wish to apply for an extension of these benefits after your 26 weeks has expired, you must contact the Plan Administrator and submit the appropriate form, which the Plan Administrator will provide to you. You may also be required to sign a Reimbursement Agreement in a form approved by the Board of Trustees.

To qualify for Loss of Time Benefits (or an extension of existing benefits), you must (1) be an eligible Participant on the date the disability begins; (2) become unable to work in the trade due to a non-occupational accidental bodily injury, sickness, or disease; and (3) Be under the regular care of a qualified Medical Provider. You will not receive any Loss of Time Benefits for any day during which you perform any work, whether for pay or profit, even if during such period you are still under the care of a Medical Provider.

Benefit payments will start being paid beginning: (1) on the 1st day of a non-occupational accident, injury, surgery, or hospitalization; or (2) on the 8th day of disability for all other instances. Any balance of benefits that has not been paid by the end of the disability period will be paid provided that your Medical Provider provides the Plan with the required medical evidence or a certification that you are unable to work in the trade. This benefit will be coordinated and offset by other benefits you may receive such as workers' compensation benefits. Therefore, as a condition of receiving these benefits, you must sign an agreement to reimburse the Plan.

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

Once you return to work, you must notify the Plan Administrator on that date. If Loss of Time benefits are paid to you when you have returned to Covered Employment and you failed to notify the Plan Administrator, you will be required to refund those payments to the Plan within 10 days.

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

1. For any period of disability during which you are not under the care of a Medical Provider;
2. For disability due to accidental bodily injuries arising out of and in the course of employment;
3. For disability due to occupational disease. Occupational disease means a disease for which the Participant submitting the claim is entitled to receive workers compensation or other benefits provided by law;

4. For disabilities resulting from alcoholism or drug abuse;
5. For any disability caused by or related to engaging in a criminal act;
6. For cosmetic procedures, except where the procedure is needed as a result of an injury during an otherwise covered accident or event;
7. For time lost due to an experimental procedures or surgeries;
8. Surgery to correct vision deficiency in lieu of corrective lenses or contacts;
9. For time lost due to injuries incurred during military service;
10. For dental procedures, unless related to an otherwise covered accident; or
11. Due to self-inflicted injuries.

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

8.8 Life Insurance/Death Benefit

The Plan provides a life insurance/death benefit for Active Participants in the amount of $50,000.00. In order to obtain this benefit, the Beneficiary must submit to the Plan Administrator a certificate of death within one year of the Active Participant's passing. Active Participants may designate one or more Beneficiaries to this benefit. To designate your Beneficiary or change your Beneficiary, please contact the Plan Administrator. If you fail to designate anyone, the benefit will be paid out as follows:

1. The Participant's surviving Spouse; but if there is no surviving Spouse, then to
2. The Participant's surviving child or children, in equal shares; but if there are no surviving children, then to
3. The Participant's surviving parent or parents, in equal shares; but if there are no surviving parents, then to
4. The Participant's surviving siblings, in equal shares; but if there are no surviving siblings, then to
5. The Participant's estate.

If a Participant has named two or more Beneficiaries but has not specified a method of sharing the benefit proceeds, the Beneficiaries who survive the Participant shall be entitled to receive equal shares of the benefit. If any Beneficiary is a minor or otherwise incapable of giving a valid release for any payment due, the benefit proceeds payable to the minor shall be paid to his or her guardian for the minor's sole benefit. If Beneficiary predeceases the Participant, the benefit will be paid to any remaining Beneficiaries, unless the Participant had directed otherwise or the law requires a different distribution.

8.9 Medical Reimbursement Account ("MRA")

For each hour you work, a portion of the Employer Contributions paid on your behalf is allocated to your MRA. Currently $1.00 of the current contribution rate is allocated to the MRA. This rate, however, is subject to change. You must accumulate a balance of at least two times the applicable self-payment premium prior to being eligible to access the balance in the MRA. You may only use the MRA for expenses approved by the Internal Revenue Service and the Board of Trustees. For more information on expenses that the IRS has approved for payment from the MRA, please refer to IRS Publication 502: https://www.irs.gov/forms-pubs/about-publication-502.

You must submit claims for reimbursement from your MRA within 1 year of the date of service. Claims for reimbursement must be total at least $25.00 and be submitted directly to the Plan Administrator with supporting documentation (such as an Explanation of Benefits and proof of payment, such as a receipt, etc.). Expenses without sufficient supporting documentation will not be reimbursed.

Your Spouse and/or Dependents may continue to use the MRA for permitted expenses in the event of your death. If you are not receiving coverage from this Fund, but Employer Contributions are being received on your behalf, the MRA balance will not accumulate during any period that you do **not** have coverage through another health plan with benefits that are considered to provide "minimum value" under the PPACA.

You will lose any balance in the MRA if there is no activity in 24 consecutive months and you are not eligible for any other benefits under this Plan, or if you opt-out of the MRA. **The MRA is not a vested benefit; it can be revoked at any time**. For more information, please contact the Plan Administrator.

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

PART NINE
RESTRICTIONS ON YOUR COVERAGE

9.1 How does the Fund coordinate benefits with other policies or insurance?

Coordination of benefits (COB) sets out rules for order of payment of covered charges when two or more plans (other than a motor vehicle accident policy) cover the same individual. The COB rules apply generally to all benefits payable from this Plan other than the Death Benefit and Loss of Time Benefits. When any person that is eligible for benefits under this Plan is also covered by another plan (for example from their Spouse or another employer that does not pay into this Plan).

The plan that pays first (the primary plan) according to the rules will pay as if there were no other plans involved. The other plans (called secondary plans) will pay the balance due up to 100% of the allowable expenses. Any person eligible for benefits under another plan that is primary over this Plan must comply with that plan's requirements. Only after full compliance and denial by another plan will this Plan provide benefits. If any employer, who provides a health care plan other than this Plan, employs any person receiving benefits under this Plan, then that employer's health insurance program will become the primary insurance carrier.

Example: John's son Mike is 23 years old. Mike is covered under this Plan, but he also is covered under his employer's plan. Mike needs to have a shoulder surgery. The coverage from Mike's employer will pay for the surgery as if Mike did not have any other insurance. If there is any balance left over, then this Plan will provide coverage, if any, which is available for Mike's procedure. Mike will also be responsible for payment of any deductible, co-payments, or coinsurance required under this Plan that is applicable to the benefit provided to him.

This Plan will pay benefits in accordance with its applicable Schedule of Benefits if it is considered to be primary. Otherwise, the other plan will be required to pay the benefits up to the maximum it provides. This Plan will then pay any remaining amounts the other plan does not cover, provided the services are covered under this Plan. Overall, the result is that in the aggregate no more than 100% of the "covered charges" will be paid.

9.2 If my Spouse and I are covered on separate plans, which plan covers our children?

If you both entitled to benefits from separate insurance programs, and both plans cover your children, then the insurance plan that covers the person with the **earliest** birthday in the year will be considered the primary insurance carrier. For example, if your birthday is in June, but your wife or husband's is in April, then their insurance plan will be primary. If the birthdays of the two policyholders are on the same date, the policy of plan that has been in effect for the longer time will be primary.

9.3 Summary of coordination of benefits rules of this Plan

For ease of reference, this Plan generally determines its order of coverage using the following rules:

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

9.4 How are benefits coordinated if I am on Medicare?

Under certain circumstances, Medicare is the primary plan and this Plan is the secondary plan. The table below explains when Medicare is primary. **When Medicare is primary, your claims are filed with Medicare first**. After Medicare makes payment, the Fund will coordinate benefits with Medicare.

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

9.5 What if I am injured in a car or motorcycle accident?

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

Benefits under this Plan are coordinated with motorcycle insurance coverage or any other coverage that provides coverage for a motorcycle accident. Only after all other available coverage has paid will the Fund provide coverage for any covered services. In addition, if you are injured in a motorcycle accident, are **not** wearing a helmet, and have **not** purchased the $20,000.00 insurance policy required by the State of Michigan, the Plan will only provide coverage for the amount of otherwise covered expenses that *exceed* $20,000.00. If you have purchased the insurance, the insurance policy will pay first, and this Plan will pay second for otherwise covered expenses that exceed the amount of the insurance policy.

9.6 What happens if I am injured and the Plan provides benefits for me, but I receive a recovery from a third party?

The Plan has extensive subrogation rights, which means that if the Plan pays benefits on your behalf and you later recover money or other property from any third party to compensate you, your rights to that recovery are "subrogated" to the Plan up to the amount of benefits the Plan provided to you. The Plan also is **automatically** granted a lien against any settlement, judgment, or other payment that you may receive. By receiving benefits, you also agree to assist the Plan in preserving its subrogation and lien rights. The Plan may require you to sign a subrogation or similar agreement before paying claims. **For complete information about the Plan's subrogation rights, you should consult the Plan Document. Further, if you pursue litigation to recover money to compensate you for any type of injury, you should advise your lawyer that you have coverage through a plan that is governed by the Employee Retirement Income Security Act or "ERISA." The failure to do so could subject you to legal action by the Plan to recover the benefits provided to you.**

PART TEN
HOW TO FILE CLAIMS AND APPEAL DENIALS

10.1 General information about claims

Benefits are generally paid directly to the service provider who (with your written authorization) has agreed to accept payment from the Plan. Before benefits can be paid, you may need to obtain appropriate claim form(s) from the Plan Administrator or the provider of the services you received.

The Claims Administrator is the entity that reviews claims for services that you receive (i.e. doctor visits, prescription drugs, surgeries, etc.) because it is the entity that the Fund has an agreement with to administer the benefits and access its networks, providers and other services. Depending upon the type of benefit or service you receive, there is a different Claims Administrator. For benefits under this Fund, the Claims Administrators are listed below, along with their phone numbers and applicable websites.

1.	For Medical/Surgical Services: UMR	800-826-9781 / www.umr.com
2.	For Prescription Drugs: Optum Rx	877-559-2955 / www.optumrx.com
3.	For Dental Benefits: Delta Dental	800-524-0149 / www.deltadentalmi.com
4.	For Vision Services: VSP	800-877-7195 / www.vsp.com
5.	Life Insurance/Death Benefit: Plan Administrator	888 281-3461
6.	Loss of Time Benefits: Plan Administrator	888 281-3461
7.	Medical Reimbursement Account: Plan Administrator	888 281-3461

You must file your claim for benefits with the correct Claims Administrator within 1 year of the date of service. Generally, the provider of your services (i.e. your doctor or pharmacy) will file the claim on your behalf. However, there may occasionally circumstances where you are required to directly submit your claim, or provide information regarding your claim either to the Claims Administrator or the provider of the services you received. Claims filed after one year from the date of service may be declined or reduced. If you were unable to submit a claim within the 1-year deadline, you may request a waiver by contacting the Plan Administrator. Each request for waiver of this deadline will be reviewed on a case-by-case basis. Waivers, if able to be granted under law and/or any applicable contractual restrictions, will only be granted upon a showing of unique and extraordinary circumstances.

10.2 Claim Types

Claims are submitted for payment for services rendered to you. There are different types of claims, and they are generally categorized by the urgency of the claim or when the claim was submitted (before your service or after you have received it). These definitions are summaries only. For the legal definitions of the various types of claims, you should consult the Plan Document.

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

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

Pre-Service Claims. These are claims for care that are approved in advance. If enough information is available, Pre-Service claims will be decided within 15 days of the receipt of the claim. If more time is needed, this period may be extended by 15 days. You will be notified prior to the expiration of the initial 15-day period if an extension is needed. The notice will explain the reason for the delay and give an estimate of when the claim will be decided. If more information is required to decide your claim, then you will be given at least 45 days to provide that information. The claim will then be decided within 15 days of you supplying the information, or by the end of the 45-day period you had to supply that information, whichever time period expires first.

Post-Service Claims. These are claims submitted after you have obtained the treatment. If enough information is available, Post-Service claims will be decided within 30 days of the receipt of the claim. If more time is needed, this period can be extended by 30 days. You will be notified prior to the expiration of the initial 30-day period if an extension is needed. The notice will explain the reason for the delay and give an estimate of when the claim will be decided. If more information is required to decide your claim, then you will be given at least 45 days to provide that information. The claim will then be decided within 15 days of you supplying the information, or by the end of the 45-day period you had to supply that information, whichever time period expires first.

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

How time is calculated. The time periods for review start when a claim is filed correctly (i.e. identifies the claimant & condition and is sent to the proper department of the Claims Administrator), even if some additional information is needed to decide the claim. If an extension of time is needed, the time period to decide a claim is generally suspended until the additional information needed is provided, or the period of time given to you to provide the information expires.

10.3 <u>If my claim gets denied, what happens?</u>

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

10.4 If I want to appeal the denial, what do I have to do?

Appeals from Adverse Benefit Determinations are divided into **two** steps, and are referred as Step 1 Appeals and Step 2 Appeals. Step 1 Appeals are reviewed by the Claims Administrator (please remember that who the Claims Administrator is depends on what kind of claim it is, i.e. medical, dental, prescription drugs, or vision). If your Step 1 Appeal gets denied, you can file a Step 2 Appeal that is reviewed by the Board of Trustees.

If your Step 1 Appeal is denied, this is called an Adverse Benefit Determination and you will receive a notice. The notice will explain your rights and the procedures on how you may appeal that denial to the Board of Trustees. This is called a Step 2 Appeal. The procedures and the details for each step are outlined below.

Step 1 Appeal. You have **180 days** from date of your claim denial to make your appeal. You may submit your appeal yourself, or you may have an authorized representative submit the appeal on your behalf. In addition, once your appeal has been timely filed, you:

1. Can review necessary and pertinent documents on which the denial in whole or in part is based and may submit written comments, documents, records, and other information relating to the claim for benefits.
2. Will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. A document is considered relevant to your claim if the document (A) was relied upon in making the benefit determination, (B) was submitted, considered or generated in the course of making the benefit decision, or (C) demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the Plan and be consistent when applied to similarly situated claimants.

In addition, when considering your appeal, the Claims Administrator:

1. Will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination by the;
2. Will not afford deference to the initial denial of your claim;
3. Will ensure a different person than the individual who initially denied your claim considers your appeal. Also, the individual considering your appeal will not be a subordinate of the person who initially decided to deny your claim;
4. Will consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment when your appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate. The Claims Administrator will provide you the identity of this individual even if their opinion is not relied upon when considering your appeal.
5. You will be notified of the decision from a Step 1 Appeal within the following timeframes:

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

**The timeframe for deciding disability appeals may be extended by additional 45 days. If such an extension is needed, you will be notified prior to the expiration of the initial 45-day period. The notice will explain the reasons for the extension, identify any information needed, and the date a decision is expected to be made.*

If your Step 1 Appeal is denied, this is also called an Adverse Benefit Determination. You will receive a notice detailing the reasons for the denial, informing you of your right to file a Step 2 Appeal with the Board of Trustees, the rights and time limits under which you may bring a civil action, and also describing your other rights under the Plan and ERISA. The notice will also discuss procedures if your claim is of an urgent nature.

Step 2 Appeals. Following the denial of a Step 1 Appeal, you will have **180 days** from the date of the denial to submit your claim to the Board of Trustees. While the notice of the Adverse Benefit Determination will also advise you specifically what you need to do, in general your request for a Step 2 Appeal needs to:

1. Be submitted to the Plan Administrator within **180 days** of the date your Step 1 Appeal was denied;
2. Be in writing, state your name, address, and the fact that you are appealing the denial of your Step 1 Appeal;
3. Give the date of the Step 1 Appeal you filed that was denied and that you are appealing.

When the Board of Trustees reviews your Step 2 Appeal, any new evidence or additional rationale that is considered, relied upon, generated by (or at the direction of) the Board of Trustees (or its professional advisors) will be provided to you automatically and free of charge. This information will further be provided to you **before** the Board of Trustees makes a decision on your appeal so that you have an opportunity to respond to it. If this new evidence or additional rationale is received too late for you to have a reasonable opportunity to respond to it before the Board of Trustees is required to decide your appeal, the time for issuing a final decision on your claim will be suspended for a reasonable period of time until you have responded to the new evidence or rationale, or failed to respond within the time given to you. In this instance, a decision will be made as soon as possible, taking into account any medical exigencies.

If the Board of Trustees denies your appeal, this is called a Final Adverse Benefit Determination. You will receive a notice explaining the reason for the decision, and advising you of your rights relative to the decision under ERISA, including the right to an External Appeal (External Appeals are discussed later in this Section). You will also be notified if your claim is approved. You will receive notice of the Board of Trustees' decision generally within the following time frames:

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

**The timeframe for deciding disability appeals may be extended by additional 45 days. If such an extension is needed, you will be notified prior to the expiration of the initial 45-day period. The notice will explain the reasons for the extension, identify any information needed, and the date a decision is expected to be made.*

10.5 Do I have to go through the appeals process?

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

However, if the error of the Claims Administrator or the Board of Trustees is only minor or "de minimis," then you must complete the internal appeals process first before proceeding with an External Appeal (an outside review, this is discussed in more detail later in his SPD) or filing a lawsuit. A minor error is, generally, one that is not material and does not prejudice the outcome or the review of your appeal, or that is part of a good faith exchange of information between you and the Claims Administrator or the Board of Trustees. In these instances, you must complete **both** levels of the internal appeals process before seeking an external appeal or filing a lawsuit. If you believe the claims process has not been strictly adhered to, you may request a statement from the Claims Administrator or the Board of Trustees. The Claims Administrator or the Board of Trustees will provide you with a response within 10 days. If you pursue an External Appeal or a lawsuit, and a court or the entity that considers the External Appeal rejects your assertion that the Claims Administrator or the Board of Trustees did not strictly adhere to the claims process, you will be able to return to the internal claims and appeals processes of this Plan.

10.6 When can I ask for an External Appeal of a denial by the Board of Trustees?

Appeals from decisions made by the Board of Trustees are called External Appeals. However, not all decisions of the Board of Trustees are eligible for External Appeal. Only the following types of claims are eligible: (1) claims involving an exercise of medical judgment; (2) claims that result in a recession of coverage; or (3) coding errors, but only to the extent a coding error involved an exercise of medical judgment. Claims regarding the application of other provisions of this Plan, for example, whether or not you met the eligibility requirements, are **not** subject to External Appeal. The process for requesting an External Appeal, as well as an expedited External Appeal (for urgent care claims) is discussed in detail below.

Request for External Appeal. If the Board of Trustees denies your claim (you receive a Final Adverse Benefit Determination), you have 4 months to request an External Appeal. If there is no corresponding date that is 4 months after the date of receipt of the denial, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Preliminary Review. Within five (5) business days of receiving the receipt of the request for an External Appeal, the Plan Administrator will complete a Preliminary Review of the request to determine the following:

1. Whether you were covered under this Plan at the time the health care item or service was requested or, in the case of a retrospective review, whether you were covered under this Plan at the time the health care item or service was provided to you;
2. Whether the Adverse Benefit Determination or the Final Adverse Benefit Determination relates to your failure to meet this Plan's requirements for eligibility
3. Whether you have exhausted this Plan's internal appeal processes (the Step 1 and Step 2 Appeals) unless you were not required to exhaust these processes;
4. Whether you have been provided all the information and forms required to process an External Appeal.

Post-Preliminary Review. Within one (1) business day after completion of the Preliminary Review, the Plan will issue a written notice to you noting the reasons if the claim is not eligible for External Appeal, along with contact information for the Employee Benefits Security Administration (EBSA), or, the information needed if the application for the review is not compete. The claimant shall have the **latter** of (a) the four (4) month filing period, or (b) the 48-hour period following your receipt of the notification to provide any additional information that is needed.

Referral to Independent Review Organization (IRO). At the conclusion of the Preliminary Review, the Plan will then refer eligible claims to a randomly selected IRO and immediately provide coverage if the decision of the Board of

Trustees is overturned. The Plan shall adhere to all terms of the contract with the IRO. No costs will be imposed on you for filing an external review.

10.7 Is there an option for an expedited External Appeal?

Yes. The process for seeking an expedited External Appeal is outlined below. You may request an expedited External Appeal at the time you receive either of the following:

1. An Adverse Benefit Determination that involves a medical condition where delay would jeopardize your health or ability to regain maximum function and you have made a request for an expedited Internal Appeal;

   OR

2. You receive a Final Adverse Benefit Determination where you have a medical condition where the timeframe for a standard External Appeal would jeopardize your health or ability to regain maximum function, or, if the determination involves an admission, availability of care, continued stay, or a health care or service for which you received emergency services but you have not yet been discharged.

Preliminary Review. Immediately upon receipt of the request for an expedited review, the Plan shall determine whether the request meets the requirements for external review. This determination is made by applying the criteria for the preliminary review of a standard External Appeal, which is discussed above.

Post-Preliminary Review. Within one business day after completion of the Preliminary Review, the Plan Administrator will issue a written notice. If your claim is not eligible, it will explain if why and also include contact information for the Employee Benefits Security Administration (EBSA) or tell you what additional information is needed if the application for the review is not compete. If the Plan Administrator needs more information, you will have the **latter** of (a) the 4-month filing period, or (b) the 48-hour period following the receipt of the notification to provide any additional information that is needed.

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

PART ELEVEN: WHAT ARE MY RIGHTS AND RESPONSIBILITIES?

11.1 Your rights under ERISA

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

1. Examine, without charge, all plan documents, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description and insurance contracts and any documents filed by the Plan with the U.S. Department of Labor, such as detailed financial reports, etc. This examination may take place at the Plan Administrator's office and at other specified locations such as the work site or the union hall.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. 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.
4. 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.
5. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people (the Board of Trustees) 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 plan benefit or exercising your rights under ERISA. In addition:

1. If your claim for a benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, within certain time schedules.
2. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file a suit in a federal court. In such a case, the court may require the 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 Plan Administrator.
3. 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.
4. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision concerning a QDRO or Medical Child Support Order, you may file suit in federal court. If the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal

fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about this statement, or about your rights under ERISA, you should first contact the Plan Administrator and then contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

11.2 HIPPA, HITECH, and GINA Privacy Rights

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

11.3 When do I have to notify the Fund of changes in my life?

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

1. **Marriage**. To add a Spouse and any eligible Dependents to coverage, the marriage must be reported within 30 days. A copy of the certificate of marriage must be filed with the Plan Administrator. The Spouse and any eligible Dependents will then be covered from the moment of marriage.
2. **New Children.** To add a child to coverage, the birth must be reported within 30 days. A copy of the birth certificate must be filed with the Plan Administrator. The child, however, is always covered from the moment of birth.
3. **Adoptions**. Adoption or placement of a child must be reported within 30 days to add the child as an eligible Dependent and a copy of the legal adoption papers or court order for placement must be filed with the Plan Administrator. Coverage will then be effective as of the date of the adoption or placement for adoptions.
4. **Change of Address**. Any change of address must be reported within 30 days.
5. **Name Change**. Any name change must be reported within 30 days.
6. **Deaths**. Deaths should be reported immediately. A certified copy of the death certificate is required.
7. **Divorce** - Divorce must be reported immediately and a copy of the judgment of divorce must be filed in the Plan Administrator. A former Spouse is no longer eligible for benefits as of the date of the divorce, except as provided under COBRA. The Plan will take action to recoup payments made and coverage provided due to a failure to provide notice of a divorce. Eligible Dependent children will continue to be covered if they continue to qualify as Dependent children under this Plan.
8. **Change of Employment Status**. If you or your Spouse switches employers, returns from a leave of absence, moves to full or part-time employment, then you must notify the Plan Administrator within 30 days.

11.4 Child Medical Support Orders

Where a court has issued a child medical support order, the Plan is required to honor this order if the order meets the requirements of federal law. For a copy of the written procedures for seeking a determination from the Plan as to whether an order is "qualified," contact the Plan Administrator.

11.5 What if I bring a lawsuit against the Plan, can I sue in any court I want to?

No. Any lawsuits filed against this Plan or its Board of Trustees must be brought in the Federal District Court for the Western District of Michigan, or the applicable state court in the county of Ingham if there is no federal jurisdiction over the particular issue.

11.6 What happens when circumstances or benefits change?

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

APPENDIX A
MEDICAL SURGICAL & PRESCRIPTION DRUG BENEFITS FOR ACTIVE PARTICIPANTS

Summary of Cost Sharing Provisions

	IN NETWORK	OUT OF NETWORK
Deductible (please note that the deductible does not apply to prescription drugs)	$500 Individuals $1,000 Family	$1,000 Individuals $2,000 Family
Copayments	$20 Office visits $100 Emergency Room	N/A Office visits $100 Emergency Room
Coinsurance	You Pay 20% Plan pays 80%	You Pay 40% Plan pays 60%
Out of Pocket Maximum (this maximum includes deductibles, copayments and coinsurance amounts)	$5,000 Individuals $10,000 Families	No maximum limit for individual or for families

Preventive Services

	In-Network	Out-of-Network
Health Maintenance Exam	No Charge	Not Covered
Annual Gynecological Exam	No Charge	Not Covered
Well-Baby and Well-Child Exam	No Charge	Not Covered
Immunizations	No Charge	Not Covered
Routine Mammogram	No Charge	Not Covered
	Preventive Services not listed above but required by the Patient Protection and Affordable Care Act of 2010 (PPACA) and its implementing regulations will be covered in-network at no charge.	Not Covered

Hospital Care

	In-Network	Out-of-Network
Facility Fee (i.e. hospital room)	20% co-insurance after deductible	40% co-insurance after deductible
Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible

Alternatives to Hospital Care

	In-Network	**Out-of-Network**
Skilled Nursing Care (120 days maximum per calendar year)	20% co-insurance after deductible	Not Covered
Hospice Care (bereavement counseling covered provided care is obtained within six months of death)	No Charge	No Charge
Respite Care	5 days of coverage during 30-day period	5 days of coverage during 30-day period
Home Health Care	20% co-insurance after deductible	Not Covered
Rehabilitation Services (Physical, speech and occupational therapy limited to combined maximum of 60 visits per calendar year)	20% co-insurance after deductible	40% coinsurance after deductible
Private Duty Nursing	50% coinsurance after deductible	50% coinsurance after deductible

Surgical Services

	In-Network	**Out-of-Network**
Surgery, including related surgical services and anesthesia	20% co-insurance after deductible	40% coinsurance after deductible
Physician/Surgeon Fees	20% coinsurance after deductible	40% co-insurance after deductible
Oral Surgery (some limitations apply, please contact UMR for further information, some services may be covered under the Dental Plan)	20% coinsurance after deductible	40% co-insurance after deductible
For Temporomandibular Joint Disorder	20% coinsurance after deductible	40% co-insurance after deductible

Physician Office Services

	In-Network	**Out-of-Network**
Primary care visit to treat an injury or illness	$20 copay	40% co-insurance after deductible
Specialist Visit (Chiropractic care limited to 24 visits per year)	$20 copay	40% co-insurance after deductible
Preventive care / screening / immunization	No Charge	Not Covered

Maternity Services

	In-Network	**Out-of-Network**
Preventive Pre-Natal and Post-Natal Care	No Charge	Not Covered
Childbirth Professional and Facility Services (dependent pregnancies/births are covered)	20% co-insurance after deductible	40% co-insurance after deductible

Office Visits	20% co-insurance after deductible	40% co-insurance after deductible

Diagnostic Services

	In-Network	**Out-of-Network**
Laboratory and Pathology Tests	20% co-insurance after deductible	40% co-insurance after deductible
Diagnostic Tests and X-Rays	20% co-insurance after deductible	40% co-insurance after deductible
Imaging Tests (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible

Emergency Medical Care

	In-Network	**Out-of-Network**
Hospital Emergency Room (copay waived if admitted or for accidental injury)	$100 copay	$100 copay
Urgent Care Center	$20 copay	40% co-insurance after deductible
Emergency care transportation services	20% co-insurance after deductible	20% co-insurance after deductible

Other Services

	In-Network	**Out-of-Network**
Durable Medical Equipment	20% co-insurance after deductible	40% co-insurance after deductible
Orthotics & Prosthetics	20% co-insurance after deductible	20% co-insurance after deductible
Hearing Aid (one every 36 months)	Implantable devices covered at 10% coinsurance after deductible, otherwise no charge for non-implantable devices	Not Covered
Hearing Aid Evaluation (one every 36 months)	No Charge	Not Covered
Ordering & Fitting Hearing Aid (once every 36 months)	No Charge	Not Covered
Hearing Aid Conformity Test (once every 36 months)	No Charge	Not Covered
Retail Health Clinics	$20 copay	40% co-insurance after deductible
Telemedicine Services when provided through Teladoc	No charge	Not covered
Autism Screening Services (birth through age 2)	No charge	Not covered

Human Organ Transplant

	Designated Facilities	**Non-designated Facilities**
Human Organ Transplants	No Charge	40% co-insurance after deductible
Bone Marrow Transplants	No charge	40% co-insurance after deductible
Cornea and Skin Transplants	20% co-insurance after deductible	40% co-insurance after deductible

Donor Services (if procedure at performed designated facilities, transportation and housing services limited to $10,000, relocation fees not covered)	No Charge	No Charge

Mental Health Care and Substance Abuse Treatment

	In-Network	**Out-of-Network**
In-Patient Mental Health Care	20% co-insurance after deductible	40% co-insurance after deductible
In-Patient Substance Abuse Care	20% co-insurance after deductible	40% co-insurance after deductible
Out-Patient Mental Health Care	20% co-insurance after deductible	40% co-insurance after deductible
Out-Patient Substance Abuse Care	20% co-insurance after deductible	40% co-insurance after deductible

Prescription Drug Benefits

	In-Network		**Out-of-Network**	
	30 Day Supply	**90 Day Supply**	**30 Day Supply**	**90 Day Supply**
Tier 1: Generic Drugs	$4 copay	$10 copay	$4 copay plus 25% of approved amount	N/A
Tier 2: Preferred Brand Drugs	$40 copay	$100 copay	$40 copay plus 25% of approved amount	N/A
Tier 3: Non-Preferred Brand Drugs	$80 copay	$200 copay	$80 copay plus 25% of approved amount	N/A
Tier 4: Generic and Preferred Brand Specialty Drugs	25% coinsurance of approved amount up to $200 (subject to step therapy and prior authorization)	N/A	In-network coinsurance plus 25% of approved amount (subject to step therapy and prior authorization)	N/A
Tier 5: Non-Preferred Brand Specialty Drugs	40% coinsurance of approved amount up to $300 (subject to step therapy and prior authorization)	N/A	In-network coinsurance plus 25% of approved amount (subject to step therapy and prior authorization)	N/A

APPENDIX B
MEDICAL SURGICAL & PRESCRIPTION DRUG BENEFITS FOR EARLY RETIREES & RETIREES ON MEDICARE

	IN NETWORK	OUT OF NETWORK
Deductible (please note that the deductible does not apply to prescription drugs)	$300 Individuals $600 Family	$400 Individuals $800 Family
Copayments	$20 Office visits $100 Emergency Room	N/A Office visits $100 Emergency Room
Coinsurance	You Pay 10% Plan pays 90%	You Pay 20% Plan pays 80%
Out of Pocket Maximum (this maximum includes deductibles, copayments and coinsurance amounts)	$6,850 Individuals $13,700 Families	$13,700 Individuals $27,400 Families

Preventive Services

	In-Network	Out-of-Network
Health Maintenance Exam	No Charge	Not Covered
Annual Gynecological Exam	No Charge	Not Covered
Well-Baby and Well-Child Exam	No Charge	Not Covered
Immunizations	No Charge	Not Covered
Routine Mammogram	No Charge	Not Covered
	Preventive Services not listed above but required by the Patient Protection and Affordable Care Act of 2010 (PPACA) and its implementing regulations will be covered in-network at no charge.	Not Covered

Hospital Care

	In-Network	Out-of-Network
Facility Fee (ex., hospital room)	10% co-insurance after deductible	30% co-insurance after deductible
Physician/surgeon fees	10% co-insurance after deductible	30% co-insurance after deductible
Oral Surgery (some limitations apply, please contact UMR for further information, some services may be covered under the Dental Plan)	10% coinsurance after deductible	30% co-insurance after deductible

Alternatives to Hospital Care

	In-Network	**Out-of-Network**
Skilled Nursing Care (120 days maximum per calendar year)	20% co-insurance after deductible	Not Covered
Hospice Care (bereavement counseling covered provided care is obtained within six months of death)	No Charge	No Charge
Respite Care	5 days of coverage during 30-day period	5 days of coverage during 30-day period
Home Health Care	10% co-insurance after deductible	Not Covered
Rehabilitation Services (Physical, speech and occupational therapy limited to combined maximum of 60 visits per calendar year)	10% co-insurance after deductible	30% co-insurance after deductible
Private Duty Nursing	50% coinsurance after deductible	50% coinsurance after deductible

Surgical Services

	In-Network	**Out-of-Network**
Surgery, including related surgical services and anesthesia	10% co-insurance after deductible	30% co-insurance after deductible
Physician/Surgeon Fees	10% co-insurance after deductible	30% co-insurance after deductible
For Temporomandibular Joint Disorder	10% coinsurance after deductible	30% co-insurance after deductible

Physician Office Services

	In-Network	**Out-of-Network**
Primary care visit to treat an injury or illness	$20 copay	30% co-insurance after deductible
Specialist Visit (Chiropractic care limited to 24 visits per year)	$20 copay	30% co-insurance after deductible
Preventive care / screening / immunization	No Charge	Not Covered

Maternity Services

	In-Network	**Out-of-Network**
Preventive Pre-Natal and Post-Natal Care	No Charge	Not Covered
Childbirth Professional and Facility Services (dependent pregnancies/births are covered)	10% co-insurance after deductible	30% co-insurance after deductible
Office Visits	10% co-insurance after deductible	30% co-insurance after deductible

Diagnostic Services

	In-Network	**Out-of-Network**
Laboratory and Pathology Tests	10% co-insurance after deductible	30% co-insurance after deductible
Diagnostic Tests and X-Rays	10% co-insurance after deductible	30% co-insurance after deductible
Imaging Tests (CT/PET scans, MRIs)	10% co-insurance after deductible	30% co-insurance after deductible

Emergency Medical Care

	In-Network	**Out-of-Network**
Hospital Emergency Room (copay waived if admitted or for accidental injury)	$100 copay	$100 copay
Urgent Care Center	$20 copay	30% co-insurance after deductible
Ambulance Services	10% co-insurance after deductible	10% co-insurance after deductible

Other Services

	In-Network	**Out-of-Network**
Durable Medical Equipment	10% co-insurance after deductible	10% co-insurance after deductible
Hearing Exam (one every 36 months)	No Charge	Not Covered
Hearing Aid (one every 36 months)	No Charge Implantable devices covered at 10% coinsurance after deductible, otherwise no charge for non-implantable devices	Not Covered
Hearing Aid Evaluation (one every 36 months)	No Charge	Not Covered
Ordering & Fitting Hearing Aid (once every 36 months)	No Charge	Not Covered
Hearing Aid Conformity Test (once every 36 months)	No Charge	Not Covered
Telemedicine services when provided through Teladoc	No charge	Not covered
Autism Screening Services (birth through age 2)	No charge	Not covered

Human Organ Transplant

	Designated Facilities	**Non-designated Facilities**
Human Organ Transplants	No Charge	40% co-insurance after deductible
Bone Marrow Transplants	No charge	40% co-insurance after deductible
Cornea and Skin Transplants	20% co-insurance after deductible	40% co-insurance after deductible
Donor Services (if procedure at performed designated facilities, transportation and housing services	No Charge	No Charge

limited to $10,000, relocation fees not covered)		

Mental Health Care and Substance Abuse Treatment

	In-Network	Out-of-Network
In-Patient Mental Health Care	10% co-insurance after deductible	30% co-insurance after deductible
In-Patient Substance Abuse Care	10% co-insurance after deductible	30% co-insurance after deductible
Out-Patient Mental Health Care	10% co-insurance after deductible	30% co-insurance after deductible
Out-Patient Substance Abuse Care	10% co-insurance after deductible	30% co-insurance after deductible

Prescription Drug Benefits

	In-Network		Out-of-Network	
	30 Day Supply	**90 Day Supply**	**30 Day Supply**	**90 Day Supply**
Tier 1: Generic Drugs	$4 copay	$8 copay	$4 copay plus 25% of approved amount	N/A
Tier 2: Preferred Brand Drugs	$40 copay	$80 copay	$40 copay plus 25% of approved amount	N/A
Tier 3: Non-Preferred Brand Drugs	$80 copay	$160 copay	$80 copay plus 25% of approved amount	N/A
Tier 4: Generic and Preferred Brand Specialty Drugs	15% coinsurance of approved amount up to $150 (subject to step therapy and prior authorization)	N/A	15% coinsurance of approved amount up to $150 plus 25% of approved amount (subject to step therapy and prior authorization)	N/A
Tier 5: Non-Preferred Brand Specialty Drugs	25% coinsurance of approved amount up to $300 (subject to step therapy and prior authorization)	N/A	25% coinsurance of approved amount up to $300 plus 25% of approved amount (subject to step therapy and prior authorization)	N/A

APPENDIX C
DENTAL BENEFITS THROUGH DELTA DENTAL

Benefits

Please note that the PPO Network provides the deepest discounts and greatest cost savings to you. A Premier Dentist provides more savings, but not as much as a PPO Dentist. A Non-Participating Dentist still provides savings, but the least amount of savings to you. For more information, please consult the information sent to you from Delta Dental or contact them directly at 800-524-0149 / www.deltadentalmi.com

Service	DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIER DENTIST	NON-PARTICIPATING DENTIST
	Plan Pays	Plan Pays	Plan Pays
Diagnostic and Preventive			
Diagnostic/Preventive Services – exam, cleaning, fluoride, space maintainers	100% of the allowed amount	100% of the allowed amount	100% of the allowed amount
Emergency Palliative Treatment – to temporarily relieve pain	100% of the allowed amount	100% of the allowed amount	100% of the allowed amount
Sealants – to prevent decay of permanent teeth	100% of the allowed amount	100% of the allowed amount	100% of the allowed amount
Brush Biopsy – to detect oral cancer	100% of the allowed amount	100% of the allowed amount	100% of the allowed amount
Radiographs – X-rays	100% of the allowed amount	100% of the allowed amount	100% of the allowed amount
Basic Services			
Minor Restorative Services – fillings and crown repair	75% of the allowed amount	75% of the allowed amount	75% of the allowed amount
Endodontic Services – root canals	75% of the allowed amount	75% of the allowed amount	75% of the allowed amount
Periodontics Services – to treat gum disease	75% of the allowed amount	75% of the allowed amount	75% of the allowed amount
Oral Surgery Services – extractions and dental surgery	75% of the allowed amount	75% of the allowed amount	75% of the allowed amount
Major Restorative Services – crowns	75% of the allowed amount	75% of the allowed amount	75% of the allowed amount

***** *When you receive services from a non-participating dentist, the percentages in this column indicate the portion of Delta Dental's non-participating dentist fee that will be paid for those services. The non-participating dentist fee may be less than what your dentist charges and you are responsible for the difference.*

Annual Maximums & Deductibles

MAXIMUM PAYMENTS	
For All Services	$1,000 per person per calendar year
DEDUCTIBLES	
Single Coverage	$100
Family Coverage	$300

The following benefit limits shall apply:

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Space maintainers are payable once per area per lifetime for people up to age 19.
- Bitewing X-rays are payable twice per calendar year and full-mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per three-year period for the occlusal surface of first and second permanent molars up to age 20. The surface must be free from decay and restorations.
- Veneers are payable on incisors, cuspids, and bicuspids once per tooth per five-year period when necessary due to fracture or decay.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Metallic inlays are Covered Services.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Reline and rebase of dentures and tissue conditioning are payable once in any three-year period.
- Implants are payable for first and second molars, bicuspids, canines, and incisors, once per tooth per lifetime for people age 16 and older.
- Crowns over implants are payable for first and second molars, bicuspids, canines, and incisors once per tooth per five- year period for people age 16 and older.
- Occlusal guards are payable once per calendar year. Five limited occlusal adjustments are Covered Services in any five- year period.

APPENDIX D
VISION BENEFITS

GENERAL

This Schedule lists the vision care services and vision care materials to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Certificate to which it is attached.

Member Doctors are those doctors who have agreed to participate in VSP's Choice Network.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Member Doctors and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $15.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

VISION CARE SERVICES

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Eye Examination	$10.00 copay	Reimbursement up to $45.00 less $10.00 copay (member responsible for any difference)

Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations every 12 months.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	$15.00 copay*	Reimbursement up to approved amount less $15.00 copay (member responsible for any difference)
Bifocal	$15.00 copay*	Reimbursement up to approved amount less $15.00 copay (member responsible for any difference)
Trifocal	$15.00 copay*	Reimbursement up to approved amount less $15.00 copay (member responsible for any difference)
Lenticular	$15.00 copay*	Reimbursement up to approved amount less $15.00 copay (member responsible for any difference)

Available once every 12 months.

Frames	$15.00 copay	Reimbursement up to $70.00 less $15.00 copay (member responsible for any difference)

Available once every 24 months.

*Less any applicable Copayment.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available once every 12 months in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses again for -- months and frames for -- months.

Necessary-
Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Necessary	**Professional Fees and Materials**	**Professional Fees and Materials**
	$15.00 copay	Reimbursement up to $210.00 less $15.00 copay (member responsible for any difference)
Elective	**MEMBER DOCTOR BENEFIT**	**NON-MEMBER PROVIDER BENEFIT**
	Professional Fees and Materials**	**Professional Fees and Materials**
	$130.00 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105.00 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)

**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

LOW VISION BENEFIT

The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses.

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Supplementary Testing	Covered in Full	Up to $125.00

Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

Copayment for Supplemental Aids: 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is $1,000.00 (excluding Copayment) every two years.

NON-MEMBER PROVIDER BENEFIT

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

NOT COVERED

There is no benefit for professional services or materials connected with:

- Orthoptic or vision training and any associated supplemental testing; Plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;

- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

- Costs for services and/or materials above Plan Benefit allowances;

- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE PLAN LIMITATIONS IF, IN THE OPINION OF VSP's OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.