PLUMBERS AND PIPEFITTERS
LOCAL UNION NO. 333
HEALTH & WELFARE PLAN

2019 SUMMARY PLAN DESCRIPTION

MID-MICHIGAN MECHANICAL CONTRACTORS ASSOCIATION

GCC/IBT

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PART ONE:
GENERAL INFORMATION

1.1 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, and on whose behalf an Employer makes contributions to this Fund.

→ Apprentice – means a person who is duly sworn in as a member of the Union and who is a registered apprentice with the Plumbers and Pipefitters Local 333 Apprenticeship Program.

→ Beneficiary – means the person or persons designated by a Participant to receive benefits from the Plan in the event of his/her death, or, in the absence of an effective designation, if such designated person or persons shall have died, the first of the following classes of beneficiaries, then surviving, in successive preference, the Participant's: (a) Spouse; (b) children; (c) parents; (d) brothers and/or sisters; and (e) estate. The term "children" shall include legally adopted childrren. For purposes of other benefits under the Plan, the term Beneficiary shall mean the Participant's eligible Spouse or child.

→ Benefit Year – means the calendar year.

→ Claim – means a request for a Plan benefit by an eligible Participant or his/her Dependent.

→ Collective Bargaining Agreement or CBA – means an agreement between an Employer and the Union to which Employer has agreed to provide fringe benefit contributions to the Fund.

→ Continuing Eligibility – means the requirements for a Participant and/or his/her Dependents to continue eligibility for benefits under the Plan after meeting the requirements for Initial Eligibility.

→ Contribution Hours – means the hours worked in Covered Employment, for which an Employer has made Employer Contributions to this Fund pursuant to a Collective Bargaining Agreement, or other written agreement. Only hours for which contributions are received by the Fund will be deemed Contribution Hours.

→ Covered Employment – means employment with an Employer, for which the Employer has agreed, through a written Collective Bargaining Agreement with the Union, or other written agreement, to contribute to this Fund.

→ Dependent – Dependents are your Spouse and your children. For a "Dependent child" to be eligible for benefits, that child must be a son, daughter, stepchild, adopted child, 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 incapable of self-sustaining employment because of mental or physical handicap, who is dependent upon you for support and maintenance, and whose disability began prior to reaching age 26.

→ Disabled – means that as a result of a physical or mental condition, the Board of Trustees find, on the basis of satisfactory medical evidence, a Participant is prevented from engaging in Covered Employment. Disabilities occurring as a result of any of the following will not meet this definition: (1) use of narcotics; (2) disabilities contracted, suffered, or incurred while the Participant was

engaged in or resulted from participation in any criminal activity; or (3) comes from a self-inflicted injury that is not the result of a medical condition.

→ 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 – means 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 this Fund.

→ Employer – means 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 this 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;
- 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;
- Any council, committee, or other body composed of representatives of one or more labor organizations of which the Union 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.

In the case of an Employer electing to contribute pursuant to the provisions the last four (4) provisions above, contributions must be uniformly made with respect to all Employees of that Employer.

→ Employer Contributions – means those sums required to be paid to the Plan pursuant to the governing Collective Bargaining Agreement between an Employer and the Union.

→ Hour Bank – means a notional account where hours in excess of those required to meet this Plan's requirements for Continuing Eligibility are stored. These hours can then be used to continue eligibility in months where the Active Participant does not work the minimum number of hours required to continue coverage. Only Active Participants may maintain an Hour Bank.

→ Hours of Service – means equivalent hours where during the time period that the Retiree was an Active Participant made full or partial self-payments to continue eligibility and equivalent hours

where during the time period that the Retiree was an Active Participant and was not working, but still received credits from the Plan to continue coverage.

→ Initial Eligibility – means the requirements for the Participant and his/her Dependents to become initially eligible for benefits under the Plan.

→ Leave of Absence – means any leave granted by an Employer for reasons of health or public service, including but not limited to leave under The Family Medical Leave Act, for maternity or paternity leave, for service in the Armed Forces of the United States, or other such leave that is approved by the Active Participant's Employer.

→ Medical Reimbursement Account or MRA – means an account used exclusively to pay for certain medical out-of-pocket expenses as specified under the Internal Revenue Code and not otherwise covered by the Plan.

→ Medically Necessary – means health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

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

→ Pension Plan– means the Plumbers and Pipefitters Local 333 Pension Plan.

→ Medical Provider – means a Doctor of Medicine, osteopathy, chiropractic, 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.

→ Plan Year or Fiscal Year – means the time period of July 1 through June 30.

→ Predecessor Plans – means the Plumbers and Pipefitters Local 313 Health and Welfare Plan, the Battle Creek Plumbers and Pipefitters Local 335 Group Insurance Plan and the Plumbers and Pipefitters Local 388 Health Care Fund. The Predecessor Plans shall not grant any right, title or interest in this Plan, unless same is specifically provided for herein.

→ Qualified Medical Support Order – means a medical support order which creates or recognizes the existence of an alternate recipient's right to receive benefits as a Dependent under this Plan and includes:

- The name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order;
- A reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient or the manner in which such type of coverage is to be determined (not to exceed the level of coverage offered by the Plan);
- The period to which such order applies; and
- The legal name of this Fund.

→ Retiree – means an individual who has retired from Covered Employment and who is receiving pension benefits from a plan sponsored by the Union.

→ Sickness – means disease, mental, emotional or nervous disorders, and covered pregnancy. A recurrent sickness shall be considered as one sickness. All related sicknesses shall be considered

as one sickness. Concurrent sickness shall be deemed to be one sickness unless such sicknesses are totally unrelated.

→ Spouse – means the individual to whom an Employee is legally married to. A marriage certificate shall be required as proof of a valid marriage. Legal separation is also considered the dissolution of the marriage, and once effective the Spouse will no longer be considered a Spouse under the Plan.

→ Union – means the United Association of Journeymen Plumbers and Journeymen Steamfitters and Pipefitters Local Union No. 333, or any successor thereto.

1.2 General Information about the Fund

The Plumbers and Pipefitters Local Union No. 333 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 Mid-Michigan Mechanical Contractors Association – appoints half of the Trustees, while the other half of the Trustees is 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). This Plan is self-funded, meaning the benefits are paid from the assets of the Trust. Some ancillary benefits, however, are provided through a policy of insurance. These benefits are described in detail within this SPD.

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 Plan Administrator is a third-party entity that administers the Fund on the Board of 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 Plan Administrator is TIC International Corporation, Inc. The phone number where you can reach the Plan Administrator is (866) 348-9499 and the address is 6525 Centurion Dr., Lansing, Michigan 48917.

The Plan's federal identification number is 38-3544316. The Plan ID Number is 501.

1.3 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 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.

1.4 Who is responsible for the Administration of the Plan?

The Board of Trustees, or its designated representatives or agents, will have the fullest possible discretionary authority to administer all aspects of the Plan's operations. This includes, but is not limited to, the exclusive right and discretion to interpret all terms and provisions of the Plan's governing documents, which include, but are not limited to, the Health & Welfare Plan, the Trust Agreement, this Summary Plan Description, any Summary of Material Modifications, or any document, instrument, or record used to administer the Plan, as well as any amendments or modifications to these documents. Such authority and discretion will be to the broadest extent possible as permitted under and/or by the law. Unless otherwise expressly provided by applicable law, the Board of Trustee's determination on all matters related to the Plan will be final and binding on all concerned parties.

1.5 Who are the members of the Board of Trustees?

Union Trustees

Price Dobernick
5405 S. Martin L. King Jr. Blvd.
Lansing, Michigan 48911-3593

George VanCoppenolle
Plumbers and Pipefitters Local Union 333
3101 Allied Industrial Rd.
Jackson, Michigan 49201

Joseph Michilizzi
Plumbers and Pipefitters Local Union 333
5906 E. Morgan Road
Battle Creek, Michigan 49037

Christopher Keck
Plumbers and Pipefitters Local Union 333
5405 S. Martin L. King Jr. Blvd.
Lansing, Michigan 48911-3593

Employer Trustees

Kevin Jonas
Paul E. Bengel Company
420 E. Prospect St.
Jackson, Michigan 49203

Jason Kreger
Aladdin, Inc.
4809 James McDivitt
Jackson, Michigan 48201

Chad Myers
Myers Plumbing & Heating
16825 Industrial Parkway
Lansing, Michigan 48906

John Green
John E. Green Co.
220 Victor Ave.
Highland Park, Michigan 48203

Alternate Trustee

Becky Brimley
Mid-Michigan Mechanical
Contractors Assn.
901 S. Cedar Street, Suite 200
Mason, Michigan 48854

1.6 Who is the Fund's legal counsel?

The Fund's legal counsel is Novara Tesija & Catenacci, P.L.L.C. Their address is 888 W. Big Beaver Road, Suite 600, Troy, Michigan 48084. 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.

1.7 How are legal papers served on the Fund?

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

1.8 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, at any time, choose to provide some or all of the Fund's benefits on an insured basis.

1.9 Where are the Plan's records and reports stored?

The Board of Trustees will keep such records and other data as may be necessary for the proper administration of the Plan. Upon receipt of a written request, the Board of Trustees shall furnish you and/or a Beneficiary with a copy of the Plan, Trust Agreement, or latest annual report, subject to exceed the lesser of: (1) the actual cost of reproduction; or (2) $0.25 per page.

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 an 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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (480 hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours as applicable).

Non-Discrimination. The Fund complies with all 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, please 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.

Primary Care/OB/GYN Care. The Plan does not impose any restrictions on your choice to designate a primary care provider, pediatrician, or require prior approval to obtain OB/GYN care.

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 you lose the other coverage, you can enroll in coverage again from the Fund (special enrollment). **If that happens, you must request reenrollment in the Plan within thirty (30) days 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 must provide a copy of the new baby's birth certificate to the Plan Administrator within thirty (30) days of the birth.**

If you are adding a new Spouse, child, including stepchild, or adopted child that is not a newborn, you need to notify the Plan Administrator within thirty (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 in Part Eleven (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, (s)he 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 (30)-day window to request enrollment or provide the required information, such as a marriage license.

1.13 Employer Contributions

Employer Contributions are 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 in which contributions are due for, but have not yet been paid to the Fund, by your Employer, will not be counted as Employer Contributions toward eligibility for benefits under this Plan.

1.14 Termination of Eligibility

Eligibility for benefits under this Plan shall terminate on the last day of the month for which you or your Dependents have failed to meet any applicable requirement for eligibility. If you are continuing eligibility by making self-payments (discussed later), eligibility for benefits shall terminate on the last day of the month preceding the month in which you cease making self-payments.

1.15 Reinstatement Upon Return from Military Service

Contributions, benefits and service credit with respect to qualified military service will be provided in accordance with Section 414(u) of the Internal Revenue Code, as amended from time to time.

1.16 Reciprocity for work in other Union jurisdictions

The Board of Trustees may enter into reciprocity agreements with other health and welfare funds 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 allow you to meet the Continuing Eligibility requirements of this Fund (the "home fund"). If you work in another jurisdiction and have Employer Contributions made to another fund on your behalf, you may request that such contributions be transferred to this Fund via a reciprocity agreement. All of the hours worked for which the contributions are actually transferred to this Fund will be credited you, for eligibility purposes, regardless of the contribution rate in effect in the transferring fund's area.

PART TWO:
ELIGIBILITY FOR ACTIVE PARTICIPANTS

2.1 What are the requirements for Active Participants to become eligible under the Plan?

Active Participants become eligible for benefits on the first day of the month following the month in which the Fund receives either (a) at least two-hundred fifty (250) hours of Employer Contributions in any consecutive two (2)-month period or (b) at least five-hundred (500) hours of Employer Contributions in any consecutive five (5)-month period.

Example 1: Alex starts work in February. He works 130 hours in February, and 120 hours in March. Alex will be covered under the Plan beginning April 1.

Example 2: Sue starts work in February. She works 100 hours in each of the following months: February, March, April, May and June. Sue would be covered under the Plan starting on July 1.

The Plan Administrator will determine your eligibility automatically. Initial Eligibility rules apply to you if you have been ineligible for more than twenty-four (24) months. You cannot make self-payments (discussed below) to establish Initial Eligibility.

Once you establish Initial Eligibility, you will be eligible for benefits for a period of three (3) consecutive months. Additionally, 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. Please note other benefits under this Plan may have additional eligibility conditions that you need to meet prior to receiving benefits.

2.2 Is there a way to expedite eligibility?

Yes, under certain circumstances. Employees of newly organized Employers may elect to expedite eligibility by starting with a negative 250-hour balance in the Hour Bank. The negative balance will be made up through hours you work in excess of the requirements for Continuing Eligibility. If you want to use this option, you must notify the Plan Administrator within **ten (10) days** of starting Covered Employment so that the Plan Administrator can activate your coverage.

Example: ABC Company is organized is June, and Ed selects expedited eligibility. Ed will begin coverage immediately, and once he has worked at least 250 hours, any excess hours will be credited to his Hour Bank up to the maximum of 650.

This option is not available to you if are a current or past Employee or Participant. If you expedite Initial Eligibility under this provision and you cease being available for from an Employer for any reason other than death, disability, retirement or a Leave of Absence, the Fund may take back any or all of your

hours in your Hour Bank (not just those hours limited to Continuing Eligibility as discussed below). Your eligibility will then terminate, and you will be offered coverage under COBRA, if you qualify.

2.3 What are the monthly requirements to stay eligible under the Plan?

After becoming initially eligible for benefits and after the expiration of the initial three (3)-consecutive month period, you maintain eligibility by working at least one-hundred thirty (130) hours every month. **Remember, only hours actually paid by your Employer count towards eligibility.** If your Employer fails to pay on time, you will have to continue eligibility by using any hours that you have accumulated in your Hour Bank or by making a self-payment.

Continuing Eligibility is based on a three (3)-month bookkeeping system, in which hours worked in the current month provide coverage as the first day of the third month thereafter, as indicated below:

Hours Worked in:	Count for Eligibility In:
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

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

Contribution Hours received by the Fund in excess of 130 are credited to your Hour Bank, up to a maximum of 650 hours. In any month that you do not work at least 130 hours, the Fund will automatically take hours from your Hour Bank to continue eligibility. If you do not have enough hours in the Hour Bank, you can continue coverage through self-payments. The terms and conditions for making self-payments are described below in Section 2.6.

In the case of your death, your surviving Spouse or your Dependents may use the balance in your Hour Bank to continue coverage in conjunction with the Plan's terms and conditions. The Hour Bank may also be used to reinstate eligibility. However, the hours from the Hour Bank must be used within six (6) months of the date your coverage is terminated; otherwise, if you have more than one-hundred thirty (130) hours, they will be forfeited back to the Plan.

Please note that in order to use the Hour Bank, you must be available for work from an Employer unless you are Disabled, retire or take a Leave of Absence. Failure to register on the Union's out of work list or maintain your book with the Union will result in a rebuttable presumption that you are not available for work. As a result, the balance in your Hour Bank and MRA will be forfeited to the Fund. You also (as noted in Section 2.6) will not be eligible to make self-payments. You will then, if eligible, be offered coverage under the COBRA provisions of this Plan.

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

If you do not work enough hours to stay eligible or your Employer is delinquent, you can still continue coverage by either drawing from your Hour Bank, your MRA, by making a self-payment, or using a combination of these methods if you are otherwise eligible to do so. The terms and conditions of making self-payments are described in Section 2.6 below.

2.6 How can I make self-payments?

If you do not work at least 130 hours in a month and do not have enough hours in your Hour Bank to continue coverage, you may be able continue coverage by making a full or partial self-payment. A full self-payment is made when made when there are no Contribution Hours received on your behalf for a particular month and when you have no hours remaining in your Hour Bank. Partial self-payments are self-payments that are offset by Contribution Hours, hours from your Hour Bank, or a combination of these two methods. The current self-payment rate is determined by taking 130 multiplied by the in-force contribution rate under the CBA, which is then reduced by any Contribution Hours, hours from the Hour Bank, funds from the MRA, or a combination of these methods. Please note that you can make a maximum of six (6) consecutive **full** self-payments. However, there is no limit on the number of partial self-payments you can make.

> *Example: Peter works 130 hours each in January, February, March and April but does not work any hours in May. He does not have any hours in his Hour Bank. Even if Peter does not find another job with an Employer, provided he is otherwise available for work, registers on the out of work list and maintains his book, he can make full self-payments until November to continue coverage.*

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.**

Please note that in order to be eligible to make self-payments, you must be available for work from an Employer unless you are Disabled, retire or are on a Leave of Absence. Failure to register on the Union's out of work list or to maintain your book with the Union will result in a rebuttable presumption that you are not available for work. As. a result, you will not be eligible to make self-payments and the balance in your Hour Bank and your MRA will be forfeited to the Fund. You will then, if eligible, be offered coverage under the COBRA provisions of this Plan.

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

If your coverage is terminated for **more** than twenty-four (24) months, you must again meet the requirements for Initial Eligibility. If your eligibility is terminated for **less** than twenty-four (24) months, you may re-establish eligibility on the earlier of: (1) the first day of the month following the month in the Fund receives at least two-hundred fifty (250) Contribution Hours in any two (2) consecutive calendar months; or (2) the first day of the month following the month in which the Fund receives at least one-hundred thirty (130) Contribution Hours from your Employer or from your Hour Bank.

Example: Joe makes self-payments in February and March to continue coverage, but he does not make a payment in April. He returns to work in June. In June and July, the Fund receives 140 and 150 Contribution Hours. Joe's coverage will be reinstated effective August 1.

PART THREE:
ELIGIBILITY FOR OFFICE EMPLOYEES

3.1 What are the requirements for initial eligibility for office employees?

Class O Participants are employed by an Employer but are not working in Covered Employment. You are considered a full-time Class O Participant if you work thirty-two (32) hours or more a week. You become eligible for benefits no later than ninety (90) days following the month in which the Fund receives at least one-hundred sixty (160) hours of Employer Contributions.

The Plan Administrator will determine your eligibility automatically. In order to be eligible, however, you must execute all necessary enrollment forms. Please note that Class O eligibility is contingent on the Employer making contributions for all office workers. Furthermore, the number of Class O Participants permitted in the Plan is limited by law,and may be reduced, if necessary, to comply with legal requirements.

3.2 What are the monthly requirements to stay eligible?

After becoming initially eligible for benefits, you must continue to maintain eligibility. You will remain eligible as long as the Fund receives at least one-hundred sixty (160) Contribution Hours each month.

3.3 Are there any means of continuing eligibility if my Employer is delinquent?

No. Class O Participants may not make self-payments, and do not earn an Hour Bank.

3.4 How can I reinstate coverage?

If your Employer is delinquent, your coverage will be reinstated the first day of the month following the month in which once the Fund receives at least one-hundred sixty (160) Contribution Hours.

PART FOUR:
ELIGIBILITY WHEN YOU RETIRE FROM COVERED EMPLOYMENT

4.1 What are the requirements to qualify for coverage when I retire prior to age 65?

In order to initially qualify for coverage as a Retiree you must meet **all** of the following requirements:

1. Be age fifty-two (52) or older;
2. Not be eligible for Medicare;
3. Retire from Covered Employment or from employment as a Class O alumni Participant (i.e. you were formerly an Active Participant that later became a Class O Employee);
4. Have been an Active Participant or a Class O alumni Participant that was covered by this Plan for at least 12 of the 24 months prior to the date of retirement;
5. Have been eligible as a participant in the Pension Plan for at least ten years prior to the date of retirement;
6. Be credited with at least 5,000 Hours of Service in the five years immediately preceding the date of retirement;
7. Apply for monthly retirement benefits from the Pension Plan or apply for Social Security retirement benefits;
8. Maintain continuity of coverage through the date of retirement, except those Retirees that did not have coverage available prior to the Effective Date provided they meet all other requirements of this Section.

4.2 What are the monthly requirements to stay eligible?

Coverage is maintained by timely remitting the required self-payment premiums each month. You will be notified by the Plan Administrator of the monthly amount due to maintain your coverage. The self-payment amount is established and subject to change by the Board of Trustees. You may make arrangements between this Plan and other pension, annuity or similar funds for direct payment of these premiums.

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.

4.3 May I use any banked hours in my Hour Bank and funds from my MRA?

Yes, you may use all hours in the Hour Bank prior to being required to make self-payments for coverage. You may also use the funds in your MRA for expenses that qualify for reimbursements.

4.4 What happens if I die as a Retiree?

In the event of your death, your eligible Dependents will continue to be covered until the end of the third calendar month following the calendar month in which the death occurred before additional self-payments are required to continue coverage. If there are hours remaining in your Hour Bank at the time of your death, eligible Dependents may use these hours prior to making self-payments.

4.5 How may I add my Spouse after my coverage begins?

If, after beginning coverage, you get married or have a Spouse who loses an employer-sponsored coverage, you may add your Spouse onto your coverage as long as you provide notice to the Plan within thirty (30) days from the date of your marriage or the termination of your Spouse's other coverage.

4.6 Is there an option to opt-out if I have other coverage available?

Yes. If you have coverage through your spouse or other employment, you may opt out of coverage through the Plan. You may reenroll by notifying the Plan Administrator within 30 days of any of the following events: (1) divorce; (2) your Spouse's death; (3) loss of employment; or (4) an event that causes a non-voluntary termination of such other coverage. Reinstatement for any other event will be not permitted until January 1 of the following year, and the Retiree must advise the Plan Administrator during Open Enrollment, which runs from December 1 to December 31, of the request to reinstate. You must certify to the Fund that the coverage opted out in favor is not (1) only a Health Reimbursement Account and (2) provided minimum value under the Patient Protection and Affordable Care Act (PPACA).

4.7 What if I return to work as a Retiree?

If you return to Covered Employment, the amount of Employer Contributions received by the Fund will be used to offset your monthly self-payment for that month. If you work enough hours in a particular month you will not be required to make a self-payment for that month. However, you will not be able to bank excess Employer Contributions.

4.8 What happens to my coverage when I become eligible for Medicare, or if I retire after turning age 65?

If you are retired and age 65 or older, you have the option of purchasing a Medicare Advantage Plan from a third-party provider of such coverage at a group rate negotiated by the Plan. **However, this coverage is not administered, paid for, nor guaranteed by the Plan.** The Board of Trustees does not guarantee the adequacy, quality, or market competitiveness of the rate that is negotiated. The negotiation of the discounted rate by the Plan is only an accommodation and not a right. You will also be provided with a dental and life insurance benefits, which is described in more detail later in this SPD. The Board of Trustees reserves the rights to cease providing all forms of retiree coverage at any time, it is **not** a vested benefit.

4.9 **Is Retiree coverage vested?**

No, coverage is not a vested or guaranteed benefit for Retirees. At the Board of Trustees' discretion, it may be expanded, reduced or cancelled at any time.

PART FIVE: ELIGIBILITY FOR DISABLED PARTICIPANTS

5.1 What are the requirements to qualify for coverage if I become Disabled?

In order to qualify for coverage as a Disabled Participant, you must meet **all** of the following requirements:

1. Be Disabled;
2. Be an eligible Active Participant at the time the disability occurs;
3. Must have been, at the time the disability occurred, eligible in this Plan as Active Participant by means of the Plan's receipt of Contribution Hours (i.e. you were not continuing coverage solely by drawing hours from the Hour Bank or making self-payments with the Plan receiving zero Contribution Hours);
4. The Fund must have received at least eight-thousand (8,000) Contribution Hours in this Plan or a Predecessor Plan during the eight (8)-year period immediately preceding the disability;
5. File an application for such coverage in the time and manner prescribed by the Board of Trustees; and
6. Agree to submit to an examination by a Physician, medical provider, or clinic selected by the Board of Trustees to establish your status as a Disabled Participant or to confirm your continued disability status.

5.2 When will my coverage begin?

If you are an Active Participant who applies for disability coverage, you will be classified as a Class D Participant and will be eligible on the first day of the month as of which the Board of Trustees approves your application.

5.3 How do I continue coverage?

Active Participants that are Disabled will receive an automatic credit for twelve (12) months of coverage. If you become Disabled, no self-payments withdrawals from your Hour Bank or MRA are required during this initial twelve (12)-month period. Thereafter, Participants that became Disabled when they were an Active Participant may make up to six (6) full self-payments after exhaustion of the balance in the Hour Bank.

5.4 What if I am also receiving Loss of Time Benefits?

If you are eligible to receive Loss of Time benefits, starting on the eighth (8th) day of the temporary disability, thirty-three (33) Contribution Hours (up to a maximum of one-hundred thirty (130) hours per month and up to the maximum amount of hours permitted in the Hour Bank) will be credited to your Hour Bank. As noted in Section 5.3, if you remain Disabled after your initial twelve (12) months of coverage

expire, you can use your Hour Bank to continue coverage before being required to make self-payments to continue coverage.

Example: Mike is Disabled as of June 1, 2019 and is receiving Loss of Time Benefits. For up to the next twelve (12) months, Mike can remain on the Plan without having to make a self-payment or use his Hour Bank. As a result of receiving Loss of Time benefits, Mike's Hour Bank reaches the maximum of 650 hours. In June of 2020, Mike is still Disabled. Although his twelve (12) months of coverage have expired, he can now begin to use his Hour Bank to continue coverage before being required to make self-payments.

5.5 How may I reinstate my coverage?

Once coverage for Disabled Participants is terminated, it cannot be reinstated.

PART SIX:
ELIGIBILITY FOR SURVIVING SPOUSES & DEPENDENTS OF SURVIVING SPOUSES

6.1 What coverage is available to a surviving Spouse?

Surviving Spouses of Active Participants, Disabled Participants and Retirees are eligible to continue coverage provided both you and your surviving Spouse were covered by this Fund at the time of your death. Surviving Spouses of Class O Participants will be offered coverage under COBRA.

6.2 What are the requirements to stay eligible for coverage?

Surviving Spouses may draw on any balance in the Hour Bank to continue eligibility prior to making self-payments.

Surviving Spouses of Disabled Participants who die during the twelve (12)-month period of initial coverage will continue coverage for the balance of that period. Thereafter, any balance in the Hour Bank will be exhausted before self-payments are required. Arrangements may be made between this Fund and other pension, annuity, or similar funds for direct payment of self-payment premiums.

6.3 What coverage is available to Dependents?

Dependents of the surviving Spouse continue coverage through the surviving Spouse. If there is no surviving Spouse, the eligible Dependents continue coverage by exhausting the Hour Bank or making self-payments.

6.4 When will coverage for the surviving Spouse and any Dependent children terminate?

Coverage for your surviving Spouse and any Dependent children will terminate upon the occurrence of any of the following conditions: (1) when the surviving Spouse becomes eligible for coverage as an employee through his or her employment; (2) upon remarriage of the surviving Spouse; (3) on the last day of the month for which either the surviving Spouse or Dependent made timely self-payments; or (4) when the Dependent no longer meets this Plan's definition of Dependent.

PART SEVEN:
ELIGIBILITY FOR DEPENDENTS

7.1 How is eligibility determined for Dependents?

If an individual meets the definition of a Dependent, then he or she is eligible for coverage.

7.2 Which individuals meet the definition of a Dependent?

The following are those individuals who meet the definition of a Dependent under the Plan:

1. Your Spouse;

2. Your son, daughter, stepchild, adopted child, child lawfully placed for adoption, or child meeting the definition of a "foster child" who is lawfully placed with you, and who is under the age of twenty-six (26);

3. A disabled child who is incapable of securing or maintaining employment because of such disability, who is dependent upon you for support and maintenance, whose disability began prior to reaching age 26, and where proof of disability has been submitted to the Plan Administrator at least thirty (30) days prior to the child's coverage would otherwise end; and

4. Any other alternative individual who is legally recognized under a Qualified Medical Child Support Order ("QMCSO") to receive benefits as an eligible Dependent.

7.3 How is coverage available for the Dependents of a court order or the QMCSO?

The Plan will provide coverage otherwise available in accordance with a valid order of a court, determined by the Board of Trustees to be a QMCSO. A QMCSO must recognize the individual to receive benefits and provide a description of the benefits and timeframe of coverage. The Plan Administrator will establish reasonable methods to notify affected individuals, segregate the dollar amounts, determine whether the order is qualified and distribute the applicable benefits. Any payments and reimbursements will be made either to the Dependent child or his or her custodial parent or legal guardian.

PART EIGHT:
CONTINUATION OF COVERAGE UNDER FMLA AND USERRA

8.1 What coverage is available under FMLA?

A contributing Employer which is a "covered employer" as that term is defined by the Family Medical Leave Act ("FMLA") will, in order to provide or continue coverage for an eligible Participant, immediately notify the Plan Administrator when such Participant has been granted family or medical leave.

Both the Employer and you, as the Participant, must provide the notices, information and documentation as may be required by the Board of Trustees and under the law. The Fund will continue coverage during the period of any leave for which you are eligible for under the provisions of the FMLA, provided: (1) the Employer timely remits the required payments under the Plan for such coverage; and (2) both the Employer and you comply with all applicable requirements established by the Board of Trustees.

8.2 What coverage is available under USERRA?

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), if you leave Covered Employment to enter service in the armed forces, or other uniformed services of the United States, the Plan will provide coverage for you and your Dependents, free of charge, for up to five (5) years. Additionally, Contribution Hours 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 twenty-four (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 herein, unless your period of service is less than thirty-one (31) days, in which case coverage will be provided at no additional cost.

You must return to Covered Employment or register on the Union's out-of-work list within ninety (90) days of your discharge under honorable conditions from the services or within twenty-four (24) months of discharge if you are recovering from an illness or injury incurred during or aggravated by your service. Upon return to Covered Employment or registration on the Union's out-of-work list, your Hour Bank, if any, will be restored. You will also be eligible for coverage without having to re-establish eligibility. However, if the period of military service exceeds five (5) years, you must again establish Initial Eligibility before coverage will be reinstated.

PART NINE:
CONTINUATION OF COVERAGE UNDER COBRA

9.1 What is COBRA?

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") offers you and your Dependents the opportunity to temporarily extend your health care coverage under the Plan, at group rates, under certain circumstances, after coverage under the Plan would normally end.

Within the first ninety (90) days of you and your Dependents receiving coverage under this Plan, the Plan Administrator will provide you and/or your Dependents a general notice that describes your rights under COBRA.

9.2 How does an individual become eligible to receive COBRA coverage?

To be eligible for coverage under COBRA, you must experience a qualifying event. If a qualifying event occurs, the Plan Administrator will provide an election notice to you and your Dependents within fourteen (14) days of receiving notice that the qualifying event has occurred.

9.3 What are the qualifying events that apply to me?

If you are working in Covered Employment, you 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) you experience a reduction in your hours of employment.

9.4 What are the qualifying events for my Dependents?

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

1. The termination of your employment for any reason (other than gross misconduct);
2. A reduction in your hours of employment;
3. Your death;
4. Your divorce or legal separation;
5. You become eligible for Medicare; or
6. In some circumstances, upon the filing by your Employer of a Chapter 11 Bankruptcy Reorganization petition.

9.5 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 qualifying event also dictates when the notice has to be provided. Additionally, 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 **sixty (60) days** of the occurrence and provide a copy of the decree of divorce or legal separation 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 automatically terminate 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 a Dependent and his mother getting a divorce.

For all other qualifying events: your Employer must notify the Plan Administrator within **thirty (30) days** of the occurrence to qualify for COBRA continuation coverage.

Failure to notify the Plan Administrator within the time specified will result in termination of your or your Dependent's health care coverage as of the date of the qualifying event.

9.6 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 (discussed later in this section).

Qualifying Event	Maximum Continuation Period		
	Employee	Spouse	Children
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

9.7 Can my COBRA coverage be extended?

Once you start coverage through COBRA, you may qualify for continuation coverage. You may extend coverage due to two (2) reasons: (1) when you are found to be Disabled by the Social Security Administration ("SSA"); and (2) when there is a second qualifying event during the first eighteen (18) months of coverage under COBRA.

9.8 What are the requirements to extend COBRA coverage for a Disabled Participant?

If you are Disabled, your continuation coverage may be extended to a total period of twenty-nine (29) months if:

1. The SSA determines that you were Disabled either prior to beginning COBRA coverage; or it determines that before the first eighteen (18) months of COBRA coverage expired, you were Disabled within sixty (60) days from the date that you first began COBRA coverage; and

2. You notify the Plan Administrator in writing of a Social Security Disability ("SSD") award within the first eighteen months (18) of the COBRA continuation coverage and within sixty (60) days of (a) the date on which SSA issues the disability determination; (b) the date on which the qualifying event occurs; or (c) the date on which you or your Dependents lose (or would lose) coverage under the Plan as a result of the qualifying event, whichever is later.

Example: John was laid off on February 1, 2018, did not make a self-payment and elects COBRA. He was injured in a fall on March 15, 2018 and applies for SSD. 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.

9.9 Is notification required if SSD status is lost?

Yes. If you are awarded SSD status, but later the SSA determines that you are no longer Disabled, you must notify the Plan Administrator within **thirty (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.

9.10 What happens if there is a second qualifying event?

If a second qualifying event occurs while you and any of your Dependents are on COBRA, you and your Dependents may be entitled to an additional eighteen (18) months of coverage under COBRA for a total coverage period of thirty-six (36) months. 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 twenty-six (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.

9.11 What are the requirements to extend COBRA coverage for the second qualifying event?

You must provide the Plan Administrator with written notice of the second qualifying event **sixty (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 twenty-six (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 eighteen (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 sixty (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.

9.12 How much does COBRA continuation coverage cost?

The cost of COBRA continuation coverage, excluding weekly disability benefits, provided by this Fund, for eighteen (18) months, shall be determined by the Board of Trustees from time to time, but shall not exceed one-hundred two percent (102%) of the applicable health insurance premium. The Board of Trustees may charge up to one-hundred fifty percent (150%) of the applicable health insurance premium for COBRA coverage in excess of the eighteen (18) months.

PART TEN
BENEFITS UNDER THIS PLAN

10.1 Major Medical, Surgical, and Prescription Drug Benefits

Major medical, surgical, and prescription drug benefits for Active Participants, Class O Participants, Disabled Participants, Retirees under age 65 that are not eligible for Medicare, Surviving Spouses, and their Dependents are listed in ***Appendix A***. This Appendix also lists all applicable cost sharing requirements (i.e. co-payments, deductibles, coinsurance) for these benefits.

10.2 Are there any medical or prescription drug benefits available to retirees age 65 or older and eligible for Medicare?

No. If you are retired and age 65 or older, you have the option of purchasing a Medicare Advantage Plan from a third-party provider of such coverage at a group rate negotiated by the Plan. **However, this coverage is not administered, paid for, nor guaranteed by the Plan.** Additionally, the Board of Trustees does not guarantee the adequacy, quality, or market competitiveness of the rate that is negotiated. The negotiation of the discounted rate by the Plan is only an accommodation and not a right. The Board of Trustees reserves the rights to cease providing this accommodation at any time.

10.3 What death benefits are available?

The Fund has contracted several insurance providers to provide death benefits to certain classes of Plan Participants. Note that the benefits are subject to the provisions of the underlying insurance policy issued by the insurance carrier and applies to all individuals eligible to receive the benefit under the insurance policy. Those terms are incorporated into this Plan. The death benefit levels are summarized below. **Please note that to claim benefits, a death certificate must be provided to the Plan Administrator within 1 year of the individual's death. Claims submitted after this 1-year period will not be paid.** For further details please refer to the policy of insurance or contact the Plan Administrator.

Participant/Beneficiary	Principal Sum
Active and Class O Participants (to age 70)	$50,000
Active and Class O Participants (age 71 or older)	$25,000
Retirees (to age 70)	$25,000
Retirees (age 71 or older)	$15,000
Spouse/Surviving Spouse (to age 70)	$5,000
Spouse/Surviving Spouse (age 71 or older)	$2,500
Disabled Active Participant	$50,000
Dependent children (over 6 months of age)	$5,000
Dependent children (under 6 months of age)	$500

The Fund will also provide a self-funded one (1)-time payment per lifetime for the loss of any finger or thumb in the amount of $6,250.00 to Active Participants only. Loss with reference to a finger or thumb means complete severance from the tip of the finger through the third joint or the tip of the thumb through the second joint. This benefit will **not** be paid if (1) you receive compensation for the injury from another benefit plan or policy of insurance ; (2) the injury occurred as a result of the use of alcohol narcotics, medications not prescribed by physician or taken in contravention to a physician's instruction, or recreational drugs, whether legal or illegal ; and (3) you fail notify the Plan Administrator within ninety (90) days of the date of the accident. Note, the payment for the loss of the finger or thumb is subject to the same exclusions and/or restrictions as the AD&D benefits outlined under the policy of insurance. Please review the policy as you are bound by those terms.

10.4 How do I designate Beneficiaries?

In your application for insurance, you may name as many Beneficiaries as you would like to receive your death benefit. You may, from time to time, change your list of Beneficiaries, subject to any legal restrictions. Any designations and/or changes to the list of Beneficiaries, must be made in writing, signed by you and filed with the Fund. Only those Beneficiaries on written record with the Fund at the time of your termination of service will receive the applicable life insurance benefits.

10.5 What happens to my death benefits if I do not designate any Beneficiaries?

If you have not designated any Beneficiaries, the proceeds will pass in descending order to the following individuals (provided there are no laws contradicting this list):

1. Your surviving Spouse; then to
2. Your surviving children, in equal shares; but if there are no survivors, then to
3. Your surviving parent or parents, in equal shares; but if there are no survivors, then to
4. Your surviving siblings, in equal shares; but if there are no survivors, then to
5. Your estate.

10.6 What happens if I do not specify how my death benefit proceeds are to be divided?

If you have named two (2) or more Beneficiaries but do not specify how the proceeds of the death benefit will be divided amongst them, the Beneficiaries who survive you will be entitled to receive equal shares of the benefit.

10.7 What if any named Beneficiary is a minor?

If any Beneficiary is a minor or is not able to provide a valid release for any payment due, insurance proceeds will be payable to the legally appointed guardian. Any such payment will be for the sole benefit of such Beneficiary and will release the insurance company of any further liability.

10.8 What happens if the named Beneficiaries die before me?

In the instance that any named Beneficiaries die before you, the insurance proceeds will be paid to the surviving named Beneficiaries in equal shares, unless you specify in writing differently and provided there are no laws contradicting this list.

10.9 What is the Optional Life Insurance policy?

The Plan offers you, your Spouse, and your Dependents the choice of purchasing Optional Life Insurance ("Optional Life") and AD&D (collectively, "Optional Coverage"). Note, however, if you purchase Optional Life, then you must also purchase AD&D and if you purchase the optional AD&D component. Premium payments for this option coverage are not paid for by the Plan; you must make these payments through an automatic deduction. The amount of the benefit is specified by the carrier, since it is the carrier that individually issues each policy. For more information on purchasing this optional coverage, please contact the Plan Administrator.

10.10 What are Loss of Time benefits?

You are eligible to receive Loss of Time benefits if you are temporarily unable to work in Covered Employment due to being Disabled or experiencing a Sickness (including pregnancy).

10.11 What are the requirements to become eligible for Loss of Time benefits?

To qualify for Loss of Time benefits, you must fill out the appropriate forms and provide written proof supporting your eligibility to the Plan Administrator within ninety (90) days of the occurrence of being Disabled or experiencing a Sickness. You must also execute a Subrogation and Reimbursement Agreement in favor of the Plan. You may also be required to submit to an independent medical examination to confirm Initial Eligibility.

10.12 What are the requirements to continue to be eligible for Loss of Time Benefits?

To continue to receive Loss of Time benefits, you must continue to remain Disabled or experience a Sickness, be under the care of a Physician or other medical provider, and remain registered on the Union's out of work list. The Plan Administrator may require proof that you continue to meet all eligibility requirements.

10.13 What is the benefit period and benefit amount for Loss of Time Benefits?

The Plan will pay up to twenty-six (26) weeks of Loss of Time Benefits in the amount of three-hundred dollars ($300) per week. 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 Physician or other medical provider.

The Board of Trustees may extend these benefits for an additional twenty-six (26) weeks (for a total of fifty-two (52) weeks) so long as you continue to be eligible for such benefits and are not deemed Disabled by the SSA. You may be required to provide additional documentation, or be required to submit to an additional independent medical examination to receive an extension. Additionally, thirty-three (33) hours will be added to your Hour Bank during each week of disability, up to a maximum of one hundred thirty (130) hours per month.

10.14 When will I be paid the Loss of Time Benefits?

Benefit payments will start being paid beginning: (1) on the first (1st) day of becoming Disabled; or (2) on the eighth (8th) day of experiencing a Sickness.

10.15 What about if I experience successive disabilities or Sicknesses?

Successive disabilities or Sicknesses separated by less than five (5) working days under full-time Covered Employment will be considered as one (1) period of disability or Sickness for the purposes of receiving Loss of Time benefits. In order for the disability or Sickness to be considered separately; (1) it must be due to a different cause; and (2) it must have commenced after you have returned to Covered Employment.

10.16 What should I do if I return to work after being Disabled or experiencing a Sickness?

Once you return to work, you must notify the Plan Administrator on that date.

10.17 Are there any exclusions for Loss of Time benefits?

Yes, Loss of Time Benefits will **not** be paid to you under the following circumstances:

1. For any period of disability or Sickness during which you are not under the care of a Physician or other medical provider;
2. For any disability or Sickness due to occupational disease or injury. "Occupational disease or injury" shall mean a disease or injury for which you submitted a Claim is entitled to receive benefits under the applicable Workers' Compensation Law, Occupational Disease Law, or similar legislation;
3. For disabilities or Sickness resulting from any unlawful act;
4. For any day during which you perform any form of work for pay or profit;
5. For any injuries or conditions that are the result of a motor vehicle or other vehicular accident;

6. If eligibility is being maintained by self-payment, for any month during which you perform no hours of Covered Employment; and
7. Upon commencement of payment of SSD benefits, Loss of Time benefits will no longer be paid. If you become eligible for SSD benefits, you must notify the Plan Administrator immediately.

10.18 Are my Loss of Time benefits taxable?

Yes, your 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.

10.19 What Dental benefits are available under the Plan?

The Plan provides Active Participants and Class O Participants with Dental benefits through Blue Cross Blue Shield of Michigan. If you are an Active Participant, Class O Participant, or Retiree not on Medicare, you may at any time decline the Dental benefits. The Schedule of Benefits is attached hereto as ***Appendix B***.

Retirees eligible for Medicare are provided with Class I benefits only, at no cost. The Schedule of Benefits for the Retiree Dental benefit is attached hereto as ***Appendix C***.

10.20 What expenses may I use the MRA for?

The MRA may be used for the following: (1) expenses not covered by the Plan and that are approved for payment under the Internal Revenue Code; and (2) self-payment premiums.

You cannot use your MRA to purchase or offset the cost of individual insurance coverage on a state or federal "Marketplace" where individual insurance policies under the PPACA or "healthcare reform" are sold.

10.21 How are Employer Contributions allocated to the MRA?

For each hour you work, a predetermined portion of Employer Contributions are allocated to the MRA as follows:

Date	Contribution Rate	Amount Credited Towards MRA	MRA Contribution Rate for Half of Hours Exceeding 150	Explanation
As of June 18, 2018	$10.10	$0.25 per hour	$9.85*	Hourly contribution rate increase; no change to MRA Credit
**Additionally, for each month that more than 150 Contribution Hours are received on your behalf, one half of the Contribution Hours in excess of 150 will be credited to the MRA at the applicable Health and Welfare Contribution Rate in effect for that period, minus the hourly amount credited towards the MRA.*				

10.22 Can the balance in the MRA be lost?

Yes, the Board of Trustees reserves the right to at any time to eliminate the MRA benefit and revoke some or all of the balances in the MRAs. Neither the MRA nor its balances are vested benefits. The MRA is funded solely through Employer Contributions, and is an asset of the Plan. Additionally, the MRA cannot be taken out in cash, assigned, pledged, or otherwise alienated by the account holder or any party claiming through them. Furthermore, the balance in the MRA will be forfeited to the Plan in the following circumstances:

1. If coverage is lost for a reason that does not result in immediate forfeiture of the MRA account or its balance and you do not reinstate coverage within thirty-six (36) months of the date of termination loss of coverage; or
2. You are no longer available for work from an Employer. Failure to register on the Union's out of work list or maintain your book with the Union will result in a rebuttable presumption that you are not available for work. However, this will not apply if you are Disabled, retire or are on a Leave of Absence.

10.23 Can the MRA be used by my spouse or children if I die?

Yes, your surviving Spouse and/or Dependents may continue to use the MRA in the event of your death for a period of twenty-four (24) months from the date of your death.

10.24 Are there options to opt out of the MRA?

Once annually, and again upon termination of your eligibility or employment 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 will **not** be able to establish an MRA balance again unless your eligibility terminates and you again re-establish eligibility. Note, however, upon reinstatement, the MRA may not be used to reimburse any expenses incurred during the period after opting-out and prior to being reinstated.

10.25 Are there any other benefits offered under the Plan?

The Board of Trustees may, in its sole discretion and from time to time, add such other benefits, or modify existing benefits, as they deem appropriate.

PART ELEVEN
RESTRICTIONS ON YOUR COVERAGE

11.1 Are there any exclusions to benefits under the Plan?

Yes, the Plan will not provide the following benefits (the exclusion applies to all benefits except life insurance):

1. For injury received while working for pay or profit by you and/or your Dependents, including any extra side job, weekend job, a job being performed by a friend or relative on which you and/or your Dependent is assisting (working or viewing);

2. For loss or expense from sickness, or disease, or as a result of any accidental bodily injury which arises out of or in the course of employment, which entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law;

3. For services that would not be charged if there were no insurance;

4. For pre-employment or insurance exams;

5. For treatment of injury or illness caused by war, or complications resulting from such event;

6. For care rendered in a Government Hospital or care for military service connected disabilities for which you are legally entitled to service and for which facilities are reasonably available to you;

7. For hospital confinement which starts before the effective date of eligibility;

8. In the case of the pregnancy of Dependent children, only the hospital confinement and medical expense of the Dependent child is covered. No coverage is available for the newborn child;

9. For expenses incurred for treatment as a result of suicide or attempted suicide, unless the suicide attempt is related to an otherwise covered benefit;

10. For expenses incurred for any type of family planning, other than as required under the PPACA;

11. For comprehensive nutritional programs or for visits with specialists in endocrinology and visits when required solely for the purpose of weight loss or for treatment of obesity only or for expense incurred for dietary supplements and nutritional lectures and quick weight loss programs and clinics;

12. For sterilization reversals;

13. For payment of surcharge or nonresident tax levied by community hospitals;

14. For installation of air conditioning units, humidifiers for environmental controls, whirlpools, air filters, bathroom rails, special toilet seats, commodes, chair lifts, or other non-essential home-installed conveniences even when prescribed by a Physician, including ergometers and exercycles, bicycles, etc.;

15. For elective surgery, including cosmetic surgeries which are not necessary by reason of sickness, injury or disease or for the protection of the health of the individual;

16. For medical treatment or services, if any, that are not recommended and approved or prescribed by a Physician or other medical provider;

17. For treatment of injuries sustained in an automobile accident or motorcycle or other motor vehicle accident or complications resulting from such injuries or accident. Limited coverage is offered for motor vehicle accidents on "excess coverage" basis, i.e., this Plan only covers approved amounts over and above the coverage levels provided by your auto insurance, third-party coverage or uninsured motorist coverage, up to the limits of this Plan;

18. For television, telephone, guest trays or other non-essential personal items and services including take-home prescription drugs and supplies;

19. For expenses incurred if you are engaged in any unlawful act;

20. For annual check-ups or physicals, except as required under the PPACA;

21. For expense incurred for semen analysis, fertility and infertility analysis and diagnostic expense, or in vitro fertilization or artificial insemination;

22. For expenses incurred for cosmetic surgery or experimental surgery, except required under the PPACA;

23. 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;

24. For private duty nursing;

25. For hospitalization for dental care other than when concurrent hazardous medical condition necessitates hospitalization;

26. For voluntary abortions, except in those cases where such surgery is performed to protect your or your Spouse's health;

27. For purchase of sun lamps required for any cause;

28. For experimental procedures, supplies and devices except as required under the PPACA:

29. For physical, speech, occupational and pain therapy, unless directly related to an illness or accident;

30. For temporomandibular joint (TMJ) services;

31. For hearing exams and aids;

32. For custodial care; and

33. For acne surgery and related procedures.

11.2 Are there any limitations to benefits under the Plan?

The Board of Trustees, in its sole discretion and as it deems appropriate, can modify the eligibility requirements at any time, or eliminate such benefits in their entirety. No retroactive claim to benefits will be recognized in case of such modification or elimination of coverage except as required by law.

11.3 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 (2) or more plans cover the same individual. The purpose of these rules is to avoid duplicate or overlapping payments of benefits resulting in unjust overpayments. The COB rules apply generally to all benefits payable from this Plan other than death, accidental death and dismemberment, and Loss of Time benefits. 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 (the secondary plans) will pay the balance due up to 100% of the allowable expenses.

If your employer provides a health care plan other than this Plan, that employer's health insurance program will become the primary insurance carrier. Only after full compliance and denial by another plan will this Plan pay the remaining amounts, provided the services are covered under this Plan.

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 the other 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.

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

If you both you and your Spouse are entitled to benefits under separate group health insurance programs, and both plans cover your Dependent children, then the insurance plan that covers the individual with the **earliest** birthday in the year will be considered the primary insurance carrier for the Dependent children.

Example: Eric's birthday is in June, but his wife, Natasha's, birthday is in April, then Natasha's insurance plan will be primary.

If the birthdays of the two policyholders are on the same date, the policy of plan that has been in effect for the longer time will be primary. This Plan will 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 amount payable in accordance with its schedule of benefits and this Plan will then pay any remaining amounts not covered by such other plan up to, and in accordance with, its Schedule of Benefits so that, in the aggregate, no more than 100% of the "covered charges" will be paid.

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

In the case of a car accident, this Plan provides only secondary, or "excess" coverage, for medical claims resulting from, or related to, a motor vehicle accident. This Plan directly disavows coverage and shifts the burden to the automotive insurance carrier for any and all claims for which the claimant had any no-fault, third-party, or any other insurance coverage (including uninsured motorist coverage) applicable to such motor vehicle related claim, up to the amount of coverage available from all such policy(ies). **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.**

Motorcyclists **must** purchase the minimum $20,000/$40,000 insurance policy in order to be eligible for coverage. If that policy is purchased, then the Plan will only provide coverage once all other sources of coverage (such as coverage from another driver's motor vehicle coverage or another motor vehicle policy in the household) have been exhausted. In other words, the Fund provides benefits only as a last resort, and only after all other sources of coverage have been exhausted.

11.6 What is the order of coverage under the COB rules?

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

COVERAGE TYPE	PRIMARY	SECONDARY
Coverage under two employer-provided plans	Other employer-provided plan	This Plan
Employer provided coverage	Plan covering individual as an Employee	Plan covering individual as Spouse or Dependent
Coverage for a Dependent child	Plan covering parent whose birthday is earlier in the year	Plan covering parent whose birthday is later in the year
Coverage for a Dependent child with divorced parents with court order	Plan of the parent as specified as primary insurer under Judgement of Divorce	Other parent's plan
Coverage for a Dependent child with divorced parents without court order	Plan covering parent with physical custody	Plan of Spouse with physical custody
Motor vehicle coverage	Motor vehicle plan	This Plan

11.7 How are benefits coordinated for out-of-state policies?

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

11.8 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
The Employer has 20 or more Employees, and the Participant or his/her Spouse is 65 or older	This Plan	Medicare
The Employer has less than 20 Employees, and the Participant or his/her Spouse is 65 or older	Medicare	This Plan
The Employer has 100 or more Employees, and the Participant or Dependent is Disabled	This Plan	Medicare
The Employer has less than 100 Employees, and the Participant or Dependent is Disabled	Medicare	This Plan
Participant or Dependent with End-Stage Renal Disease (ESRD)	This Plan is primary for the first 30 months after you become eligible for Medicare.	Medicare will become primary and will pay from the 31st month after you become eligible for Medicare.

11.9 What if I fail to comply with the COB rules of my plans?

Any person eligible for benefits under this Plan that is also is eligible for benefits under another health maintenance organization, preferred provider organization, or similar type of plan, which requires that health care services be obtained only from certain designated health care providers and/or organizations, and there is a failure to comply with the requirements of such policy or plan, then eligibility under this Plan will be lost. Only when benefits are denied under another health care plan, after complying with all its requirements for eligibility and for coverage, will coverage be provided under this Plan.

11.10 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 deductibles, copayments and coinsurance, for covered services that you obtain in-network. The MOOP Limit does not include premiums/self-payments, amounts balance billed, or amounts paid for non-covered services or services you obtain out of network**. Once the maximum limit is reached for the Benefit Year, the Plan begins to pay one-hundred percent (100%) of the approved amount for in-network covered services. The federal government, not the Board of Trustees, sets these limits. The limit is updated annually. For 2019, the limit is $7,900 for a person and $15,800 for a family.

11.11 Are there any disease and cost management programs?

Certain procedures and drugs are subject to disease management programs. There are several of these programs in place, and each is described in detail below. To obtain more information on each program, you can visit www.bcbsm.com.

Prior Authorization. The program helps to ensure the appropriate usage of certain medications by applying Food and Drug Administration ("FDA") approved indications and manufacturer guidelines for using certain drugs. Certain medical procedures may also have to be authorized in advance. A list of services and medications subject to the Prior Authorization Program is available from the Plan Administrator. The Prior Authorization Program is not applicable to emergency services. The Fund's Prior Authorization Programs for each class of Participants established, administered, and maintained by Blue Cross Blue Shield of Michigan.

Step Therapy. This program addresses Participants using prescription drugs to treat certain chronic or ongoing medical conditions. Many of the drugs used to manage these conditions have serious side effects. The Step Therapy Program is designed to ensure that the condition is being managed with a medication that is safe, medically appropriate and cost effective. It also aids the Fund in controlling the costs of prescription drug coverage. Prescription drugs that are placed under the Step Therapy Program generally require a Participant to have failed therapy with one or more alternative drugs before coverage for the drug included within the Step Therapy Program will be approved. The Step Therapy Program can be bypassed in whole or in part if the treating Physician or other medical provider establishes that certain clinical criteria has been meet. A list of medications subject to step therapy, as well a list of the clinical criteria to bypass the program, is available from the Plan Administrator. The Fund's Step Therapy Program is established, administered, and maintained by Blue Cross Blue Shield of Michigan.

Quantity Limits & Mail-Order Program. Certain medications will only be dispensed in quantity limits that are set by the drug's manufacturer, the FDA, or the pharmacy benefits manager. In addition, certain medications may be required to be filled through the Fund's mail-order pharmacy. The Fund's mail order program and quantity limit programs are part of the Fund's prescription drug formulary, and are established, administered, and maintained by Blue Cross Blue Shield of Michigan.

Establishment of Formulary. The Fund has contracted with a pharmacy benefit manager that is responsible for establishing the Fund's prescription drug formulary. The formulary sets forth the tiering of covered prescription drugs and identifies what drugs are, and are not, included within the formulary and therefore covered by the Fund. The prescription drug formulary is established, maintained, and administered by Blue Cross Blue Shield of Michigan.

Case Management. In selected cases involving high-risk, complicated, or high-cost treatment, professional advisers from the Fund's vendors will offer, on a voluntary basis, counsel and education regarding alternative treatment options and methods to improve clinical outcomes. The Fund's Case Management Programs are established, administered, and maintained by Blue Cross Blue Shield of Michigan.

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. The Fund's Utilization Review Programs are established, administered, and maintained by Blue Cross Blue Shield of Michigan.

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.

PART TWELVE
HOW TO FILE CLAIMS AND APPEAL DENIALS

12.1 Defined terms used under this section:

The following defined terms will be used under Part 12 of the SPD.

→ Adverse Benefit Determination – means any of the following: a denial, reduction, rescission, termination of, or failure to provide or make payment (in whole or in part) of a Claim, including any such a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon a Participant's eligibility to participate in the Plan or resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate.

→ Final Adverse Benefit Determination – means an Adverse Benefit Determination that has been upheld by the Board of Trustees at the completion of the internal appeals process.

→ Appeal – means an appeal of an Adverse Benefit Determination that is filed in accordance with this Plan's procedures for filing an Appeal.

→ Claim – means a request for a Plan benefit(s) made by a Claimant in accordance with this Plan's procedures for filing or appealing a Claim for benefits. A Claim must generally name a specific Claimant, identify a specific medical condition or symptom, identify a specific treatment, service, or product for which approval is requested, and be received by a person or organizational unit of the Claims Administrator that is customarily responsible for handling benefit matters.

→ Claimant – means a person, or their authorized representative, who has submitted a Claim for a plan benefit in accordance with this Plan's procedures for filing or appealing a Claim for benefits.

→ Claims Administrator – means the entity responsible for processing and adjudicating Claims or Appeals, and for providing notices to Participants and beneficiaries of Claim determinations and adjudications, as well as appeal determinations. For certain benefits, the Claims Administrator may be a different entity than the Plan Administrator, as detailed below:

(i) **Active Participants, Class O Participants, Disabled Participants and their Dependents**. For medical, surgical, prescription drug claims, and claims under the Dental Benefit, the Claims Administrator for Initial Benefit Determinations and Step 1 Appeals is Blue Cross Blue Shield of Michigan. For Step 2 Appeals, the Claims Administrator is the Board of Trustees. Appeals relative to the life insurance policy and the AD&D policy are handled by the insurance carrier issuing the policy (other than the self-insured portion for Active Participants only, which is administered under these rules).

(ii) **Early Retirees and their Dependents**. For medical, surgical, prescription drug claims, and claims under the Dental Benefit, the Claims Administrator for Initial Benefit Determinations and Step 1 Appeals is Blue Cross Blue Shield of Michigan. For Step 2 Appeals, the Claims Administrator is the Board of Trustees. Appeals relative to the life insurance policy and the AD&D policy are handled by the insurance carrier issuing the policy.

(iii) **Retired Participants and their Dependents**. Claims and Appeals for Retired Participants who purchase coverage supplemental to Medicare are handled by the provider or carrier through which the policy was purchased. For the Dental Benefit, the Claims Administrator for Initial Benefit Determinations and Step 1 Appeals is Blue Cross Blue Shield of Michigan. For Step 2 Appeals, the Claims Administrator is the Board of Trustees. Appeals relative to the life insurance policy are handled by the insurance carrier issuing the policy.

→ Concurrent Care Claims – means any Claim regarding an ongoing course of treatment to be provided over a period of time or number of treatments, which has previously been approved by the Plan.

→ Post-Service Claims – means any Claim that is not a "Pre-service", "Urgent Care", or "Concurrent Care" Claim.

→ Pre-Service Claims – means any Claim that, under the terms of the Plan, conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

→ Rescission – means a cancellation of coverage that has a retroactive effect and that is not the result of fraud or an intentional misrepresentation of a material fact. Cancellation of coverage due to non-payment of premiums or contributions toward the cost of coverage, including self-payments or COBRA premiums, is not a rescission.

→ Urgent Care Claims – means any Claim for medical care or treatment which cannot be decided under normal time frames because: (i) it can seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or (ii) in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. Any Claim that a Physician with knowledge of the Claimant's medical condition determines if an 'Urgent Care" Claim shall be treated as an "Urgent Care" Claim by the Plan. Otherwise, the determination regarding whether a Claim involves "Urgent Care" shall be made by an individual acting on behalf of the Claims Administrator applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

12.2 How are Claims exhausted?

If the Claims Administrator fails to adhere to the claims and appeals procedures outlined in this Part, you are deemed to have exhausted the internal claims and appeals process and may proceed with an External Review, as well as exercise any remedies available under ERISA § 502(a), or applicable state law.

12.3 What is the standard used by the Claims Administrator to adjudicate Claims and Appeals?

The Claims Administrator shall ensure that all Claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in the benefit determination. The Claims Administrator shall further ensure decisions regarding hiring, compensation, termination, promotion, or similar matters are not made based upon the likelihood that the individual would support the denial of benefits.

12.4 Within what timeframe do I have to submit Claims to the Claim Administrator?

Unless another time period is provided by this Plan, you must file Claims for benefits with the Claims Administrator within one (1) year of their occurrence. The Board of Trustees may waive this requirement where it is found that medical exigencies prevented you from timely presenting the Claim.

Except where a different time period for determination is provided (as described below), the Claims Administrator must notify you of its decision with respect to a Claim no later than ninety (90) days after its receipt of the Claim. If the Claims Administrator determines that special circumstances require an extension of time for processing the Claim, the Claims Administrator may extend the time to reach a decision up to an additional ninety (90) days. Written notice of the extension will be furnished to you prior to the termination of the initial ninety (90) day period, and will explain the circumstances requiring an extension of time, as well as identify the time and date by which the Claims Administrator expects to reach a decision.

12.5 How is time 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.

12.6 What are the notification periods for the different types of Claims?

There are different types of Claims that are decided based on the urgency of the Claim or when the Claim is submitted (before your service or after you have received it).

Urgent Care Claims will be decided within seventy-two (72) hours after receipt of a properly submitted Claim. If more information, you will be notified within twenty-four (24) hours of receipt of the Claim, and will have forty-eight (48) hours to provide the information. You will be notified of your decision either within forty-eight (48) hours of the receipt of the requested information, or at the end of the initial forty-eight (48) hours given to you to provide it. Oral notice of the decision may be provided, but written notice will be provided within three (3) days of the oral notification.

Concurrent Care Claim will be decided at a time sufficiently in advance of the reduction or termination to allow you to appeal that decision. If you request to extend a course of treatment approved, you will be notified within twenty-four (24) hours after receipt of your request for that extension, if you requested the extension at least twenty-four (24) hours prior to the expiration of the approved period of time or number of treatments.

Pre-Service Claims will be decided within fifteen (15) days of receipt of the Claim. If more time is needed, this period may be extended by fifteen (15) days. You will be notified prior to the expiration of

the initial fifteen (15)-day period if an extension is needed with a notice explaining the reason for the delay and providing an estimate of when the Claim will be decided. If more information is required to decide your Claim, then you will be given forty-five (45) days to provide the information. The Claim will then be decided within fifteen days (15) of receiving the requested information or within the initial forty-five (45)-day period to provide the information, whichever occurs first.

Post-Service Claims will be decided within thirty (30) days of the receipt of the Claim. If more time is needed to decide your Claim, then it may extend the period by an additional fifteen (15) days. You will be notified prior to the end of the initial thirty (30)-day period if an extension is needed with a notice explaining the reason for the delay and providing an estimate of when the Claim will be decided. If more information is required to decide your Claim, you will be given forty-five (45) days to provide the information. The Claim will then be decided within fifteen (15) days of receiving the requested information or within the initial forty-five (45)-day period to provide the information, whichever occurs first.

Disability Claims will generally be decided within forty-five (45) days after the receipt of the Claim. If more time is needed to decide your Claim, then this period can be extended by thirty (30) days. If additional time is still needed, then this timeframe may be extended by an additional thirty (30) days. The notice will explain the reasons for the second notice and will give you an estimate of when the Claim will be decided. If more information is required to decide your Claim during this extension period, you will be given forty-five (45) days to provide it. The Claim will then be decided within thirty (30) days of you supplying the information, or by the end of the forty-five (45)-day period you had to supply that information, whichever time period expires first.

12.7 If my Claim gets denied, what happens?

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.

12.8 If I do not speak English, how are the services and notices provided to me?

All notices will be made in a culturally and linguistically appropriate manner. If you live in a county where ten percent (10%) or more of the population is literate in the same non-English language, then all notices and applicable services will be provided in such language.

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

Appeals from Adverse Benefit Determinations are divided into **two (2)** 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. This is not a Final Adverse Benefit Determination. 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.

12.10 How does the Step 1 Appeals process work?

You have **one-hundred eighty (180) days** from date of your Claim denial to make your appeal in writing. 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; and
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 Claims Administrator;
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, including his/her subordinate, considers your Appeal, provided he/she is a fiduciary of the Plan. Also, the individual considering your Appeal will not be a subordinate of the person who initially denied 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 certain treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate. The health care professional shall be an individual who is neither an individual who was consulted in connection with the initial denial, nor the

subordinate of any such individual. The Claims Administrator will provide you the identity of this individual even if their opinion is not relied upon when considering your Appeal;

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

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 forty-five (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.*

The period for review for Step 1 Appeals will begin when the Appeal is filed in accordance with the Plan's procedures. If an extension of time is necessary, the period for rendering a decision will be delayed to the time that the notification of the extension is sent to you.

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.

12.11 How does the Step 2 Appeals process work?

Following the denial of a Step 1 Appeal, you will have **one-hundred eighty (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 **one-hundred eighty (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; and
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 forty-five (45) days. If such an extension is needed, you will be notified prior to the expiration of the initial forty-five (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.*

12.12 Do I have to go through the appeals process?

You are generally required to exhaust the internal Claims and Appeals processes of this Plan before you are permitted to seek external appeal or file a lawsuit with respect to your claim. However, if the 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 ten (10) days. If you pursue

an External Appeal or a lawsuit, and a court or the entity that considers the External Appeal rejects your assertion that the 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.

12.13 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 four (4) months to request an External Appeal. If there is no corresponding date that is four (4) months after the date of receipt of the denial, then the request must be filed by the first (1st) day of the fifth (5th) month following the receipt of the notice.

Example 1: 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.

Example 2: 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; and
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 EBSA, or, the information needed if the application for the

review is not compete. You have the **latter** of: (1) the four (4) month filing period; or (2) the forty-eight (48)-hour period following your receipt of the notification to provide any additional information that is needed.

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

12.14 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 (1) 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 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: (1) the four (4)-month filing period, or (2) the forty-eight (48)-hour period following the receipt of the notification to provide any additional information that is needed.

Referral to an IRO. 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.

12.15 What are my rights in reference to bringing a civil action under ERISA § 502(a)?

You must file a lawsuit to challenge any denial by the Plan of your right to current or future benefits within one (1) year after your Claim for benefits (or to establish a right to future benefits) is finally denied by the Plan. Other Plan-based lawsuits must be brought within one (1) year after they accrue.

The Plan requires that Participants and Beneficiaries pursue all Plan-based benefit claims and appeals procedures before filing a lawsuit to obtain Plan benefits.

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

- On the day following the date on which the Plan finally denies your Claim for benefits (or right to future benefits).
- On the day following the last day for you to appeal a Plan denial of your Claim for benefits or future benefits (if you decide not to appeal that denial).
- On the day following the last date on which you could file a Claim for benefits under the Plan (if you do not file a Claim before the applicable claim-filing deadline.

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

Need to Use Plan Claims and Appeals Procedures. The Plan requires Participants and Beneficiaries to exhaust internal Plan remedies before filing a court action to vindicate Plan-based rights. If you do not file a benefit Claim or take permitted appeals from denied Claims, you may be prevented from filing a lawsuit to enforce your rights.

Future Notices about these Limits. The Board of Trustees will provide you with periodic additional notice of the limit at least annually and at other appropriate times (e.g., in letters from the Fund itself concerning your benefit claims). But, these requirements apply even though all Fund communications may not remind you of them.

PART THIRTEEN: MY RIGHTS AND RESPONSIBILITIES?

13.1 What are my 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.
6. Obtain a statement telling you what rights you have with respect to benefits offered by the Plan. THIS STATEMENT MUST BE REQUESTED IN WRITING AND IS NOT REQUIRED TO BE GIVEN MORE THAN ONCE A YEAR. The Plan must provide this statement free of charge.

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 thirty (30) days, you may

file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to one-hundred ten dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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, 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.

13.2 What are my rights under HIPAA, HITECH, and GINA?

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and The Health Information Technology for Economic and Clinical Health ("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.

13.3 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 sixty (60) 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 Dependent child to coverage, the birth must be reported within sixty (60) days. A copy of the birth certificate must be filed with the Plan Administrator. The Dependent child, however, is always covered from the moment of birth.
3. **Adoptions**. Adoption or placement of a Child must be reported within sixty (60) days to add the Dependent 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. **Foster children**. Placement of a foster child must be reported within sixty (60) days to add the Dependent child. A copy of the entry of the court order must also be filed with the Plan Administrator. Upon the foster child leaving the care of the Participant, the Plan Administrator must be notified within sixty (60) days of this event and coverage will end on the last day of the month in which this event occurs.
5. **Change of Address**. Any change of address must be reported within thirty (30) days.
6. **Name Change**. Any name change must be reported within thirty (30) days.
7. **Deaths**. Deaths should be reported within thirty (30) days. A certified copy of the death certificate is required.
8. **Divorce** - Divorce must be reported within thirty (30) days 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.
9. **Change of Employment Status**. If you or your Spouse switches employers, returns from a Leave of Absence, moves to full or part-time employment, you must notify the Plan Administrator within thirty (30) days.

13.4 How does the Plan treat 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.

13.5 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.

13.6 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 AND PRESCRIPTION DRUG BENEFITS FOR:
ACTIVE PARTICIPANTS, CLASS O PARTICIPANTS, RETIREES NOT ELIGBILE FOR MEDICARE DISABLED PARTICIPANTS, AND ALL ELIGIBLE DEPENDENTS OF THESE CLASSES

PLUMBERS & PIPEFITTERS LOCAL 0070047180000 - 07702 Effective Date: 01/01/2019

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services.***

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - Select specialty pharmaceuticals do not require preauthorization.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Eligibility Information

Members	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
Sponsored dependents	• Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.
No-fault automobile accidents, option 3	Clarifies how payment for medical services will be coordinated between BCBSM and a member's motor vehicle insurance carrier when a member is involved in a motor vehicle accident. In all instances: • BCBSM will be the **secondary** plan when paying benefits for injuries that are a direct or indirect result of a motor vehicle accident, regardless of the provisions contained in a member's no- fault motor vehicle insurance policy, and • BCBSM will not duplicate benefits available under a member's no- fault motor vehicle insurance policy. **Note:** The BCBSM payment, when combined with any payment a member receives under their no-fault motor vehicle insurance policy, will not be more than 100 percent of the BCBSM approved amount for covered services.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-network	Out-of-network
Deductible	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in- network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in- network physician's office.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in- network deductible.
Flat-dollar copays	• $40 copay for office visits and office consultations • $40 copay for medical online visits • $40 copay for chiropractic and osteopathic manipulative therapy • $250 copay for emergency room visits • $40 copay for urgent care visits	• $250 copay for emergency room visits

Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services

Benefits	In-network	Out-of-network
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost- sharing amounts	$1,500 for one member, $3,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost- sharing amounts for prescription drugs, if applicable	$7,900 for one member, $15,800 for the family (when two or more members are covered under your contract) each calendar year	None
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures **Note:** Limited to one per member per calendar year.	100% (no deductible or copay/coinsurance), **Note:** Additional well-women visits may be allowed based on medical necessity.	70% after out-of-network deductible
Gynecological exam **Note:** Limited to one per member per calendar year.	100% (no deductible or copay/coinsurance), **Note:** Additional well-women visits may be allowed based on medical necessity.	70% after out-of-network deductible
Pap smear screening - laboratory and pathology services **Note:** Limited to one per member per calendar year.	100% (no deductible or copay/coinsurance),	70% after out-of-network deductible
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible

Benefits	In-network	Out-of-network
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	70% after out-of-network deductible
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible

Benefits	In-network	Out-of-network
Fecal occult blood screening **Note:** limited to one per member per calendar year	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Flexible sigmoidoscopy exam **Note:** limited to one per member per calendar year	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Prostate specific antigen (PSA) screening **Note:** limited to one per member per calendar year	100% (no deductible or copay/coinsurance),	70% after out-of-network deductible
Routine mammogram and related reading	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$40 copay per office visit	60% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	$40 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	$40 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	$40 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$250 copay per visit (copay waived if admitted or for an accidental injury)	$250 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Inpatient consultations	80% after in-network deductible)	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after out-of-network deductible

Benefits	In-network	Out-of-network
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	80% after in-network deductible	60% after out-of-network deductible

Voluntary abortions	Not covered	Not covered
Refractive keratoplasties, including but not limited to LASIK and PRK services - subject to age and medical criteria	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1- 800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance use disorder treatment

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible

Benefits	In-network	Out-of-network
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a vendor are not covered.	$40 copay per online visit	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible

Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self- management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$40 copay per visit	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities
	Limited to a **combined** 60-visit maximum per member per calendar year	

Benefits	In-network	Out-of-network
Durable medical equipment **Note:** DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost- sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

BCBSM Preferred RX Program

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Note: If your prescription is filled by any type of in-network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list, you do not need to pay the difference in cost between the maximum allowable cost and the BCBSM approved amount for the brand-name drug. You pay only your applicable copay.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 – Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay 10% of approved amount, but not less than $20 or more than $200 for each covered drug	You pay 10% of approved amount, but not less than $20 or more than $200 for each covered drug	You pay 10% of approved amount, but not less than $10 or more than $100 for each covered drug	You pay $5 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay 10% of approved amount, but not less than $20 or more than $200 for each covered drug	No coverage	No coverage
	84 to 90-day period	You pay 10% of approved amount, but not less than $20 or more than $200 for each covered drug	You pay 10% of approved amount, but not less than $20 or more than $200 for each covered drug	No coverage	No coverage
Tier 2 – Preferred brand-name drugs	1 to 30-day period	You pay 20% of approved amount, but not less than $20 or more than $200 for each covered drug	You pay 20% of approved amount, but not less than $20 or more than $200 for each covered drug	You pay 20% of approved amount, but not less than $10 or more than $100 for each covered drug	You pay $10 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay 20% of approved amount, but not less than $20 or more than $200 for each covered drug	No coverage	No coverage
	84 to 90-day period	You pay 20% of approved amount, but not less than $20 or more than $200 for each covered drug	You pay 20% of approved amount, but not less than $20 or more than $200 for each covered drug	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay 30% of approved amount, but not less than $20 or more than $200 for each covered drug	You pay 30% of approved amount, but not less than $20 or more than $200 for each covered drug	You pay 30% of approved amount, but not less than $10 or more than $100 for each covered drug	You pay $25 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay 30% of approved amount, but not less than $20 or more than $200 for each covered drug	No coverage	No coverage
	84 to 90-day period	You pay 30% of approved amount, but not less than $20 or more than $200 for each covered drug	You pay 30% of approved amount, but not less than $20 or more than $200 for each covered drug	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs. * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	75% of approved amount

FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.

Features of your prescription drug plan	
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com/pharmacy, along with the preferred medications.** If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.
Mandatory maximum allowable cost drugs	If your prescription is filled by an in-network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay/coinsurance regardless of whether you or your physician requests the brand-name drug. **Exception:** If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay/coinsurance. **Note:** This MAC difference will not be applied toward your annual in-network deductible, your annual coinsurance, or your annual out-of-pocket maximum, if applicable.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

APPENDIX B
DENTAL BENEFITS FOR:
ACTIVE PARTICIPANTS, CLASS O PARTICIPANTS, DISABLED PARTICIPANTS, AND ALL ELIGBLE DEPEENDENTS OF THESE CLASSES

PLUMBERS & PIPEFITTERS LOCAL
0070047180000 - 05R02
Effective Date: 01/01/2019

Dental Coverage

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Network access information
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**
[1]Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
[2]A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Unmarried** dependent children: related to you by birth, marriage, legal adoption or legal guardianship, eligible for dental coverage through the last day of the month the dependent turns age 26, provided all eligibility requirements are met

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)

• Class II services	50%
• Class III services	50%
• Class IV services	Not covered

Benefits	Coverage
Dollar maximums • Annual maximum for Class I, II and III services	$1,000 per member
• Lifetime maximum for Class IV services	Not applicable

Class I services

Benefits	Coverage
Oral exams	100% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount **Note:** Once every 60 months
Dental prophylaxis (teeth cleaning)	100% of approved amount **Note:** Twice per calendar year
Pit and fissure sealants - for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatments	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	50% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	50% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	50% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	50% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery	50% of approved amount
Root canal treatment	50% of approved amount **Note:** Once every 12 months
Scaling and root planing	50% of approved amount **Note:** Once every 24 months per quadrant

Limited occlusal adjustments	50% of approved amount **Note: Limited** occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	50% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	50% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	50% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	50% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	50% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount **Note:** Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

APPENDIX C
DENTAL BENEFITS FOR RETIREES ON MEDICARE

PLUMBERS & PIPEFITTERS LOCAL
0070047180000 - 05R02
Effective Date: 01/01/2019

Dental Coverage

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Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**
[1]Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
[2]A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Unmarried** dependent children: related to you by birth, marriage, legal adoption or legal guardianship, eligible for dental coverage through the last day of the month the dependent turns age 26, provided all eligibility requirements are met

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)
• Class II services	50%
• Class III services	50%

• Class IV services	Not covered

Benefits	Coverage
Dollar maximums • Annual maximum for Class I, II and III services	$1,000 per member
• Lifetime maximum for Class IV services	Not applicable

Class I services

Benefits	Coverage
Oral exams	100% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount **Note:** Once every 60 months
Dental prophylaxis (teeth cleaning)	100% of approved amount **Note:** Twice per calendar year
Pit and fissure sealants - for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatments	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	50% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	50% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	50% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	50% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery	50% of approved amount
Root canal treatment	50% of approved amount **Note:** Once every 12 months
Scaling and root planing	50% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	50% of approved amount **Note:** **Limited** occlusal adjustments covered up to five times in any 60 consecutive months

Occlusal biteguards	50% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	50% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	50% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	50% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	50% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	**Coverage**
Removable dentures (complete and partial)	50% of approved amount **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount **Note:** Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	**Coverage**
Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.