

**MICHIGAN GLASS & GLAZING INDUSTRY
WELFARE INSURANCE PLAN
SUMMARY PLAN DESCRIPTION**



June 1, 2023

MICHIGAN GLASS AND GLAZING INDUSTRY WELFARE INSURANCE PLAN

SUMMARY PLAN DESCRIPTION

IMPORTANT NOTICE

This Summary Plan Description booklet describes the Plan on June 1, 2023. If you have questions about the Plan or your rights under the Plan, contact the Fund Office.

One word of caution: NO ONE HAS THE AUTHORITY TO SPEAK FOR THE TRUSTEES IN EXPLAINING THE ELIGIBILITY RULES OR BENEFITS OF THE FUND, EXCEPT THE FULL BOARD OF TRUSTEES OR THE FUND'S ADMINISTRATIVE MANAGER TO WHOM SUCH AUTHORITY HAS BEEN DELEGATED.

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

TABLE OF CONTENTS

IMPORTANT NOTICE

CONTACT INFORMATION.....	1
INTRODUCTION.....	4
GENERAL INFORMATION.....	5
IMPORTANT NOTICE – TIME LIMIT FOR FILING LAWSUITS.....	7
TRUSTEE AUTHORITY.....	7
DOING YOUR PART.....	8
ADMINISTRATIVE RESPONSIBILITIES.....	11
ELIGIBILITY AND COVERAGE.....	13
INITIAL ELIGIBILITY REQUIREMENTS.....	13
CONTINUING ELIGIBILITY REQUIREMENTS.....	14
DISABILITY ELIGIBILITY.....	16
TERMINATION OF ELIGIBILITY.....	16
REINSTATEMENT OF ELIGIBILITY.....	16
RECIPROCITY.....	17
ELIGIBILITY OF DEPENDENTS.....	17
SURVIVOR COVERAGE (ACTIVE PARTICIPANTS OR RETIREES).....	20
RETIREE COVERAGE.....	21
FAMILY AND MEDICAL LEAVE.....	24
MILITARY SERVICE COVERAGE.....	24
COBRA CONTINUATION COVERAGE.....	25
BENEFITS.....	31
MEDICAL, HOSPITAL AND SURGICAL BENEFITS (NON-MEDICARE ELIGIBLE ONLY).....	31
GENERAL COVERAGE RULES.....	31
MEDICAL, HOSPITAL AND SURGICAL (MEDICARE ELIGIBLE ONLY).....	33
GENERAL COVERAGE RULES.....	33
PRESCRIPTION DRUG BENEFITS (ALL PARTICIPANTS AND RETIREES).....	34
<i>SPECIAL NOTICES FOR MEDICARE-ELIGIBLE INDIVIDUALS</i>	35
HIGH-COST DRUG DISCOUNT OPTIMIZATION PROGRAM.....	35
DENTAL BENEFITS (ALL ACTIVE AND RETIRED PARTICIPANTS).....	35
VISION EXPENSE BENEFITS (ALL PARTICIPANTS AND RETIREES).....	36
LIFE INSURANCE BENEFITS (ACTIVE EMPLOYEES ONLY).....	36
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (ACTIVE EMPLOYEES ONLY).....	38
WEEKLY DISABILITY BENEFITS (ACTIVE EMPLOYEES ONLY).....	39
CLAIMS APPLICATIONS, LIMITS AND APPEALS.....	41
1. APPLYING FOR BENEFITS AND TIME LIMITS FOR CLAIMS.....	41
2. DENIAL OF CLAIMS.....	42
3. APPEALING A DENIAL OF YOUR BENEFIT CLAIM.....	42
CIRCUMSTANCES THAT CAN RESULT IN DENIAL OR LOSS OF BENEFITS.....	48

ADDITIONAL ADMINISTRATIVE MATTERS	48
FACILITY OF PAYMENT	48
EXAMINATIONS	49
TRUSTEE INTERPRETATION AND AUTHORITY	49
WORKERS' COMPENSATION NOT AFFECTED.....	49
PLAN DISCONTINUATION OR TERMINATION.....	49
RIGHT OF OFFSET.....	50
LEGAL ACTIONS – TWO YEAR TIME LIMIT.....	50
ALTERED OR FORGED CLAIMS.....	50
NOTICE OF HOURS WORKED.....	50
RIGHT TO OBTAIN, REQUIRE AND RELY ON INFORMATION	50
SPECIAL PROVISIONS FOR PARTICIPANTS AGE 65 AND OLDER.....	51
DEPENDENTS ON MEDICARE.....	53
COORDINATION WITH MEDICAID.....	53
COORDINATION OF BENEFITS/NON-DUPLICATION OF BENEFITS	53
SUBROGATION AND REIMBURSEMENT.....	56
RESTITUTION WHERE BENEFITS IMPROPERLY RECEIVED.....	58
EXCLUSIONS AND GENERAL LIMITATIONS	59
LEGAL NOTICES	62
NOTICE OF SPECIAL ENROLLMENT RIGHTS.....	62
ERISA RIGHTS.....	62
WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE	64
NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE	64
NOTICE OF PRIVACY PRACTICES	64
SOCIAL SECURITY NUMBER PRIVACY POLICY	71
YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS.....	71
SUBROGATION AGREEMENT	74

MICHIGAN GLASS AND GLAZING INDUSTRY WELFARE INSURANCE PLAN

CONTACT INFORMATION

Board of Trustees

Union Trustees

Don Stepp, Secretary
Glaziers, Architectural Metal and Glassworkers
Local Union No. 357
14587 Barber Ave.
Warren, MI 48088-6002

Robert Gonzalez
IUPAT District Council 1M
14587 Barber Ave.
Warren, MI 48088-6002

Jeremy Shannon
Glaziers, Architectural Metal and Glassworkers
Local Union No. 357
14587 Barber Ave.
Warren, MI 48088-6002

Keith Shannon
Glaziers, Architectural Metal and Glassworkers
Local Union No. 357
14587 Barber Ave.
Warren, MI 48088-6002

Employer Trustees

John Griffin, Chairman
Curtis Glass
1900 E. Maple
Troy, MI 48083

Steve Hohenshil
Glasco Corporation
18205 Weaver Avenue
Detroit MI, 48228

Gary Oberlander
Edwards Glass
32000 Plymouth
Livonia, MI 48150

Ross Winiemko
Madison Glass Company
2020 Burdette
Ferndale, MI 48220

The Board of Trustees is the legal Plan Administrator.

Fund Office/Administrative Manager

BeneSys, Inc.
Telephone: (248) 641-4957
FAX: (248) 813-9898

Mailing Address: P.O. Box 966, Troy, MI 48099-0966
Street Address: 700 Tower Drive, Suite 300, Troy MI 48098

OFFICE HOURS: Monday through Friday
7:30 a.m. to 4:30 p.m.

**Agent Designated For Service Of
Legal Process**

Joseph R. Pawlick, Esq.
Watkins, Pawlick, Calati & Prifti, PC
1423 East Twelve Mile Road
Madison Heights, Michigan 48071

Legal process may also be served on any Trustee or the Plan Administrator.

Eligibility Matters
Vision Benefits
Weekly Disability Benefits

Telephone: (248) 641-4957
FAX: (248) 813-9898

Claims and Mailing Address:
Michigan Glass and Glazing Industry Welfare Insurance Fund
P.O. Box 966, Troy, MI 48099-0966
Street Address: 700 Tower Drive, Suite 300, Troy, MI 48098
Participant Website: www.glassworkers357fringe.org

OFFICE HOURS: Monday through Friday, 7:30 a.m. to 4:30 p.m.

Health Benefits

BLUE CROSS/BLUE SHIELD OF MICHIGAN (BCBSM)
(For all BCBSM matters)

BCBSM Customer Service
Area code 313 - (313) 225-8100
Outside area code 313 - (800) 637-2227

Hearing and speech impaired customers:
Area codes 248, 313, 734 and 810 - (313) 225-6903
Area codes 231 and 616 - (616) 285-2114 or (800) 867-8980

When writing:
Blue Cross/Blue Shield of Michigan
600 Lafayette East, Mail Code X410
Detroit, Michigan 48226

Website:
<http://www.bcbsm.com>

Dental Benefits

Delta Dental of Michigan

Telephone: 800-524-0149

Fax: 517-347-5420

Claims Address: P.O. Box 9085, Farmington Hills, MI 4833-9085

Mailing Address: P.O. Box 30416, Lansing, MI 48909-7916

Street Address: 4100 Okemos Road, Okemos, MI 48864

Website: www.deltadentalmi.com

Life Insurance and Accidental Death and Dismemberment Insurance

Insured by Union Labor Life Insurance Company

Telephone: (248) 641-4957

FAX: (248) 813-9898

Claims and Mailing Address:

Michigan Glass and Glazing Industry Welfare Insurance Fund

P.O. Box 966, Troy, MI 48099-0966

Street Address: 700 Tower Drive, Suite 300, Troy, MI 48098

OFFICE HOURS: Monday through Friday, 7:30 a.m. to 4:30 p.m.

IUPAT Pension Fund

Telephone: (800) 554-2479

Website: <https://iupatpension.org>

Please note that the IUPAT Pension Fund is a separate entity and not administered by BeneSys.

INTRODUCTION

To All Participants and Dependents:

We are pleased to provide you with this Summary description of the Michigan Glass and Glazing Industry Welfare Insurance Plan.

As you read through this booklet, keep in mind that it is an effort to summarize, simply, the principal provisions of the formal Plan. It is not intended to cover every detail of the Plan or every situation that might occur. We have tried to make the Summary accurate and complete, but it is not a substitute for the Plan itself. If there is any conflict or difference between the Summary in this booklet and the Plan, the Plan will control.

Since the last booklet was published, many changes have been made in the Plan. These changes have previously been communicated to you in the form of notices and announcements. This new Summary incorporates all of those changes which have been made and which are still in effect. Accordingly, this Summary cancels, replaces, and supersedes all prior summaries, booklets and changes that have previously been communicated to you.

You should read this material carefully and keep it for reference. It will help you to understand how the Plan works, what rights and benefits it provides for you and your family, and how to obtain those benefits.

As Trustees, we pledge to maintain the best and most equitable program we can within our available resources. We hope the benefits available through the Fund will be of significant help to you and your family.

Board of Trustees

Don Stepp
Robert Gonzalez
Jeremy Shannon
Keith R. Shannon

John Griffin
Steve Hohenshil
Gary Oberlander
Ross Winiemko

June 1, 2023

GENERAL INFORMATION

TYPE OF ADMINISTRATION

The Michigan Glass and Glazing Industry Welfare Insurance Fund was created through collective bargaining. It is sponsored and administered by a board of eight Trustees. Four of the Trustees are Union Trustees, designated by Glaziers, Glassworkers and Architectural Metal Workers Local Union No. 357, an affiliate of the International Brotherhood of Painters and Allied Trades, AFL-CIO (the “Union”), and four of the Trustees are Employer Trustees appointed by Glazing Contractors Association, Inc. (the “Association”). The Board of Trustees is the legal Plan Administrator, and it has hired the firm of BeneSys, Inc. as Administrative Manager to operate the program on a day-to-day basis.

PLAN NUMBER AND EMPLOYER IDENTIFICATION NUMBER

The Fund has been assigned an Employer Identification Number by the Internal Revenue Service. It is 38-6058023. The Plan Number is 001.

UNION

The Union is the Glaziers, Glassworkers and Architectural Metal Workers Local Union No. 357, an affiliate of the International Brotherhood of Painters and Allied Trades, AFL-CIO.

EMPLOYERS

You may contact the Fund Office at any time for information on what employers participate in the Fund and whether an employer is a participating employer.

NAMED FIDUCIARY

A Named Fiduciary is the person or persons who have the authority to control and manage the operation and administration of the Fund. The Named Fiduciary for the Fund is the Board of Trustees of the Michigan Glass and Glazing Industry Welfare Insurance Fund.

PLAN NAME

The plan name is the Plan of the Michigan Glass and Glazing Industry Welfare Insurance Fund.

TYPE OF PLAN

The Plan is an employee welfare benefit plan providing medical, hospital, medical, prescription drug, dental, vision, loss of time, death, and accidental death and dismemberment benefits. The Plan is subject to the Employee Retirement Income Security Act of 1974, as amended, usually referred to as ERISA. As a participant in the Michigan Glass and Glazing Industry Welfare Insurance Fund, you are entitled to certain rights and protections under ERISA, as described in the ERISA RIGHTS section of this Summary.

PLAN MODIFICATION, AMENDMENT AND TERMINATION

The Board of Trustees may modify, amend or terminate the Plan at any time in its sole discretion. Amendments or modifications that affect participants will be communicated to participants in writing. Such amendments or modifications may have the effect of limiting, expanding or eliminating any benefit or changing the conditions, eligibility or copayment required for any benefit. In the event of termination, any remaining assets of the Fund (after all obligations are met) will be distributed in a manner which, in the sole and exclusive discretion of the Board of Trustees, best accomplishes the purposes of the Fund.

COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to collective bargaining agreements. A copy of such agreement(s) may be obtained upon written request to the Fund Office, which may make a reasonable charge for copying. Copies are also available for examination by participants and beneficiaries at the Fund Office.

SOURCE OF PLAN CONTRIBUTIONS

The Plan is funded through the Trust Fund, which receives contributions from employers at rates specified in collective bargaining agreements between the Employers and the Union and special participation agreements with the Fund and, with respect to employee self-payment amounts, by the Board of Trustees. Contributions are held in trust by the Board of Trustees pending the payment of benefits and administrative expenses. Employees, retirees, spouses and other dependents may make payments to the Fund under certain circumstances in order to continue eligibility. Any participant, surviving spouse, or beneficiary may receive, upon written request to the Fund Office, information about whether a particular employer is contributing to the Fund and, if so, the employer's address. You have a right to receive a copy of a collective bargaining agreement or to read it at the Fund Office.

WELFARE TRUST ASSETS AND RESERVES

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses. Medical, hospital, surgical and prescription drug benefits, are provided on a "self-funded" (non-insured) basis, which means that all benefits from this Plan are paid for directly from the assets of the Fund, not by any insurance company. The Fund has hired BeneSys, Inc. for claims processing and other administrative functions only. The Fund has also hired Blue Cross/Blue Shield of Michigan to provide a medical network, prescription drug network and claims processing services. The Fund has an arrangement with BCBSM to provide a provider network and administer claims. Dental benefits are insured through Delta Dental of Michigan (group number 1631-0001). Life Insurance and Accidental Death and Dismemberment Insurance are insured through the Union Labor Life Insurance Company (policy numbers G-3011 and C-4299). All other benefits, are paid directly from the Trust and are "self-funded."

A portion of Fund assets is also allocated for reserves to meet future liabilities to carry out the objectives of the Plan.

Benefits payable are limited to Fund assets available for such purposes.

PLAN YEAR

The Fund operates on a December 1 through November 30 fiscal year. This fiscal year is used for Fund accounting and for filing annual reports required by the Internal Revenue Service and the United States Department of Labor. The benefit year or claim determination period for benefits is January 1 through December 31.

ELIGIBILITY AND BENEFITS

The Plan's eligibility rules with respect to participation and benefits are generally described in this Summary.

The Board of Trustees may change the eligibility rules and/or benefit provision of the Plan at any time. The benefits provided by the Fund are limited to the assets of the Fund that are available to pay for such benefits. No participant, dependent or retiree has any vested right to any benefit provided by the Fund, now or at any time in the future.

SUMMARY PLAN DESCRIPTION

The Summary Plan Description ("Summary") is this booklet. This booklet is intended to give you an accurate summary of the benefits and provisions of the Fund's Plan. It does not describe Plan changes that occurred after the book was printed. The Plan and the Agreement and Declaration of Trust, which you can read at the Fund Office or other specified locations, contain a detailed description of the rules, regulations, benefits and provisions of the Fund. If any discrepancy exists between this book and the Plan documents (including the insurance contracts entered into by the Fund), the provisions of the Plan documents will govern.

IMPORTANT NOTICE – TIME LIMIT FOR FILING LAWSUITS

Under the Plan, no action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of these under or relating to the Plan is barred unless the complaint is filed within two years after the right of action accrues, unless a shorter time period is established by applicable statute, regulation or case law. You should seek legal advice regarding this requirement.

TRUSTEE AUTHORITY

The Board of Trustees has full authority to increase, reduce or eliminate benefits and to change the eligibility rules and other provisions of the Plan at any time. The right to change or eliminate any and all aspects of benefits provided for both current and future retirees and their dependents is a right specifically reserved to the Board of Trustees. However, the Board of Trustees intends that the Plan terms, including those relating to coverage and benefits, are legally enforceable while they are in effect.

The benefits provided by the Fund are limited to the assets of the Fund that are available to pay for such benefits, or to pay for the premiums for the insured benefits. No participant, dependent or retiree has a vested right to any benefit provided by the Fund, now or at any time in the future.

Notices of any changes or deletions of the information in this book will be provided to each participant within the time required by any applicable regulations. Before incurring any non-emergency expense, you should contact the Fund Office to confirm your current entitlement to coverage.

Only the full Board of Trustees is authorized to interpret the Plan and the benefits described in this Summary (except that the companies that provide insured benefits have full authority with respect to their policies, certificates and riders). The interpretation of the Board of Trustees with respect to matters within its authority is final and binding on all persons dealing with the Fund or claiming a benefit from the Fund. If a decision of the Board of Trustees is challenged in court, that decision will be upheld, under current law, unless it is determined by the court to have been arbitrary and capricious. No agent, representative, officer or other person from the Union or the Employers has the authority to speak for the Board of Trustees or to act contrary to the written terms of the governing Plan documents.

If you have questions about your eligibility or a claim, contact the Fund Office. Matters that are not clear, or which need interpretation, will be referred to the Board of Trustees.

DOING YOUR PART

As a participant in the Fund, you have certain responsibilities in order to protect your eligibility and receive your benefits.

Read this book. You and your spouse should take the time to read this benefit booklet and familiarize yourselves with the eligibility and benefit rules.

Keep the Fund Office informed about you. One of your most important responsibilities is to make certain that the Fund Office always has current and accurate information about you and your dependents.

Complete an Enrollment Form and Beneficiary Designation Card immediately and return it to the Fund Office if you are a new participant.

To avoid delays and loss of coverage or rights for you or your dependents, the Fund Office must be notified of the following events as set out below as soon as possible:

Marriage – To add a spouse to your coverage, your marriage must be reported to the Fund Office, accompanied by a copy of your marriage certificate. If you report your marriage with all required documentation **within 30 days** of your wedding, your spouse will be covered from the date of marriage. If you report your marriage with all required documentation to the Fund Office **later than 30 days** after your wedding, your new spouse's coverage will begin then, and it will not go back to the date of marriage – the Fund is not obligated to provide coverage effective any earlier than the first of the month following the date on which it receives the enrollment notice and all documentation.

Births – To add a newborn as an eligible dependent, the child's birth must be reported to the Fund Office, accompanied by a copy of the birth certificate, and upon review, further evidence of parentage may be required. If you report your child's birth **within 30 days** of its occurrence, your child will be covered from birth. If the birth is reported **later than 30 days**, your new child's coverage will begin then, and it will not go back to the date of birth – the Fund is not obligated to provide coverage effective any earlier than the first of the month following the date on which it receives the enrollment notice and all documentation.

Adoptions and Stepchildren – To add a child as an eligible dependent, the adoption and/or marriage (for stepchildren) must be reported **within 30 days** of its occurrence, and one or more of the following must be filed with the Fund Office: a copy of the legal adoption or Court Order placing the child in your home for adoption; marriage certificate to the child’s parent; proof of the child’s birth; and/or proof that adoption proceedings have commenced. The child will be covered from the moment of adoption (or placement for adoption) or marriage to the child’s parent, if the event is reported **within 30 days** of its occurrence. If the Fund is notified **later than 30 days** of the event, your new child’s coverage will begin then, and it will not go back to the date of adoption/marriage, as applicable – the Fund is not obligated to provide coverage effective any earlier than the first of the month following the date on which it receives the enrollment notice and all documentation.

Foster Children – To add a foster child as an eligible dependent, the foster care placement must be reported **within 30 days** of its occurrence, and one or more of the following must be filed with the Fund Office: a copy of the Court Order or other documents placing the child in your care and the child’s birth certificate. The child will be covered from the moment of placement in your care, if the event is reported **within 30 days** of its occurrence. If the Fund is notified **later than 30 days** of the event, coverage will begin then, and it will not go back to the date of the placement in your care – the Fund is not obligated to provide coverage effective any earlier than the first of the month following the date on which it receives the enrollment notice and all documentation.

Change of address or name – Any change of address, or name change, must be reported to the Fund Office immediately, in writing, signed by you. For your protection, the Fund does not accept any change of name or address via phone.

Deaths – Deaths must be reported immediately to the Fund Office. A copy of the death certificate is required in order for benefits to be payable to a beneficiary.

Divorce – Divorce must be reported immediately and a complete copy of the Judgment of Divorce, and any amendments to the Judgment, must be filed with the Fund Office. If the Fund pays benefits for a former spouse because you did not notify the Fund of your divorce, you and your former spouse, each individually and jointly, are personally liable to the Fund for any benefits or premium payments issued on behalf of your former spouse.

Birthdays – You must inform the Fund Office immediately when your dependent child attains the age of 26.

Other coverage – Notice of other health care coverage must be reported to the Fund Office **within 30 days** of the date you or your dependent(s) obtain such coverage.

Beneficiary Designation – Make sure your beneficiary designation reflects your intent at all times.

You should also tell the Fund Office if:

- You are unable to work due to accident or illness;
- Your sickness or disability has ended;

- Your employment with a contributing employer has terminated and you wish to continue your coverage by self-payment;
- You have applied for leave under the Family and Medical Leave Act (FMLA) from your employer;
- A court has entered a qualified medical child support order directing that health care coverage be provided for your child(ren) through the Fund;
- You or your dependent(s) are eligible for or have received benefits under any other health care plan, insurance contract, program or statute;
- You or your dependent(s) enter the military or other uniformed services of any country.

Follow the proper procedures for receiving benefits, filing claims and submitting appeals. Review the information on claims processing in this Summary. When in doubt, before incurring any non-emergency expense, ask the Fund Office about claims processing and benefits.

Carry your card. You should have a benefits card. Be certain to carry this benefits card and show it whenever you receive medical services or get a prescription filled.

About your BCBSM card.

Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage. Unless you request a replacement card, you will receive new ID cards only when there is a change in your benefit plan. Call the Fund Office if your card is lost or stolen. Your provider can call BCBSM to verify your coverage until you receive your new card. If you need additional ID cards, you can request new cards at no cost. Go to bcbsm.com and log in to Member Secured Services or call the Fund Office or the BCBSM Customer Service phone number on the back of your ID card.

Prevent fraud. If your provider asks for another form of identification, do not worry. Checking a cardholder's identification is one way providers help protect you against unauthorized use of your ID card. You can help prevent fraud by reporting a lost or stolen ID card and by checking your Explanation of Benefits ("EOB"). If you see a discrepancy on your EOB, contact your provider first to see if it is an error. If it is not and you believe it is a fraudulent billing or use of your card, then let BCBSM know. There are four ways you can report suspected fraud:

1. Visit the BCBSM Web site at bcbsm.com
2. Write or fax BCBSM. You can download the form on the BCBSM Web site, fill it out online, print it and mail or fax it to BCBSM. The address and fax number are printed on the form.
3. Call the BCBSM Anti-fraud Hotline at 1-800-482-3787. The hotline is open Monday through Friday from 8:30 a.m. to 4:30 p.m.
4. Call the Fund Office.

All fraud reports are confidential, and you remain anonymous.

Keep copies of all bills and EOBs. It is important that you keep any bills, receipts and EOBs that you receive. These can be valuable in any claim or appeal you may make, and, possibly, as your only record of benefits and care you have received.

Keep notices you receive from the Fund. After the publication of this Summary, you will receive notices of any changes as they occur. You should keep those together with this Summary booklet so that you will have a complete record of the Plan's communications to you regarding your benefits.

Identify yourself. When you write to the Fund Office, please be sure to include your name, your trade, the last four digits of your Social Security number or the alternative identification number assigned to you by the Fund Office and your employer in your letter. If you call, please be sure to have your Social Security number or the alternative identification number handy. Please note that, due to privacy laws, the Fund Office will not release your protected health information to your spouse or dependents unless you have a signed authorization form on file with the Fund Office.

Notify the Fund Office when you or one of your dependents becomes eligible for Social Security benefits and/or Medicare coverage. You must sign up for Medicare Parts A and B, and send a copy of the Social Security Award letter and/or the Medicare Card to the Fund Office immediately.

Protect your and your dependents' COBRA rights. Your surviving, separated or divorced spouse, and/or your children who no longer qualify as eligible dependents **must** notify the Fund Office **within 60 days** of the date on which the event occurred that resulted in their loss of eligibility that they want to continue their coverage under the Fund through self-payments under COBRA. If the Fund does not receive notice within the 60-day period, they will **lose** their right to continue coverage through self-payments under COBRA. (See page 25 of this Summary for detailed information regarding COBRA.)

ADMINISTRATIVE RESPONSIBILITIES

The Plan Administrator, as a legal matter, is the Fund's Board of Trustees. However, the Board of Trustees has divided the day-to-day operations of the Fund into two areas of responsibility and has delegated them to the Fund Office or one of the Fund's service providers.

Fund Office Functions

The Fund Office is responsible for the following:

- Day-to-day details of running the Fund, including financial and record-keeping functions.
- All matters pertaining to eligibility.
- Self-payments, including actives, retirees, surviving spouse and COBRA.
- Determination and processing of claims for the following benefits:
 - Weekly Disability Benefits
 - Vision Expense Benefits
- Receiving and forwarding to Union Labor Life Insurance Company claims for Life Insurance and Accidental Death and Dismemberment Benefits.
- Reviewing and presenting appeals to the Board of Trustees

Service Provider Functions

Blue Cross/Blue Shield of Michigan: The Fund has a contract with Blue Cross Blue Shield of Michigan (BCBSM) Preferred Provider Organization (PPO) to provide and maintain a network of providers that active and non-Medicare retiree participants and their dependents, can use as a preferred provider organization. BCBSM administers and pays all Medical, Surgical, Hospital and Prescription drug claims.

Delta Dental: The Fund has a contract with Delta Dental of Michigan to insure all dental expense claims in accordance with the Delta Dental of Michigan schedule of benefits.

Union Labor Life Insurance Company: The Fund has a contract with Union Labor Life Insurance Company (policy numbers G-3011 and C-4299) to provide Life Insurance and Accidental Death and Dismemberment Benefits.

FREE CHOICE OF PROVIDER

You have the free choice of any provider. However, the amount of benefits paid by Blue Cross/Blue Shield of Michigan, Delta Dental or the Fund may vary and/or be severely limited based on the provider you choose and the provider's participation in Blue Cross/Blue Shield of Michigan or Delta Dental.

DISCHARGE OF LIABILITY

Any payment made by the Fund in accordance with the Plan will fully discharge the Fund's liability to the extent of the payment.

YOUR EXPLANATION OF BENEFITS (EOB)

When a claim you incurred is processed, you will receive an Explanation of Benefits statement, commonly referred as EOB. This statement is not a bill. At the top of the EOB, you will find a Customer Service phone numbers and an address to use for inquiries.

An EOB is a record of paid or rejected claims. It also lists any amounts applied to deductibles and/or copays. All health care claims administrators will accept the EOB statement to process any available benefits for coordination of benefits. They can be used to keep track of medical expenses for tax purposes.

Note: It is very important for your provider and the Fund Office to have your correct mailing address. In most cases, your EOB will be mailed to the address that is on the BCBSM system. However, if a payment is being sent directly to you, the address that is on the claim form will be used for mailing purposes.

Online BCBSM EOB statements. You can sign up to receive your BCBSM EOB statements online. With online EOBs, you can access your EOB statements safely and securely from any personal computer at any time to track the following:

- Health care services
- Benefit payment histories
- Status of deductibles and copays

Go to bcbsm.com and log in to Member Secured Services to register for online EOBs.

About your BCBSM EOB. Briefly, the BCBSM EOB tells you:

- The family member who received services
- The date services were provided (“claims processed from...to...”)
- “Summary of Balances” includes the provider(s) of the services, details about charges and payments, including the amount saved by using PPO network providers
- “Summary of Deductibles and Copayments” provides your deductible and copay requirements as well as a total of all deductibles and copays paid to date
- “Helpful Information” includes messages and reminders
- “Detail on Services” summarizes the BCBSM payment and shows your balance

If you see an error, contact your provider first. If your provider cannot correct the error, call the customer service number on your EOB.

PROOF OF AUTHORITY IN THE EVENT OF YOUR INCAPACITY

If you become mentally, physically or otherwise unable to handle your financial affairs, the Fund may need to deal with a legally appointed guardian, conservator or person holding the power of attorney on your behalf. You are responsible for providing the Fund with any information and documentation regarding someone who has or may have authority to act in your place.

ELIGIBILITY AND COVERAGE

INITIAL ELIGIBILITY REQUIREMENTS

You will be initially eligible for benefits on the first day of the month after you have been credited with 420 hours of work and employer contributions in four consecutive calendar months or less and you will remain eligible based on those hours of work and employer contributions for two months. Eligibility begins on the first day of the second month after the eligibility rules have been met.

Example: If you work a total of at least 420 hours (for which all employer contributions have been received by the Fund) in August, September, October and November you become eligible for benefits on January 1 and you will remain eligible based on those hours of work and employer contributions for the months of January and February.

When you become eligible, the Fund Office will send you an Enrollment Form to report all of your eligible dependents. This form should be completed and returned to the Fund Office as quickly as possible with copies of applicable birth and marriage certificates and, in cases of divorce, court orders. Be certain to report all changes (i.e., additions and deletions) among your dependents to the Fund Office immediately.

CONTINUING ELIGIBILITY REQUIREMENTS

1. Continuation by Working

Once you have established initial eligibility for benefits, you will continue to be eligible as long as you have worked and have been credited with 140 hours of work and employer contributions per month. Continuing eligibility is effective for the first day of the third month following the month in which the foregoing requirement was met. Thus, hours worked (with all contributions received) gains eligibility as set out below:

<u>Hours worked (with contributions received) for the month of...</u>	<u>Determines eligibility for the month of...</u>
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. Continuation Without Working

If your eligibility would otherwise terminate due to insufficient hours of work and/or employer contributions received by the Fund, you may maintain eligibility as a participant by drawing on your Hourly Reserve Bank or by making self-payments, subject to the rules and limitations set out below. You may continue eligibility for a maximum of six consecutive months by drawing on your Hourly Reserve Bank and/or making self-payments. After that, you may continue coverage only under the Plan's COBRA provisions, set out on page 25 of this Summary.

If you are a participant that is eligible based on work not covered by the Union's collective bargaining agreement, or are employed by the Union, you cannot draw on your Hourly Reserve Bank and/or make self-payments to maintain eligibility.

a. Continuation by Drawing on the Hourly Reserve Bank

An Hourly Reserve Bank is established for you by the Fund Office. For each calendar month in which the Fund receives employer contributions in excess of 140 hours based on your hours of work, the hours in excess of 140 hours are "deposited" in your Hourly Reserve Bank. **The maximum number of hours you can have in your Hourly Reserve Bank is 420 hours – no excess hours are credited after that maximum is reached.**

When your eligibility would otherwise terminate due to insufficient hours of work and/or employer contributions received by the Fund for a month, the number of hours needed to equal 140 hours for that month will be withdrawn from your Hourly Reserve Bank to continue your eligibility.

When your eligibility would otherwise terminate due to insufficient hours of work and/or employer contributions received by the Fund for a month, but the hours in your Hourly Reserve Bank are insufficient to maintain eligibility, you may make a self-payment for the difference in hours needed to maintain your eligibility for that month (see below).

Your Hourly Reserve Bank remains active for up to six months after your eligibility terminates. However, after six months of ineligibility, any remaining hours in an Hourly Reserve Bank are cancelled.

You cannot receive Weekly Disability Benefits while maintaining your eligibility by using your Hourly Reserve Bank and/or making self-payments.

b. Continuation by Self-Payments

If you cannot fulfill the 140 hour requirement for continuing eligibility by a combination of working and drawing on your Hourly Reserve Bank, you may maintain eligibility by making self-payments, subject to the six consecutive month maximum, which commences from the first day of the month following the last Eligibility Month for which you were eligible based **solely** on your meeting the 140 hour requirement for continuing eligibility by working.

The self-payment rate is your eligibility shortfall of hours with contributions, multiplied by the current hourly employer contribution rate under the collective bargaining agreement.

Example: If you work 100 hours in a month for which all contributions were received and you do not have any hours in your Hourly Reserve Bank, then your shortfall for eligibility for that month is 40 hours. Your self-payment amount is 40 hours times the current hourly employer contribution rate under the collective bargaining agreement.

If, at any time during the six-month period in which you are eligible to continue coverage by your Hourly Reserve Bank or by self-payments, you elect not to do so and, as a result, your eligibility is terminated, you shall not again be eligible to make self-payments under this provision. Your eligibility can then only be continued under COBRA, if timely elected.

The Fund Office shall make a reasonable effort to notify you that you have the option to make self-payments when your eligibility for benefits is about to terminate. If you fail to make a self-payment when due (or if you fail to reinstate through hours of work and employer contributions), your coverage will be terminated. Self-payments are due on the 25th of the month before the eligibility month. For example, self-payment for eligibility for benefits for the month of October is due September 25th. **It is important that you keep the Fund Office notified of your current mailing address.**

You are not eligible to receive Weekly Disability Benefits while maintaining your eligibility by self-payment.

3. Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you or they have other health insurance coverage, you may subsequently enroll yourself or your dependents in this

Plan provided that you request enrollment within **30 days** after such other coverage ends. Proof of the other health care coverage and its termination date will be required for re-enrollment.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll such newly acquired dependent for coverage provided that you request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption. Appropriate proof will be required for enrollment.

DISABILITY ELIGIBILITY

If you become disabled while you are eligible for benefits, your eligibility will be continued for the balance of the month in which you became disabled and thereafter for up to a total 18 consecutive months from the date of your disability, without cost to you. For this purpose, you are disabled if you are unemployable as a result of an illness or injury either on or off the job, and such disability continues for one week or more.

Example: If you work 140 hours in January, February and March, you would be eligible by work hours through the month of June. However, if you are injured and become disabled in the Month of March, after working at least 140 hours for that month, your coverage based on work will continue through the month of June and, starting July you will be covered based on disability. Your coverage based on disability will continue until the later of the date you are no longer disabled or 18 months.

In order to qualify for this eligibility, you must be under the treatment of a physician, file a claim form **within 30 days of the onset of disability** and submit satisfactory written medical evidence of your disability to the Fund Office. Upon approval of your application, your disability eligibility will be retroactive to the date your disability commenced.

After the 18-month maximum period of disability eligibility, you may continue coverage through use of the balance of the hours in your Hourly Reserve Bank and through self-payments. However, the total of your disability eligibility period and the period in which your eligibility is maintained through the Hourly Reserve Bank and self-payment cannot exceed 24 consecutive months.

TERMINATION OF ELIGIBILITY

If the Fund receives insufficient hours with contributions on your behalf, if your Hourly Reserve Bank is insufficient to make up the difference, if you fail to make the required self-payments, if you have exhausted your disability eligibility and/or if you have exhausted the six-month period in which you are eligible to continue coverage by your Hourly Reserve Bank or by self-payments, your eligibility will terminate on the last day of the last month for which you had maintained eligibility. After that, your eligibility can only be continued under COBRA continuation coverage.

REINSTATEMENT OF ELIGIBILITY

If your eligibility terminated within the prior twelve months, you will be eligible for benefits again on the first day of the third month after you have been credited with a total of 140 hours of work and employer contributions in two consecutive calendar months or less and you will remain eligible based on those hours of work and employer contributions for one month. If you still have them, you may use hours remaining in

your Hourly Reserve Bank toward reinstatement. However, after six months of ineligibility, any remaining hours in your Hourly Reserve Bank are cancelled.

Example: If your eligibility ends on April 30 and you then work 140 hours in September and October for which all contributions are received, you will again become eligible for benefits on January 1 and you will remain eligible based on those hours of work and employer contributions through the month of January.

RECIPROCITY

The Board of Trustees has entered into reciprocity agreements with other insurance and health care funds covering glaziers and glassworkers working in several locals around the country. Under these reciprocity agreements, employer contributions made on your behalf may be transferred from the fund in the area where you are working to your home fund upon your written request and authorization. Transferring contributions may enable you to meet the continuing eligibility requirements of this Fund or another fund. If you work in another jurisdiction and employer contributions are made to another fund on your behalf, you should inquire as to whether such contributions can be transferred to this Fund under a reciprocity agreement.

Because hourly contribution rates vary, it is possible that, even though the hours you work in another jurisdiction would have been sufficient for you to continue eligibility if you had worked in this jurisdiction, the amount of employer contributions sent to the Fund would not be sufficient to continue your coverage because the contribution rate where you worked was lower. In that case, the Fund will credit you with prorated hours based on the contributions it receives and, in order to continue your coverage, you will be required to pay the difference between hours needed to continue your eligibility and hours credited multiplied by the current hourly employer contribution rate under the collective bargaining agreement. If the contribution rate is higher where you worked, no additional hours are credited.

You should contact the Fund Office to find out whether there is a reciprocity agreement between this Fund and another fund and, if there is, sign the necessary request form to have employer contributions transferred. **Don't wait until after you start working** – the Fund can sometimes get a reciprocity agreement in place if there is not already one between the funds, but the Fund can almost never get an agreement in place that covers work already performed.

ELIGIBILITY OF DEPENDENTS

1. Eligibility of Spouses and Children

Generally, your dependents are eligible anytime you are eligible for benefits. The only exceptions are (1) when your dependent no longer meets the Plan's definition of dependent, (2) when your dependent enters the armed forces of any country, (3) when your dependent becomes eligible for coverage as a participant in his/her own right, (4) when continuing coverage under COBRA is not elected by or for your dependents, or (5) when dependent coverage is eliminated from the Plan by the Board of Trustees. Eligibility is not automatic – you need to complete and return the Enrollment Form with all required documentation to the Fund Office.

Dependents are **never** eligible for Life Insurance Benefits, Accidental Death and Dismemberment Benefits or Weekly Disability Benefits.

A. Eligibility of Spouses, and Children Under Age 26

The dependents that can be included in your coverage are your lawful spouse, and any of your children until the end of the calendar month in which they reach age 26. For purposes of eligibility under this Plan, a “Child” is your biological son or daughter, your legally adopted child (including a child placed for adoption), your step-child and your foster child prior to the last day of the calendar month in which such child reaches age 26. It does not matter if the child is married, in school or not, or has other coverage available – your child is still eligible for coverage under the end of the month in which the child reaches age 26 as long as you are eligible.

Birth certificates and marriage certificates are required to establish proof of eligibility as a dependent. If you were never married to the mother of the dependent child you claim, you must provide proof of paternity, such as a duly registered birth certificate naming you as the father, an order of filiation, an adoption order, or other order of the court such as a qualified medical child support order. In the event that proper proof is not filed and a claim is received, the Fund Office is required to request and obtain such proof before the claim can be processed.

Note Regarding Qualified Medical Child Support Orders: Under Federal law, the Fund must recognize qualified medical child support orders (QMCSO) mandating continuation of health care coverage for certain dependent children. A QMCSO is a court order that recognizes the right of an alternate recipient (child) to receive benefits under the Fund. A QMCSO may not require the Fund to provide a type or form of benefit not otherwise provided to children of participants. A QMCSO is usually issued in a divorce where the participant is ordered by the court to continue to provide medical support for the children where the children are not residing full-time with the participant. The Fund Office or legal counsel for the Fund will determine whether a document is a QMCSO. If the document is determined to be a QMCSO, the Fund will notify the eligible employee or retiree and the possible alternate recipient (or custodial parent or issuing agency, as appropriate). If the document is determined not to be a QMCSO, the Fund will send a letter describing the reason for that determination.

It is your obligation to notify the Fund **immediately** upon your divorce or legal separation. **If you delay in providing notice of your divorce or legal separation to the Fund, and the Fund pays any benefits or claims on behalf of your ineligible former or separated spouse, you are legally responsible to repay the Fund for any amounts paid by the Fund. This is a responsibility you accept when you enroll your spouse for coverage.** The Fund reserves the right to recover the amount of any benefits paid on behalf of your former or separated spouse from you, from your former or separated spouse, and from both of you, through offsetting the amount paid on behalf of your former or separated spouse from any future benefits payable to you, through litigation, through termination of your participation in the Fund and through any other lawful means. The Fund’s attorneys pursue recoveries of such amounts aggressively.

B. Eligibility for Disabled Children

Your *unmarried* dependent child may continue coverage under the Plan after the end of the calendar month in which s/he reaches age 26 if s/he becomes totally and permanently disabled from either a physical or mental condition prior to the end of the calendar month in which s/he reaches age 26, and his/her eligibility shall continue as long as such permanent disability exists, and you remain eligible.

2. Enrollment of Dependent Spouses and Children

You may enroll your dependents at the time of your initial eligibility under the Plan.

If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, after your initial eligibility, you may enroll that new dependent for coverage under the Plan **within 30 days** of the date that person becomes your dependent by giving written notice to the Fund Office and including copies of the birth certificate or other proof of parentage for children such as an order of filiation or adoption order, marriage certificates and divorce judgments establishing responsibility for health care for stepchild(ren). If notice with all required documentation is provided **later than 30 days** of the date that person becomes your dependent, your dependent shall not be eligible for coverage before the first day of the month following the month within which notice is received by the Fund.

If you do not enroll one or more of your eligible dependent(s) for coverage at the time of your initial eligibility, or the acquisition of the dependent if later, due to such dependent(s)'s coverage under another health plan, you may enroll such eligible dependent(s) upon the subsequent loss of that other coverage provided that the enrollment is made **within 30 days** of the loss of the other coverage. If you want to re-enroll a dependent child whom you previously elected to disenroll, then the dependent child shall be eligible for coverage as soon as administratively feasible, but not before the first day of the month following the month within which the election is received by the Fund

3. Termination of Dependent Eligibility

A. Termination of Coverage for Spouses

Your spouse's coverage ends upon the earliest of the following dates:

- (1) the date on which your eligibility ends,
- (2) the last day of the calendar month in which a Judgment of Divorce or Judgment or Order of Legal Separation from you is entered,
- (3) the day on which your spouse enters into the armed forces of any country, or
- (4) the day on which the Board of Trustees eliminates spousal coverage under the Plan.

It is your obligation to notify the Fund **immediately** upon your divorce or legal separation. **If you delay in providing notice of your divorce or legal separation to the Fund, and the Fund pays any benefits or claims on behalf of your ineligible former or separated spouse, you are legally responsible to repay the Fund for any amounts paid by the Fund. This is a responsibility you accept when you enroll your spouse for coverage.** The Fund reserves the right to recover the amount of any benefits paid on behalf of your former or separated spouse from you, from your former or separated spouse, and from both of you, through offsetting the amount paid on behalf of your former or separated spouse from any future benefits payable to you, through litigation, through termination of your participation in the Fund and through any other lawful means. The Fund's attorneys pursue recoveries of such amounts aggressively.

Any coverage for a former or separated spouse after the end of the month of the date of entry by the court of a judgment of divorce or legal separation is available only under the terms of COBRA continuation coverage. If the Fund Office is not notified of a divorce or legal separation within 60 days of the date of the Judgment is entered by the Court, the Fund has no obligation to, and will not, offer COBRA coverage. See page 25 for details on COBRA continuation coverage.

B. Termination of Coverage for Children

Children who qualify as your dependents will be eligible for benefits **until** the earliest of the following dates:

- (1) the date your eligibility ends;
- (2) the end of the calendar month in which the child reaches the age of 26, unless the child satisfies the eligibility requirements for unmarried disabled children age 26 and older;
- (3) the date the child becomes eligible for benefits from the Fund as a result of hours worked and employer contributions received by the Fund on behalf of the child based on covered employment;
- (4) the date the child enters the armed forces of any country;
- (5) the date the child is no longer a dependent as defined in the Plan; or
- (6) the date dependent child coverage is eliminated from the Plan by the Board of Trustees.

SURVIVOR COVERAGE (Active Participants or Retirees)

Survivor coverage is an alternative to COBRA for surviving spouses, to continue coverage, with or without your dependent children, under the Plan. Survivor coverage is usually less expensive, and is not subject to the time limits of COBRA continuation coverage.

If you die when you are covered by the Fund, your surviving spouse and dependents who were covered with you at the time of your death may continue their coverage under the Fund by making self-payments. Survivor coverage starts on the first day of the month following your death, or when your Hourly Reserve Bank, if any, falls below 140 hours – that is, your surviving spouse is allowed to use the remaining coverage you had under your Hourly Reserve Bank at the time of your death.

Survivor coverage requires that your spouse make a self-payment to the Fund each month, to be received on or before the 25th of the month prior to the coverage month in the Fund's administrative office. For your convenience, you can enroll into the Fund's ACH payment option and have your self-payment automatically deducted from your bank account on the 25th of the month prior to the coverage month. Contact the Fund Office at 248 641 4957 for further details. Once survivor coverage has commenced, the surviving spouse must maintain continuous coverage under the Plan because survivor coverage may not be re-elected following a lapse in such coverage for any reason.

The surviving spouse may choose either to cover herself only or to cover her and the eligible dependent children as well. The choice once made cannot be changed. Dependent children have no separate right to

elect survivor coverage (that is, they can only be covered *with* your surviving spouse), but they may elect COBRA continuation coverage as set forth below if the surviving spouse does not elect to cover them under survivor coverage.

If the surviving spouse continues to make the required self-payments when due, coverage for the surviving spouse and any dependent children of the deceased active participant (including children of a male deceased active participant born to his surviving spouse within nine months after his death) will continue until the *earliest* of the following occurs, as applicable:

- (1) (for the surviving spouse and children) the surviving spouse remarries;
- (2) (for the surviving spouse and children) the surviving spouse becomes eligible under another group health care plan;
- (3) (for each child) the child becomes eligible under another group health care plan;
- (4) (for each child) the child no longer meets the Plan's definition of a "child";
- (5) (for the surviving spouse and children) the Plan no longer provides survivor coverage or dependent coverage; or
- (6) (for the surviving spouse and children) a required self-payment is not received when due.

The self-payment rates will be determined by the Board of Trustees from time to time and will vary depending on whether the surviving spouse is covered by Medicare and whether there are any dependent children. A person who is eligible for Medicare must participate in both Medicare Parts A and B to be eligible for coverage through the Fund, but not Medicare Part D coverage. **The Board of Trustees has the authority to change the self-payments rates for both current and future survivors – the rate a surviving spouse initially pays can be changed at any time by the Board of Trustees.**

If the surviving spouse does not elect to maintain coverage under these provisions and she makes a timely election, she and your dependent child or children may continue coverage pursuant to and subject to all provision regarding COBRA for 36 months under the terms of COBRA at the monthly COBRA rates then applicable.

RETIREE COVERAGE

1. Eligibility

*If you are part of the bargaining unit on the effective date of your retirement with the International Union of Painters and Allied Trades Union and Industry Pension Fund, you are entitled to continue coverage without cost to you from the effective date of your retirement until your Hourly Reserve Bank, if any, falls below 140 hours – that is, you are allowed to use the remaining coverage you had under your Hourly Reserve Bank at the time of your retirement. This provision on using your Hourly Reserve Bank applies to bargaining unit members *only*.*

Whether or not you were in the bargaining unit when you retired, you may elect retiree coverage if you meet the following requirements:

- (1) you were eligible for benefits on the effective date of your retirement, and
- (2) you are receiving a pension from the International Union of Painters and Allied Trades Union and Industry Pension Fund, and
- (3) you make self-payments at a rate to be established by the Board of Trustees, which may be changed from time to time at its discretion.

Your spouse and dependent children are not separately eligible for retiree coverage – they can be covered under retiree coverage only with you.

You must elect retiree coverage within **30 days** after your effective date of retirement (for bargaining unit employees only, within **30 days** after the date your Hourly Reserve Bank, if any, falls below 140 hours, if later). If you timely elect retiree coverage, it begins on your effective date of retirement (for bargaining unit employees only, the first date of the month in which your Hourly Reserve Bank, if any, is below 140 hours, if later). **If you do not timely elect retiree coverage** (or if you do not timely notify the Fund Office that you are declining immediate enrollment under the delayed enrollment option explained below), **you will not have the opportunity to elect coverage under the Plan unless you return to covered employment and thereby reinstate or re-establish eligibility.**

Your first payment, which must include the self-payment for the first and second months of coverage, must be made by the 30-day retiree coverage election deadline described above.

After you make your first payment for retiree coverage, you will be required to make monthly payments. Each of these monthly payments is due no later than the 25th of the month before that coverage period. For example, payment for August coverage is due on July 25th. For your convenience, you can enroll into the Fund's ACH payment option and have your self-payment automatically deducted from your bank account on the 25th of the month prior to the coverage month. Contact the Fund Office at 248 641 4957 for further details.

The self-payment rates will be determined by the Board of Trustees from time to time and will vary depending on whether the retiree and/or spouse are covered by Medicare and on whether there are any dependent children. A retiree and his spouse who are eligible for Medicare must participate in both Medicare Parts A and B to be eligible for coverage through the Fund, but not Medicare Part D coverage. **The Board of Trustees has the authority to change the self-payments rates for both current and future retirees – the rate you pay when you first retire can be changed at any time by the Board of Trustees.**

Failure to Elect Retiree Coverage: If you do not timely elect retiree coverage (or if you do not timely notify the Fund Office that you are declining immediate enrollment under the delayed enrollment option explained below), you will not have the opportunity to elect coverage under the Plan unless you return to covered employment and thereby reinstate or re-establish eligibility.

If you do not timely elect retiree coverage (or if you do not timely notify the Fund Office that you are declining enrollment under the delayed enrollment option explained below), coverage for your spouse and dependent children may be continued only under the provisions of COBRA continuation coverage. If you do not elect retiree coverage within the applicable period, you will **not** have the opportunity to elect coverage under the Plan unless you return to covered employment and thereby reinstate or re-establish eligibility.

Delayed Enrollment Option: If you decline retiree coverage for yourself or your dependents (including your spouse) because you have (or they have) other health care coverage, you may subsequently enroll yourself or your dependents in this Plan if the other coverage is lost, *provided* you notified the Fund Office that you are declining retiree coverage because you have other coverage by the 30-day retiree coverage election deadline set out above. You will need to provide proof of the other health care coverage when you provide this notice to the Fund Office.

If you comply with the above rules, and you or your dependents subsequently lose the other health care coverage, you can request retiree coverage for you or them from the Fund as long as you do so within **30 days** after such other coverage ends. Proof of the other health care coverage and its termination date will be required for re-enrollment.

*To summarize, to delay retiree coverage for yourself or your dependents because you or they have other coverage, you need to (1) notify the Fund that you are declining retiree coverage because you have other coverage **within 30 days of your retirement**, and provide proof of that other coverage, and (2) notify the Fund that you want to elect retiree coverage **within 30 days of the loss of that other coverage**, and provide proof of the loss of that other coverage.*

Post-Retirement Marriage/Enrollment of Newly Acquired Dependents: If you acquire a new dependent after you begin retiree coverage as a result of marriage, birth, adoption, or placement for adoption, you may enroll such newly acquired dependent for coverage provided that you request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption. Appropriate proof will be required for enrollment. If the Fund is notified **later than 30 days** of the acquiring a new dependent, your new dependent's coverage will begin then, and it will not go back to the date of birth, adoption/marriage, as applicable – the Fund is not obligated to provide coverage effective any earlier than the first of the month following the date on which it receives the enrollment notice and all documentation.

2. Termination of Retiree Coverage

If you make all required self-payments when due, your retiree coverage will continue until the earliest of the following dates:

- (1) the date on which you return to active employment; or
- (2) the date the Fund no longer provides retiree, spouse and/or dependent coverage by action of the Board of Trustees, which it has the exclusive discretion to do at any time.

The same rules on when dependent coverage terminates for dependents of actives apply to when dependent coverage terminate for dependents of retirees – that is, their coverage ends on the earliest of the following, as applicable:

- (1) (for spouses and children) the date your retiree coverage ends;
- (2) (for children) the end of the calendar month in which the child reaches the age of 26, unless the child satisfies the eligibility requirements for disabled children age 26 and older;

- (3) (for children) the date the child becomes eligible for benefits from the Fund as a result of hours worked and employer contributions received by the Fund on behalf of the child based on covered employment;
- (4) (for spouses or children) the date your spouse or child enters the armed forces of any country; or
- (5) (for spouses) the last day of the calendar month in which a Judgment of Divorce or Judgment or Order of Legal Separation from you is entered.
- (6) (for spouses and children) the day on which the Board of Trustees eliminates spousal and/or child coverage under the Plan.

3. Reinstatement in Active Employee Plan – Return to Covered Employment by Retiree

If you are covered by retiree coverage and then re-enter covered employment, you must re-establish eligibility under the initial eligibility provisions of the Plan. You will be allowed to continue to make your retiree self-payments until you have satisfied the initial eligibility provisions of the Plan.

FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act of 1993 (FMLA) provides for up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. You are eligible if you have worked for your employer (1) for at least 12 months and (2) for at least 1,250 hours in the 12 months before the leave starts and if your employer (1) is covered by the Act and (2) has at least 50 employees within 75 miles of where you work.

Whether you are eligible for family or medical leave is determined by your employer, not the Fund.

Both you and your employer are required to notify the Fund if you take a family or medical leave and to provide certain other information as required by the Board of Trustees. The Fund will continue coverage during the period of your family or medical leave, provided your employer makes all required contributions to the Fund at the same rate and in the same amount as if you were continuously employed during the period of your leave and fully complies with all requirements established by the Board of Trustees.

FMLA coverage does not include Life Insurance Benefits, Accidental Death and Dismemberment Benefits, Weekly Disability Benefits, or orthodontic coverage for participants and spouses under Dental Expense Benefits.

MILITARY SERVICE COVERAGE

If you leave covered employment to serve in the military or other uniformed services (“service”), the Uniformed Services Employment and Reemployment Rights Act (USERRA) requires that the Fund permit you to elect to continue your and your dependents’ eligibility with the Fund (except for Life Insurance Benefits, Accidental Death and Dismemberment Benefits, Weekly Disability Benefits and orthodontic coverage for participants and spouses under Dental Expense Benefits).

You should notify the Fund Office as soon as possible that you will be departing for service. If you do not notify the Fund Office before you depart for service and your departure causes you to lose coverage, the

Fund Office will generate a notice of COBRA continuation coverage. You (or your family member) must notify the Fund Office that you have departed for service **no later than 60 days** after receiving that notice of COBRA continuation coverage to be eligible for coverage during the period of your service and for special initial eligibility provisions upon your return to work.

If the Fund Office is not notified in the manner above that you have departed for service (or, if it is not feasible to provide notice, then within 30 days from when it becomes feasible to do so), your eligibility for coverage will terminate under the normal eligibility rules and you will have to meet the normal rules for reinstatement of eligibility.

Notice should be provided to the Michigan Glass and Glazing Industry Welfare Insurance Fund, P.O. Box 966, Troy, MI 48099-0966, (248) 641-4957, or at 700 Tower Drive, Suite 300, Troy, Michigan 48098.

If you serve fewer than 31 days, no selfpayment is required and no reduction of your Hourly Reserve Bank will occur – the Fund is legally required to continue your eligibility without charge if you are in the service for fewer than 31 days without charge or penalty to you.

If you serve for 31 days or more, and you (or a family member on your behalf) have provided notice to the Fund in the required time period, you may continue eligibility by making a selfpayment for each month of your service at the Fund's regular COBRA rates, for up to 24 months, or the period of your service plus 90 days, whichever is lesser. You must elect to continue coverage within time periods applicable to the election of COBRA continuation coverage.

You may continue coverage by making monthly self-payments from the beginning date of your service without using the hours in your Hourly Reserve Bank, in which case those hours will be available to you upon your return to work, as explained below, or, you can first use the hours in your Hourly Reserve Bank, if any, in which case your Hourly Reserve Bank will either be reduced or eliminated over the duration of your service, and as a result may not be available to you upon your discharge to the extent that you have used it to delay the need to make monthly self-payments.

Eligibility Upon Return to Work: If you serve between 31 days and five years, and you (or a family member on your behalf) have provided the Fund Office with notice of your departure for the services as described above, you will not have to meet the normal rules for reinstatement of eligibility if you return to work for a contributing Employer (or register on the out-of-work list) within 90 days of your discharge under honorable conditions. Your Hourly Reserve Bank will be available to you in full upon your return in the time period and manner set out above, and will be applied to provide you with eligibility upon your return.

These rules can be complicated. Therefore, please notify the Fund **immediately** when you enter military service and **immediately** upon your discharge to take advantage of your rights under the law.

COBRA CONTINUATION COVERAGE

Introduction

This section of the Summary Plan Description contains important information about your right to COBRA continuation coverage under the Plan, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. **It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

COBRA continuation coverage is a temporary extension of coverage under the Plan. COBRA continuation coverage does not include Life Insurance Benefits, Accidental Death and Dismemberment or Weekly Disability Benefits. The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This is only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under Federal law, you should contact the Fund Office and/or get a copy of the Plan.

The Board of Trustees has delegated the day-to-day responsibilities for the administration of COBRA continuation coverage to the Administrative Manager. Both the Board of Trustees and the Administrative Manager can be contacted at the Fund Office, 700 Tower Drive, Suite 300, Troy, Michigan 48098, (248) 641-4957. Please use the following mailing address for the Board of Trustees and the Administrative Manager: P.O. Box 966, Troy, MI 48099-0966.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

Cobra Continuation Coverage

COBRA continuation coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The child's parents become divorced or legally separated (but see Qualified Medical Child Support Orders, page 18); or
- The child stops being eligible for coverage under the Plan as a child.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is loss of coverage due to the end of employment or reduction of hours of employment, the Fund Office will receive that information from your contributing Employer. When the qualifying event is the death of the employee, or the employee's becoming entitled to Medicare (as of this printing, a person covered by the Plan does not lose coverage by becoming eligible for Medicare), the contributing Employer must notify the Fund Office of the qualifying event within 30 days of any of these events.

You Must Give Notice of Some Qualifying Events

In the event of the divorce or legal separation or divorce of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, the employee or his beneficiary(ies) must notify the Fund Office. The Plan requires you to notify the Fund Office within 60 days after one of these qualifying events occurs. The Fund Office may require that you provide evidence that a qualifying event has taken place, such as a copy of the Judgment of Separation or Divorce, death certificate or birth certificate. You should send written notice of the event to Michigan Glass and Glazing Industry Welfare Insurance Fund, P.O. Box 966, Troy, MI 48099-0966. Failure to comply with this requirement in the required time period will result in the permanent loss of COBRA rights.

You or your beneficiary(ies) will be required to send a full copy of your divorce decree, decree of legal separation, and/or birth certificate, as applicable to the Fund Office at P.O. Box 966, Troy, MI 48099-0966.

Continuation of coverage will **not** be permitted if the divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a child is not reported to the Fund Office within **60 days** from the **later** of the date you would lose coverage because of the occurrence of one of the events described above **or** the date you were sent your COBRA election notice, if you have provided timely notification. Some qualifying events result in an immediate loss of coverage (such as divorce and legal separation), and some are determined on a monthly basis (such as termination of employment, reduction in hours, death of the participant, and a child's no longer meeting the dependent child eligibility rules).

Therefore, you should **never delay** in notifying the Fund Office of any qualifying event, or you risk losing your rights under COBRA.

How is COBRA Coverage Provided?

Once the Fund Office receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage must be elected no later than 60 days after the qualified beneficiary receives the COBRA Election Form. If you do not submit the COBRA Election Form by the due date, you will lose your right to elect COBRA continuation coverage.

If you have a new dependent child while your COBRA continuation coverage is in effect, you have the right to elect coverage for such child if the Fund receives notice of that birth, adoption or placement for adoption within 30 days of its occurrence. A new dependent child while you are receiving COBRA continuation coverage will have the same COBRA rights as your spouse or dependents who were covered by the Plan before the event that triggered COBRA coverage. Like all qualified beneficiaries with COBRA coverage, the child's continued coverage depends on the timely and uninterrupted payment of your COBRA payments.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage begins on the date of the qualifying event (for divorce and legal separation), or on the date that Plan coverage would have otherwise been lost (for termination of employment, reduction of hours, death of the participant and loss of dependent child status).

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits fewer than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts up to 36 months after the date of his Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. **You must make sure that the Fund Office is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must send this notice to the Fund Office at P.O. Box 966, Troy, MI 48099-0966.**

- **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, you must make sure that the Fund Office is notified of the second qualifying event within 60 days of the second qualifying event's occurrence. You must send this notice to the Fund Office at P.O. Box 966, Troy, MI 48099-0966.**

Cost of COBRA Continuation Coverage

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you have to pay the full cost, including a two percent administrative surcharge, for your continuation coverage. If the Social Security Administration determines that you were disabled at the time of termination or reduction of hours and you elect to continue coverage beyond the 18-month period, you may be charged an additional 50 percent surcharge beginning on the 19th month of coverage.

You will have a grace period of at least 30 days to pay the monthly COBRA payment, except for the first monthly payment, for which you will have a one-time-only 45-day grace period.

Termination of COBRA Continuation Coverage

The law also provides that you or your dependents' COBRA continuation coverage may be terminated by the Fund for any of the following reasons, before the maximum duration period set out above:

- The Fund no longer provides coverage for similarly situated individuals;
- Payment for continuation coverage is not received by the Fund in full and when due;
- You or your dependent becomes covered under another group health plan that does not include a preexisting conditions clause that applies to you or to a covered dependent;

- If you are or become covered under another group health plan (you must notify the Fund Office immediately);
- You are receiving COBRA continuation coverage because of a disability defined under the Social Security Act, and Social Security determines that you are no longer disabled (you must notify the Fund Office within 30 days of the date of any final determination by the Social Security Administration that you are no longer disabled); or
- You provide written notice to the Fund Office that you wish to end your COBRA continuation coverage.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep the Fund Office Informed of Address Changes and Life Changes.

In order to protect your family’s rights, you should keep the Fund Office informed of any changes in your address and the addresses of family members, and in the event of any changes in your family (births, deaths, divorce, legal separation, entitlement to Medicare, etc.). You should also keep a copy, for your records, of any notices you send to the Fund Office.

Plan Contact Information

Michigan Glass and Glazing Industry Welfare Insurance Fund
 Street Address: 700 Tower Drive, Suite 300, Troy MI 48098
 Mailing Address: P.O. Box 966, Troy, MI 48099-0966
 Telephone: (248) 641-4957
 FAX: (248) 813-9898

BENEFITS

MEDICAL, HOSPITAL AND SURGICAL BENEFITS (Non-Medicare Eligible Only)

GENERAL COVERAGE RULES

No medical, surgical or hospital benefits are provided unless the services are both:

- Medically necessary (but see post-mastectomy services, page 64), and
- Not excluded from coverage.

A list of exclusions can be found on page 59 of this Summary.

Also, some services that are both medically necessary and not excluded from coverage may not be covered because the services were provided by an out-of-network provider. There are also cost-sharing rules, which will in most cases impose financial responsibility on you for copayments, deductibles and co-insurance amounts. Those details are provided in the next section, below.

OPERATION OF BCBSM'S SIMPLY BLUE PPO

The Fund participates in BCBSM's Simply Blue PPO. Medical benefits under the Plan are subject to deductible, copayment, coinsurance and, in some instances, self-payment requirements. Active Participants and non-Medicare retirees receive coverage under the Plan through the self-funded arrangement with BCBSM. Upon retirement and the exhaustion of the then earned continuing eligibility as a result of employer contributions, participants are no longer eligible for coverage under the self-funded arrangement with BCBSM.

"Benefits at a Glance" for Active and Pre-Medicare Retiree coverage is attached at Appendix A, at the end of this Summary.

Under a PPO program, some providers are "in-network" and some providers are "out-of-network" or "non-network". You may contact the Fund Office, the BCBSM or your health care provider directly to see if they are in-network/participating providers. You can also access this information online at <http://www.bcbsm.com>.

It is almost always to your financial advantage to use participating in-network providers. Some benefits are provided at a lower cost when using in-network providers, and some benefits are not covered at all unless you use in-network providers. A few benefits are provided at the same cost whether provided in-network or out-of-network.

A. In-Network Benefits

Annual In-Network Deductible, Fixed Dollar Copays and Percent Copays: When you receive services in-network you must pay an in-network deductible before payment will be made for benefits by the Plan, except where a fixed dollar copayment is required. This deductible is required to be met each calendar year. You are also responsible for any copays charged to received services. Please refer to the Benefits at a Glance document at Appendix A at the end of this Summary for a detailed description of deductibles and copays.

When one individual has met the annual in-network deductible, benefits are payable for covered services for that individual for the remainder of that calendar year. In-network services for the remaining family members will be paid for the remainder of that calendar year when the full family deductible has been met for that year.

Note: The usual and customary amount is BCBSM PPO's maximum payment level or the provider's billed charge for the covered service, whatever is lower. Deductibles and copays, if any, are deducted from the usual and customary amount.

B. Out-of-Network Benefits

When Out-of-Network Benefits Apply: Benefits will be covered at the out-of-network level when a BCBSM PPO physician, or facility does not provide or refer your care.

Using participating in-network providers usually limits your out-of-pocket expenses, and the provider bills the Fund directly for your services.

When you use a **non-participating**, out-of-network provider, the Fund will pay the usual and customary amount after your deductible and out-of-network copays have been deducted. You may be responsible for paying the difference between the provider's actual charge and the usual and customary amount.

Annual Out-Of-Network Deductible, Fixed Dollar Copays and Percent Copays: When you receive services out-of-network you **must** pay an out-of-network deductible **before** payment will be made for benefits by the Plan, except where a fixed dollar copayment is required. This deductible is required to be met each calendar year. You are also responsible for any copays charged to received services. Please refer to the Benefit at a Glance document attached at the end of the SPD for a detailed description of deductibles and copays.

Note: When one individual has met the annual out-of-network deductible, benefits are payable for covered services for that individual for the remainder of that calendar year. Out-of-network services for the remaining family members for that calendar year will be paid when the full family deductible has been met for that calendar year.

Note: The usual and customary amount is BCBSM PPO's maximum payment level or the provider's billed charge for the covered service, whatever is lower. Deductibles and copays, if any, are deducted from the usual and customary amount.

C. Coverage Outside of BCBSM PPO Coverage Area

When you need medical care outside of the service area for BCBSM PPO, but in the United States, use the contact information on the back of your card, and you will be given the nearest participating physician or hospital. You are responsible for paying applicable deductible and copays and for services not covered by this Plan, whether the services are provided within the BCBSM PPO Network for in-network coverage or outside of the BCBSM PPO Network for out-of-network coverage. However, you will not be expected to pay any out-of-network copays or deductibles if you receive treatment for an accidental injury or a medical emergency.

Important: You may need to submit itemized receipts directly to BCBSM if you receive services from a non-network provider.

When you need medical care outside of the United States, you are covered if the hospital is accredited and the physician is licensed. Obtain itemized receipts, preferably written in English. The usual and customary amount for covered services will be paid at the rate of exchange in effect on the day you received your services, minus any deductibles or copays that may apply. **Only** emergency treatment and emergency inpatient care received outside the country are covered at the in-network levels; all other treatment is covered as out-of-network care.

Please note that, unless stated otherwise, a participant's dependent(s) will receive the same coverage, services, etc. that the participant receives.

MEDICAL, HOSPITAL AND SURGICAL (Medicare Eligible Only)

GENERAL COVERAGE RULES

No medical, surgical or hospital benefits are provided unless the services are both:

- Medically necessary (but see post-mastectomy services, page 64), and
- Not excluded from coverage.

A list of exclusions can be found on page 59 of this Summary.

Also, some services that ARE both medically necessary and not excluded from coverage may not be covered because the services were provided by an out-of-network provider. There are also cost-sharing rules, which will in most cases impose financial responsibility on you for copayments, deductibles and co-insurance amounts. Those details are provided in the next section, below.

OPERATION OF BCBSM'S MEDICARE PLUS BLUE GROUP PPO

The Fund participates in BCBSM'S Medicare Plus Blue Group PPO, a Medicare Advantage plan. Medicare Plus Blue PPO combines original Medicare Part A (hospital) and Part B (medical) coverage and expands your coverage to include additional preventive services and much more. Under Medicare Plus Blue PPO, you must continue to pay the applicable Medicare Part B premium, as well as the monthly self-payments at a rate to be established by the Board of Trustees, which may be changed from time to time at its discretion.

When you become covered by BCBSM Medicare Plus Blue PPO, you will receive a document entitled "Evidence of Coverage." For specific information about your benefits and cost-sharing responsibilities, you should always rely on that primarily.

The Fund has an insurance contract for BCBSM's Medicare Plus Blue PPO. Under this PPO program, some providers are "in-network" and some providers are "out-of-network". You may contact the Fund Office or www.bcbsm.com for a listing of Medicare Plus Blue PPO providers by county, or you may simply contact health care providers directly to see if they are participating.

An in-network provider is a physician, hospital or other licensed facility or health care professional who provides services through the Medicare Plus Blue PPO network. Medicare Plus Blue PPO network providers have a signed participation agreement with BCBSM to accept the BCBSM-approved amount as payment in full for services covered under your health care plan. Using Medicare Plus Blue PPO network providers limits your out-of-pocket costs for covered services to any in-network deductible and copays (percent and fixed dollar copays) that may be required by the Fund's contract with BCBSM.

A non-network provider is a physician, hospital or other licensed facility or health care professional who has not signed a participation agreement with BCBSM to provide services through the BCBSM Medicare Plus Blue PPO network. You are generally required to pay higher deductibles and copays for covered services received outside the Medicare Plus Blue PPO network.

Important: Outside the Medicare Plus Blue PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept the BCBSM-approved amount plus your out-of-network deductible and copays as payment in full for covered services. Nonparticipating providers have not signed a participation agreement with BCBSM. They can bill you for any differences between their charges and the BCBSM-approved amount (called balance billing).

It is almost always to your financial advantage to use participating in-network providers and facilities. Some benefits are provided at a lower cost when using in-network providers, and some benefits are not covered at all unless you use in-network providers. A few benefits are provided at the same cost whether provided in-network or out-of-network.

“Benefits at a Glance” for Medicare Eligible Retiree coverage is attached as Appendix B at the end of this Summary.

Please note that, unless stated otherwise, a participant's dependent(s) will receive the same coverage, services, etc. that the participant receives.

PRESCRIPTION DRUG BENEFITS (All Participants and Retirees)

Prescription drug benefits under the Plan are subject to deductible, copayment, coinsurance and, in some instances, self-payment requirements. Active Participants and non-Medicare eligible retirees receive coverage under the Plan through the self-funded arrangement with BCBSM. Medicare eligible retirees receive coverage under the Medicare Plus Blue Group PPO policy.

“Benefits at a Glance” for Active and Pre-Medicare Retiree coverage is attached at Appendix A at the end of this Summary, and for Medicare Eligible Retiree coverage is attached as Appendix B at the end of this Summary.

You can have your prescriptions filled at a network or non-network pharmacy. The choice is always yours. Remember that when your prescriptions are filled through a non-network pharmacy, you have higher out-of-pocket costs.

Please note that, unless stated otherwise, a participant's dependent(s) will receive the same coverage, services, etc. that the participant receives.

Special Notices for Medicare-Eligible Individuals

The Fund's actuary has determined that the Fund's prescription drug program is on average at least as good as that being provided by Medicare Part D. This means that if you do not sign up for Medicare Part D now, you will *not* have to pay a higher premium for Medicare Part D if you sign up later.

Therefore, the Fund encourages you, if you determine that it is in your best interest to do so, to remain with the prescription drug coverage provided by this Plan and not to sign up for Medicare Part D. If you do decide to sign up for Medicare Part D, your prescription drug coverage with this Fund will be terminated.

Please be alert for special notices regarding the Fund's prescription drug benefits for retirees and how those benefits relate to benefits provided under Medicare Part D. Please contact the Fund Office if you have questions about retiree prescription drug coverage and/or Medicare Part D.

HIGH-COST DRUG DISCOUNT OPTIMIZATION PROGRAM

The Fund's High-Cost Drug Discount Optimization Program is provided under the Fund's arrangement with BCBSM and administered for BCBSM by PillarRx. This program will assist you by identifying available manufacturer assistance coupons. If a prescription drug you take has a manufacturer assistance coupon available (a "program-eligible drug") you will automatically be included in the program. PillarRx will assist you with program enrollment. Once enrolled, your final cost for any program-eligible drug(s) will be lower, or you may pay nothing at all. If you do not cooperate with PillarRx to enroll in the program, a copay of up to 30% of the cost of the prescription will apply for any program-eligible drug(s).

DENTAL BENEFITS (All Active and Retired Participants)

The Fund has engaged Delta Dental PPO of Michigan as the insurer of its dental benefits program. You do not need an ID card or a claim form to receive treatment, but at your first visit after your Delta Dental coverage begins, it is helpful if you provide your dentist with your group number (1631-0001) and member ID for your dentist's records.

Through Delta Dental PPO (Point-of-Service) you have access to two of the nation's largest networks of participating dentists: Delta Dental PPO and Delta Dental Premier network. Delta Dental PPO and Delta Dental Premier dentists will submit claims for you, charge you only for your copayment, if any, request no balance billing above the contracted fee. Non-participating dentists may require you to submit your own claims, charge you the full cost of a procedure, and may ask for full, up-front payment.

You are not required to go to a Delta Dental participating provider to receive benefits under the Plan, and the Fund's arrangement with this dental PPO is not an endorsement or recommendation of any of the Delta Dental-participating providers by the Fund. The Fund Office can provide you with a directory to find a participating dentist near you, or you can contact Delta Dental to find out if your dentist is a Delta Dental participating provider. For a complete list of services covered by Delta Dental, copayments, annual maximums and exclusions, see the Delta Dental Benefits at a Glance at Appendix C to this Summary.

FMLA coverage and USERRA coverage do not include orthodontic coverage for participants and spouses under Dental Expense Benefits.

VISION EXPENSE BENEFITS (All Participants and Retirees)

The Fund will pay benefits to participants and dependents for the following optical services in the following amounts:

<u>Benefit</u>	<u>Amount</u>
<i>Eye Exams once every 12 months by an:</i>	
Ophthalmologist	\$ 75.00
Optometrist	\$ 65.00
 <i>Prescribed lenses once every 12 months:</i>	
Single	\$110.00
Bifocal	\$130.00
Trifocal	\$140.00
Progressives	\$150.00
Contact Lenses	\$140.00
Frames once every 24 months	\$120.00

You may go to any licensed optometrist or ophthalmologist to receive covered services. Submit your claims to the Fund Office within 90 days from the date the service was provided.

Vision Expense Benefits shall **not** be payable for the following:

- Sunglasses or tinted lenses, unless they are prescribed to be worn at substantially at all times by an ophthalmologist for medical reasons
- Routine yearly examinations required by an employer in connection with the occupation of the individual
- Vision expenses resulting for occupational bodily injury or disease

LIFE INSURANCE BENEFITS (Active Employees Only)

Life insurance benefits in the amount of \$30,000 are payable to the beneficiary upon the death of an Active Employee (an employee who is eligible by either employer contributions or during the six-month period in which you are eligible to continue coverage by your Hourly Reserve Bank or by self-payments). The Life Insurance benefit is insured with a policy issued by a commercial insurance company and is subject to all terms and exclusions of that policy. Benefits are payable based on the policy of the commercial insurance company with which the Fund contracts.

Participants eligible under the disability eligibility provisions or COBRA provisions of the Plan, dependents, retirees and surviving spouses are not eligible for Life Insurance benefits.

An amount not to exceed \$500 may be paid from the \$30,000 Life Insurance Benefit to any person incurring the expense of your burial, provided a receipt is submitted to and determined satisfactory by the Claims Administrator.

Where any term in this Summary conflicts with the policy issued by the commercial insurance company, **the terms of the policy shall control.** A copy of the current policy is available upon request.

Benefit Termination: Your Life Insurance Benefit coverage terminates immediately when your coverage under this Plan terminates. Your Life Insurance Benefit coverage also terminates immediately upon your coverage under COBRA as a Retiree, and upon entry into full-time active military service. If your policy terminates because of entry into full-time active military service, it will be reinstated on the date that you return to work for a participating employer, if within 90 days of your discharge.

Conversion Policy: A person whose eligibility for this Life Insurance Benefits has terminated may apply for a Conversion Policy. The Conversion Policy is issued by the same commercial insurance company that issues the Fund's policy, and you must apply within 31 days of the date of termination or reduction. The premium that such person will owe will be based on the standard premium rate according to the amount of insurance, class of risk, gender and age of the person. You should contact the commercial insurance company for information on this.

Claims

Proof of death must be provided to the Fund Office within ninety (90) days of the date of death of the Active Employee, but in no event, other than legal incapacity, later than one year after the loss.

Beneficiary

You may designate as your beneficiary any person or persons you choose, and you may change your beneficiary at any time without the consent of the prior beneficiary/ies. The designation of a beneficiary must be on a form provided by or satisfactory to the Fund, and it takes effect when it is received by the Fund Office. Your beneficiary designation is for your Life Insurance benefit and for your Accidental Death and Dismemberment benefit.

If you designate your spouse as beneficiary, and then you are later divorced from that spouse, that divorce does **not** automatically terminate the designation of your former spouse as beneficiary. ***Therefore, if you are divorced and you wish to change your beneficiary, you must designate a new beneficiary by completing the necessary forms, which are available at the Fund Office.*** Even if your divorce decree provides that your former spouse waives rights to your life insurance, you must still complete a new beneficiary card to implement that provision and identify your beneficiary. It is your responsibility to always make sure that your beneficiary designation reflects your wishes.

If you name more than one beneficiary, the living beneficiaries shall be entitled to equal shares unless you specify otherwise on your beneficiary form.

If there is no named Beneficiary, or if no named Beneficiary is surviving at the time of your death, payment will be made to the first surviving class in the following order of preference:

- a. your surviving spouse;
- b. your children, in equal shares;
- c. your parents, in equal shares;
- d. your brothers and sisters, in equal shares; or
- e. the executors or administrators of your estate.

If the beneficiary is a minor or is otherwise incapable of giving a valid release for any payment due, the amounts payable to such beneficiary shall be paid to his or her duly appointed guardian. If there is no legal guardian, the Claims Administrator may pay the individual or institution that has, in its opinion, custody and principal support of such beneficiary. The insurance company will be fully discharged of its liability for any amount of benefit so paid in good faith.

FMLA coverage and USERRA coverage do not include Life Insurance Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Active Employees Only)

Accidental death and dismemberment benefits in the principal sum of \$30,000 are payable to the beneficiary upon the death of an Active Employee (an employee who is eligible by either employer contributions or during the six-month period in which you are eligible to continue coverage by your Hourly Reserve Bank or by self-payments). The Accidental Death and Dismemberment benefit is insured with a policy issued by a commercial insurance company and is subject to all exclusions of that policy. Benefits are payable based on the policy of the commercial insurance company with which the Fund contracts.

Participants eligible under the disability eligibility provisions or COBRA provisions of the Plan, dependents, retirees and surviving spouses are not eligible for Accidental Death and Dismemberment Benefits.

Where any term in this Summary conflicts with the policy issued by the commercial insurance company, **the terms of the policy shall control.** A copy of the current policy is available upon request.

The Fund pays the percentage of the principal sum shown below if you are injured and that injury results in any of the losses listed below. The loss must occur within 365 days of the accident that caused the injury. If you suffer more than one loss as a result of any one accident, only one amount, the largest, will be paid.

For Loss of:	Percentage of Principal Sum:
Life.....	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot.....	100%
One hand or one foot and sight of one eye.....	100%
One hand or one foot	50%
Sight of one eye	50%

Claims

Proof of loss must be provided to the Fund Office within 90 days of the loss or as soon as reasonably possible, but no later than one year after the loss except in cases of legal incapacity.

Beneficiary

In the event of loss, the benefit is paid to the covered person, except in case of loss of life, where benefits will be paid to the beneficiary. Your designated beneficiary for the Life Insurance Benefits (described above) is your designated beneficiary for the death benefit payable under the Accidental Death and Dismemberment policy.

Exclusions

Payment shall **not** be made under this provision for any loss resulting from or caused directly or indirectly, wholly or partly by:

- Bodily or mental illness or disease of any kind;
- Ptomaine or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- Suicide or attempted suicide, while sane or insane;
- Intentional self-inflicted injury;
- Participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion;
- War or act of war, whether declared or undeclared; any act related to war or insurrection;
- Service in the armed forces of any country while such country is engaged in war; or
- Police duty as a member of any military, naval or air organization.

FMLA coverage and USERRA coverage do not include Accidental Death and Dismemberment Benefits.

WEEKLY DISABILITY BENEFITS (Active Employees Only)

If you are eligible for benefits and are unable to work because of an accident occurring **off** the job, an accident **not** involving an automobile or other motor vehicle licensed to be on the road, or any illness **not** connected with employment, you will be entitled to Weekly Disability Benefits for a maximum of 26 weeks or the period of your disability, whichever is shorter. If you remain wholly and continuously disabled, you may receive an additional 13 weeks of Weekly Disability Benefits, for a maximum of 39 weeks of Weekly Disability Benefits. The weekly benefit is \$350.00 per week for journeymen, service and apprentice glaziers, and inside glassworkers, and \$245.00 per week for residential and allied trainees. Payment for one day of disability is 1/7th of the amount of the weekly benefit.

If you have an occupational-related disability, you are not entitled to Weekly Disability Benefits. However, if your Workers' Compensation benefits are in dispute or are delayed, you may be entitled to Weekly Disability Benefits, upon agreeing to repay the Fund back any Weekly Disability Benefits you received, if and when your Workers' Compensation claim is approved. If the Fund pays you a benefit and you receive a settlement, you must repay the Fund up to the amount of benefits received. If you do not do so, the Fund has the right to treat the benefits paid as your debt and may pursue recovery and/or reduce any future benefits payable to you. Please see the Subrogation and Reimbursement section of this SPD on page 56 for more information.

Benefits are payable from the first day of disability due to an injury or accident, from the first day when confined to a hospital and from the first day following surgery in an outpatient department of a hospital. Benefits are payable from the eighth day of disability due to an illness and pregnancy.

You will not be eligible for a new Weekly Disability Benefit period for disability due to the same or related causes until you have returned to work for an employer on a full-time basis for at least two weeks. Under no circumstances will you be eligible for more than 26 weeks of Weekly Disability Benefits (or 39 weeks, if applicable), whether received during one or more Weekly Disability Benefit periods, as a result of a disability due to the same or a related cause.

In determining when one disability period ends and a new period begins, all disability absences due to the same or related causes and separated by less than 14 days of active work will be considered as occurring in a single disability period. If a new disability period is due to a cause different from the causes of any prior disability, it must be separated from the prior disability by 14 days of full-time active work in order for the eligible participant to be eligible for payment for that absence. No period of disability will be considered as beginning more than three days prior to the first medical visit or treatment.

Benefits are not payable during a strike unless the disability commenced prior to the strike and while you were still actively employed.

You must file a Weekly Disability Benefits claim form with the Fund Office within 90 days after the first day of disability and submit written proof that you are disabled before benefits will be paid. You must also file a claim form to apply for the additional 13 weeks of coverage if you are wholly and continuously disabled.

You will be required to complete IRS Form W-4 at the Fund Office, and federal income tax and Social Security taxes will be withheld from your Weekly Disability Benefit payments. You will receive an IRS Form W-2 from the Fund Office by January 31 of the year following the year in which you received Weekly Disability Benefits for your use in filing your income tax return.

Weekly Disability Benefits are **not** payable:

- For any day during which the eligible participant has performed any work, anywhere, for pay or profit.
- For any period during which the eligible participant is not under the care of a legally qualified physician.
- In the event an eligible participant is disabled as a result of an automobile accident.
- In the event that an eligible participant is eligible for loss-of-time/weekly disability benefits from another plan, provided such benefits are equal to those provided by this Plan.
- For disability due to accidental bodily injuries arising out of and in the course of such eligible participant's employment or a disease for which the eligible participant is entitled under the applicable Workers' Compensation Law, Occupational Disease Law or similar law.
- While maintaining your eligibility by using your Hourly Reserve Bank or by self-payment.

FMLA coverage and USERRA coverage do not include Weekly Disability Benefits.

CLAIMS APPLICATIONS, LIMITS AND APPEALS

1. Applying for Benefits and Time Limits for Claims

Eligibility Determinations

Your eligibility for benefits is determined by the Fund Office based on receipt of hours/contributions, self-payments and all other relevant factors required to become eligible. Your dependent eligibility is determined by BeneSys based on information provided on forms available from the Fund's administrative office and supporting documentation.

Claims for Medical, Hospital, Surgical, Prescription Drug Benefits, Dental Benefits, Vision Benefits, Life Insurance Benefits, Accidental Death and Dismemberment Benefits, and Weekly Disability Benefits

Blue Cross Blue Shield of Michigan is responsible for the processing and determination of all claims for Medical, Hospital, Surgical and Prescription Drug Benefits.

Delta Dental is responsible for the processing and determination of all Dental Benefits covered by group coverage agreements and other contracts issued by it.

The Fund Office is responsible for the processing and determination of all claims for Vision Benefits.

Union Labor Life Insurance Company is responsible for the processing and determination of all claims for Life Insurance Benefits and Accidental Death and Dismemberment Benefits, covered by group coverage agreements and other contracts issued by it.

The Fund Office is responsible for the processing and determination of all claims for Weekly Disability Benefits.

Claim forms for benefits that are processed and/or covered by the Fund's policies of insurance, group enrollments, coverage agreements, administrative services agreements or other documentation with or from its service provider(s) other than BeneSys are available from those organizations and all such forms and supporting documentation must be submitted to those organizations and in conformity with the requirements of those organizations, including all time limits and proofs. The Fund has no liability for any claim determination made by its service providers.

Claim forms for medical, hospital, surgical and prescription drug benefits are available from Blue Cross Blue Shield of Michigan, and all such forms and supporting documentation must be submitted **within six months from the date the claim occurred**. If you disagree with a determination made by Blue Cross Blue Shield of Michigan, you must appeal directly to Blue Cross Blue Shield of Michigan and comply with Blue Cross Blue Shield of Michigan's claims appeal process.

Claim forms for dental benefits are available from Delta Dental, and all such forms and supporting documentation must be submitted **within 24 months from the date the service was provided**. If you disagree with a determination made by Delta Dental, you must appeal directly to Delta Dental and comply with Delta Dental's claims appeal process.

Claim forms for vision benefits available from the Fund Office. All such forms and supporting documentation must be submitted within 90 days from the date the service was provided.

Claim forms for weekly disability benefits are also available from the Fund Office. They must be submitted within ninety (90) days from the onset of your disability. After submission of the initial application, you then have an additional 30 days to submit the documentation required to perfect the claim for benefits (including, but not limited to, the physician's report).

Claim forms for Life Insurance Benefits and Accidental Death and Dismemberment Benefits are available from the Fund Office. They must be submitted within 90 days.

If processing of a claim for vision benefits or weekly disability benefits cannot be completed because of missing information, the Fund Office will notify you and advise of the specific reason why the processing of the claim cannot be completed and what information is necessary to permit the processing of the claim to continue. It is your responsibility to gather this information and submit it within the required time period. If a claim for benefits under this Plan is completely or partially denied by the Fund Office for any reason, you will be notified with the specific reason for denial within the time periods required by applicable regulations. In unusual circumstances, additional time will be required to process the claim, in which case you will be notified when additional time is needed.

If you disagree with a determination made by the Fund Office, you must appeal directly to the Board of Trustees and comply with the Board's claims appeal process.

Any claim form or other material submitted by or on behalf of any claimant that contains a material alteration or forged or false information, including signatures, will be rejected. The Board of Trustees reserves the right to forward such matters to appropriate law enforcement agencies for whatever action deemed appropriate. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any manner, including civil litigation.

Any action in law or equity brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to this Plan shall be barred unless the complaint is filed ***within two years*** after the right of action therefor accrues, unless a shorter period is established by applicable statute, regulation or case law.

2. Denial of Claims

If your claim is denied by the Fund Office or another Fund service provider, you will be informed of the reason for the denial on the "Explanation of Benefits" you receive. If the denial is due to missing information or a missing signature, you should supply the information directly to the service provider. If the denial is due to any other reason and you believe that the claim should have been covered, you should follow the procedure set out below for appealing a denial of your benefit claim.

3. Appealing a Denial of Your Benefit Claim

Every effort is made to process your claims promptly and correctly. If your claim for benefits is denied in whole or in part, the Fund Office or another Fund service provider will notify you of the denial in writing. To appeal the denial or payment, you must follow these steps:

A. Appeals Regarding Eligibility Determinations, Weekly Disability Benefits and Vision Benefits.

You may appeal a denial of a claim related to an eligibility determination or a claim for Weekly Disability Benefits, and/or Vision Benefits by writing out the reasons for your disagreement and the facts on which you rely for your claim to benefits and mailing your appeal within 180 days of the notice of denial to the Board of Trustees, Michigan Glass and Glazing Industry Welfare Insurance Fund, P.O. Box 966, Troy, MI 48099-0966. No special form is required. Just be sure that what you have written explains your position as clearly as you can state it. You have the right to appoint someone else (such as a lawyer) to prepare and submit your appeal to the Fund. Make sure your name, the last four digits of your social security number, trade and name of the claimant (such as your spouse) are included to avoid delays in processing your appeal.

The claimant or the claimant's authorized representative on the claimant's behalf, will have the opportunity to review pertinent documents and other information relevant to the claim free of charge if you submit a written request. Reasonable access to, and copies of, relevant information will be provided upon request. Whether information or a document is "relevant" is determined in accordance with ERISA Regulation §2560.503-1(m)(8), 29 CFR 2560.503-1(m)(8).

When a claimant's appeal is received, it will be reviewed "de novo" (meaning "anew" and without deferring to the initial denial of your claim) and additional materials and information you submit with the appeal, if any, will also be reviewed.

The claimant, or the claimant's representative, may submit issues, comments, additional legal arguments and new information in writing consideration in the appeal. The review of the appeal will take into account all materials and information received from before the review and decision on your appeal, whether or not that information was previously submitted or considered in the initial determination on the claim.

The Board of Trustees will respond to appeals of denials of claims regarding eligibility and for benefits administered by BeneSys in the following timeframes: no later than 72 hours after receiving an appeal of a denial of a pre-service urgent care claim, no later than 30 days after receiving an appeal of a pre-service non-urgent care claim, and no later than five days after the Board of Trustees' first regularly scheduled meeting following receipt of your appeal of a post-service care claim, unless your appeal is filed less than 30 days prior to such meeting, in which case it will be reviewed at the subsequent Board of Trustees' meeting. (Denials of claims for benefits administered by the Fund Office are addressed in the prior section.)

If, due to special circumstances, the Board of Trustees requires additional time to review an appeal of a claim for post-service care, the claimant will be notified in writing of the special circumstances and when a determination will be made. The Board of Trustees will communicate its decision and the reasons for the decision in writing within five days after it makes its decision on your appeal.

The claimant may request a personal appearance before the Board of Trustees, which the Board of Trustees has the discretion to permit or deny, based on whether it concludes that a personal appearance would help the Board to reach its conclusion. Such a request must be made in writing. The claimant may designate someone of his choice to represent him or her at such an appearance at his/her own expense.

You will be notified, in writing, of the Board of Trustees' decision with respect to your appeal, including (if your appeal is denied) the reasons and specific references to Plan documents upon which the Board of Trustees' decision was based.

The Board of Trustees has the sole and exclusive authority and discretion to interpret and to apply the rules of the Plan, the Trust and other rules and regulations of the Fund. Under the law, this authority means that the Board of Trustees' decision shall be upheld unless the Court finds that it was arbitrary and capricious. Please note that under the Plan, no action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of these under or relating to the Plan is barred unless the complaint is filed within two years after the right of action accrues, unless a shorter time period is established by applicable statute, regulation or case law. You should seek legal advice with respect to these requirements.

B. Appeals Regarding Claims for Medical, Hospital, Surgical and Prescription Drug Benefits.

If a BCBSM denies a claim for Medical, Hospital, Surgical or Prescription Drug Benefits, in whole or in part for reasons other than ineligibility of the claimant, the claimant may appeal the denial in the manner set forth in the Fund's policies of insurance, group enrollments, coverage agreements, administrative services agreements or other documentation with or from its service provider(s), which are incorporated by reference as if printed verbatim herein.

If a claim for Medical, Hospital, Surgical or Prescription Drug Benefits is denied based on the claimant's ineligibility for benefits under the Plan at the relevant time, the claimant may appeal the ineligibility determination to the Board of Trustees, which appeal will be determined in accordance with all applicable and effective laws and regulations.

Most questions or concerns about decisions BCBSM makes on claims or requests for benefits can be resolved through a phone call to one of BCBSM's Customer Service Representatives. You can locate the phone number on your Explanation of Benefits statement, in the letter BCBSM sends to notify you that BCBSM has not approved a request for benefits or on the back of your ID card.

In addition, the Employee Retirement Income Security Act of 1974, as amended (ERISA) claims procedure regulations protect you by providing you the opportunity to request review of an adverse benefit determination.

An adverse benefit determination is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on your eligibility to participate in the Michigan Glass and Glazing Industry Welfare Insurance Fund. You should request review of adverse benefit determinations by BCBSM on a pre-service claim, an urgent care claim, or a post-service claim directly to BCBSM, except denials based on your eligibility to participate in the Fund, in which case, as stated above, you should direct your request for review to the Fund Office.

“Pre-service claim” means a claim for a benefit where your plan conditions receipt of the benefit, in completely or in part, on obtaining approval in advance of receiving medical care.

“Urgent care claim” means a claim for medical care or treatment where applying the time periods for non-urgent determinations could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician who knows your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

A claim will be found to be one involving urgent care in one of two ways. If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, BCBSM will treat it as such. Absent a determination by your physician, BCBSM will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

“Post-service claim” means all other claims that are not “pre-service claims” or “urgent care claims.”

To obtain review of an adverse benefit determination, you must follow the review procedures below. These procedures vary, depending on whether you are asking for review of a decision on a pre-service, a post-service, or an urgent care claim.

With the exception of requests for review of adverse benefit determinations involving urgent care claims, which may be made orally, all requests for review must be in writing and submitted to BCBSM at 600 E. Lafayette Blvd., Mail Code CS3A, Detroit, Michigan 48226-2998 or by facsimile to 1-877-348-2210. Normally, for all three types of claims, you must exhaust BCBSM’s internal review procedure before you can initiate a civil action under section 502(a) of ERISA to obtain benefits.

Review Procedure – Post-service claims

Under the review procedure for post-service claims, you are entitled to a two-step appeal process. BCBSM must provide you with a written determination within 30 calendar days of BCBSM’s receipt of your written requests for review at each level.

The review procedure for post-service claims provides two levels of review:

1. To initiate level 1 review, you or your authorized representative must send BCBSM a written statement explaining why you disagree with BCBSM’s determination. Please include in your request all documentation, records, or comments you believe support your position. You must request review no later than **180 calendar days after you receive BCBSM’s decision on your claim for benefits**. Mail your written request for review to the address found in the top right hand corner of the first page of your Explanation of Benefits statement, or to the address contained in the letter BCBSM sends you to notify you that BCBSM has not approved a benefit or service you are requesting. BCBSM will respond to your request for review in writing within 30 days. If you agree with BCBSM’s response, it becomes BCBSM’s final determination and the review ends.
2. If you disagree with BCBSM’s response to your request for review at level 1, you may then proceed to level 2, which is an external review. You must request review at level 2 in writing no later than 30 calendar days after you receive BCBSM’s determination at level 1.

Mail your request to the address specified in the letter BCBSM sends you to notify you BCBSM has not approved your appeal at level 1.

Again, please provide all documentation, records, and comments that you feel support your position. You will receive a written determination within 30 days of receipt of your request for review at level 2. The written determination at level 2 will be the final internal determination regarding your request for review.

1. If you disagree with the final determination, or if the determination at each level is not issued within the 30-day time frame or the review procedures for level 1 or level 2 are otherwise not complied with, you may be able to request an external review of your claim by an independent third party. To the extent your claim is eligible for external review, that process will be explained on the appeal denial letter you receive.
2. After you exhaust the review process, you also have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

Review Procedure – Pre-service claims

The review procedure for pre-service claims is identical to the review procedure for post-service claims, except that BCBSM must provide you with written determinations within shorter time frames. Appeals of pre-service claims are also handled in a two-step process. A determination will be issued within 15 calendar days of receipt of your request for a level 1 review, and within 15 calendar days of your request for a level 2 review, external review. You still have 30 days after receipt of the level 1 determination to file your level 2 appeal.

If you disagree with the final determination, or if the determination at each level is not issued within the 15-day time frame or the review procedures for level 1 or level 2 are otherwise not complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

Review Procedure – Urgent care claims

The review procedure for urgent care claims is as follows:

1. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call customer service.
2. BCBSM must provide you with BCBSM's decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review. All necessary information, including BCBSM's decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile, or other available similarly expeditious method. If BCBSM's decision is communicated orally, BCBSM must provide you or your authorized representative with written confirmation of BCBSM's decision within two business days.
3. If you disagree with BCBSM's final determination, or if BCBSM fails to issue its determination within 72 hours, or otherwise fails to comply with the review procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits.

In addition to the information found above, the following requirements apply to review of pre-service, post-service, and urgent care claims:

- You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal review procedure.
- No fees or costs may be imposed as a condition to requesting review.

- Although there are set timeframes within which you must receive BCBSM's final determination on all three types of claims, you have the right to allow BCBSM additional time if you wish.
- You 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.
- You may submit written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination.
- The person who reviews your adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The determination on review will be a new determination; the initial determination on your claim will not be afforded deference on review.
- If your request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.
- Upon request, the medical experts whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination.
- On review, you will be advised of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.
- If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion free of charge upon request.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be advised and provided an explanation of the scientific or clinical judgment free of charge upon request.
- If your health plan provides for any voluntary appeal procedures beyond the level 2 review, external review, you will be advised of those procedures in the level 1 response.

C. Appeals regarding Dental Benefits (Delta Dental)

Appeals of denials of claims related to Dental Benefits should be directed to the commercial insurance carrier, Delta Dental, unless they concern eligibility for coverage as determined under the Plan, in which case such denials must be appealed to the Board of Trustees.

D. Appeals regarding Life Insurance Benefits and Accidental Death and Dismemberment Benefits (Union Labor Life Insurance Company)

Appeals of denials of claims related to Life Insurance Benefits and Accidental Death and Dismemberment Benefits should be directed to the commercial insurance carrier, Union Labor Life Insurance Company (ULLICO), unless they concern eligibility for coverage as determined under the Plan, in which case such denials must be appealed to the Board of Trustees.

CIRCUMSTANCES THAT CAN RESULT IN DENIAL OR LOSS OF BENEFITS

- The person receiving the benefit was not eligible for benefits on the day the expense was incurred. This includes a former spouse or any person no longer eligible as a dependent when an expense was incurred.
- The claim was not received by the Fund within the required time period.
- The expense was for services not covered by the Fund or the expense was not actually incurred.
- The person for whom the claim was filed already received the maximum benefit for the type of benefit; for example, a lifetime maximum, a benefit year maximum, etc.
- The person for whom the claim was filed had not yet satisfied any required copayment imposed by the Fund.
- The person for whom the claim was filed (or another person on their behalf) failed to sign the Fund's subrogation agreement, failed to cooperate with the Fund's right of reimbursement or failed to remit the Fund's reimbursable amount from a recovery, including a partial recovery (in which case, future claims will be denied up to the amount of the Fund's reimbursable amount).
- Another entity was primarily responsible for paying benefits (see the Fund's rules on coordination of benefits).
- The Fund was terminated.

The above list does not list every reason a claim may be denied. It is only representative of the types of circumstances that might lead to a denial of a claim. If you have questions about a claim denial, contact the Fund Office.

ADDITIONAL ADMINISTRATIVE MATTERS

FACILITY OF PAYMENT

In the event of your death or mental incompetence at a time when benefits remain unpaid, such benefits will be paid to the person or institution who incurred the covered charges if the charges have not otherwise been paid.

EXAMINATIONS

The Board of Trustees has the right to ask a doctor of its choice to examine a person for whom benefits are being claimed. It also has the right to examine any and all hospital or medical records relating to a claim.

TRUSTEE INTERPRETATION AND AUTHORITY

Under the terms of the Plan and the Trust establishing the Fund, the Board of Trustees has the sole authority to interpret and apply the rules of the Plan, the Trust and any other rules and regulations, procedures or administrative rules adopted by the Trustees. Decisions of the Board of Trustees or, where Board of Trustees' responsibility has been delegated to others, its delegates, will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Board of Trustees or its authorized delegates is challenged in court, the Trust Agreement and the Plan provide that such decision is to be upheld unless a court with proper jurisdiction finds and issues a decision that it was arbitrary and capricious.

All benefits under the Plan are subject to the Board of Trustees' authority under the Trust Agreement to change them. The Board of Trustees has the authority to increase, decrease, change, amend and terminate benefits, eligibility rules or other provisions of the Plan as it may determine to be in the best interests of the Plan participants and beneficiaries.

The Plan is maintained for the exclusive benefit of the Plan's participants and their eligible dependents. All rights and benefits granted to a participant under the Plan are legally enforceable.

The right to change or eliminate any and all aspects of benefits provided for retirees and their dependents is a right specifically reserved to the Board of Trustees, since coverage for retirees and their dependents, like all of the benefits from the Fund, is not an accrued or vested benefit. The Board of Trustees has the authority to amend or terminate such benefits and to modify or increase the self-payment amount for coverage at any time. Any such change shall be effective even though an employee has already become a retiree or has met the eligibility requirements to retire now or in the future.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in place of and does not affect any requirement for coverage under any Workers' Compensation law, occupational diseases law or similar law. Benefits which would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws.

PLAN DISCONTINUATION OR TERMINATION

The Fund and its Plan may be discontinued or terminated under certain circumstances – for example, if future collective bargaining agreements and participation agreements do not require contributions to the Plan. In such event, benefits for covered expenses incurred by the termination date will be paid on behalf of eligible participants and their dependents as long as the Fund's assets are more than its liabilities. Full benefits may not be paid if the Fund's liabilities are more than its assets, and benefit payments will be limited to the funds available. The Board of Trustees will not be liable for the adequacy or inadequacy of such funds. If there are any assets remaining after payment of Fund liabilities, those assets will be used for purposes determined by the Board of Trustees according to the Trust Agreement.

RIGHT OF OFFSET

If any payment is made by the Fund to or on behalf of a person who is not entitled to the payment or to the full amount of such payment, the Fund has the right to reduce future payments to that person or to the person responsible for the erroneous payment by the amount of the erroneous payment. This right of offset will not limit the right of the Fund to recover such erroneous payments in any other manner.

LEGAL ACTIONS – TWO YEAR TIME LIMIT

Please note that under the law, no action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of these under or relating to the Plan is barred unless it is brought within two years after the first date the participant receives a determination of his rights and/or benefits under the terms of the Fund's Plan, unless a shorter period is established by applicable statute, regulation or case law. Any action in law or equity brought by a participant or beneficiary against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to this Plan must be brought in the United States District Court where the Plan is administered.

You should seek legal advice if you have questions on this matter.

ALTERED OR FORGED CLAIMS

Any claim form or other materials submitted by or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Board of Trustees reserves the right to forward such matters to appropriate law enforcement agencies for whatever action deemed appropriate. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any manner.

NOTICE OF HOURS WORKED

Each month the Fund Office will mail you a statement listing the hours that you worked. This report provides you with a summary of hours worked during the most recent month so that you may compare the Fund's records to your pay stubs.

You must report any discrepancy to the Fund Office immediately. If the discrepancy is the result of overlapping payroll periods and eligibility is adversely affected, the Fund Office will process an eligibility adjustment after you submit copies of pay stubs and/or other verification establishing that different payroll periods caused an overlapping of hours.

If your employer fails to remit contributions based on your work, the Fund will pursue collection, but you are responsible for maintaining your coverage by self-payment. If the Fund recovers some or all of the unpaid contributions, your self-payment amounts will be refunded to you based on the extent of the recovery.

RIGHT TO OBTAIN, REQUIRE AND RELY ON INFORMATION

The Board of Trustees shall have the right to require, as a condition precedent to the payment of any benefit under the Plan, all information which they reasonably deem necessary, including records of employment, proof of dates of birth and death, marital status, independent medical examinations of any person for whom

benefits are being claimed, any and all medical records relating to a claim, etc., and no benefit dependent in any way upon such information shall be payable unless and until such information so required is furnished. Such evidence shall be furnished by the Union, the Association, Employers, Employees, Participants, Dependents, beneficiaries, alternate recipients or the representative of any of them.

The Board of Trustees shall, in the absence of contrary evidence presented to them, have the right in administering the plan to rely upon information provided to them by the Union, the Association, Employers, employees, participants, dependents, beneficiaries, alternate recipients or the representatives of any of them. Neither they nor the Fund shall be held liable for good faith reliance thereon.

SPECIAL PROVISIONS FOR PARTICIPANTS AGE 65 AND OLDER

1. Medicare

Medicare is a federal health care program designed to provide health care benefits to persons who are age 65 and older, to persons who have End Stage Renal Disease (ESRD) and to certain disabled persons. The Social Security Administration is the sole authority for determining your Medicare eligibility. If you are enrolled in this coverage, you are called a “beneficiary.”

You become eligible for Medicare when you are 65 (or earlier if you are disabled or have ESRD). If you are eligible by reason of age, you may enroll at any time during a seven-month period. This period begins three months before the month in which you reach 65, and includes the actual month of your birthday and the three months following your birthday month. During this period, you must apply for Medicare through your local Social Security Administration office.

Medicare Part A is hospital insurance helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. Medicare Part B is medical insurance helps pay for physician’s services and other medical services and items. Medicare Part D plans help pay for prescription drug coverage.

The hospital insurance (Part A) portion is provided to you at no cost. **However, you must pay a monthly premium for the medical insurance (Part B) portion.** This premium is adjusted annually. You will be notified of the change before each new year.

You must enroll for Medicare Parts A and B and pay all premiums immediately when you reach age 65, (if you are still working, you may delay enrollment in Medicare Part B), but you are not required by this Plan to enroll for Medicare Part D coverage. In those cases where Parts A or B of Medicare and the Fund cover the same items or services, the Fund will pay first and then Medicare will supplement the Fund’s coverage up to the Medicare limits. In most cases, the Fund’s benefits are more generous than those provided under Medicare. Where they are not, you retain the right to file your claim with Medicare for whatever supplemental coverage is available. Your combined benefits from Medicare and the Fund will remain unchanged even though the Fund, rather than Medicare, is the primary payer.

You should not forget to continue to pay the Part B Medicare premium for medical services for your own protection. Failure to pay the Part B premium on time will result in the loss of Medicare protection for medical services. However, if you are working at age 65, you may be able to delay enrollment in Medicare Part B, without a penalty, until you stop working.

Special Notice Regarding Medicare Part D: If you are eligible for Medicare, you should be receiving a special notice regarding the Fund's Prescription Drug Benefits and how those benefits relate to prescription drug benefits available under Medicare Part D. Please contact the Fund Office if you have questions regarding retiree prescription drug coverage under this Plan and/or Medicare Part D.

If you enroll in Medicare prescription drug coverage, you will lose your prescription drug coverage with the Michigan Glass and Glazing Industry Welfare Insurance Fund. The Michigan Glass and Glazing Industry Welfare Insurance Fund will not provide prescription drug coverage for participants who enroll in Medicare prescription drug coverage. If you enroll in the Medicare prescription drug program, the Michigan Glass and Glazing Industry Welfare Insurance Fund will continue to provide you with your other nonprescription health benefits.

2. Employed Persons Aged 65 or Older

If you are eligible by way of hours worked in covered employment and you continue to work beyond the date you become eligible for Medicare (age 65), you have two options for health care coverage:

Option 1: Continue your regular current coverage as your primary health care plan. This is automatic unless you indicate in writing that you do not want to continue this coverage.

Important: If you continue to be covered through the Michigan Glass and Glazing Industry Welfare Insurance Fund for your primary health care benefits, **you should still apply for Medicare benefits, especially Part A.**

- Part A of Medicare, the hospital insurance, is offered at no cost to you. It may provide **additional** benefits to your group coverage.
- Part B of Medicare, the medical insurance, is available for a monthly premium. However, you can delay enrollment in Part B without penalty if you enroll following Medicare's rules.

If you delay enrolling for Medicare Part B coverage when you reach 65, you may enroll during the special enrollment period that begins on the first day of the first month in which you are no longer covered by your group plan and ends two months later.

You do not need to enroll in Medicare Part D coverage, as explained in the prior section.

Option 2: Select Medicare as your primary health care plan. However, if you select this option, federal regulations prohibit the Fund from providing you with supplemental coverage. You must file a written notice with the Fund Office and with Medicare if you choose this option.

Reminder: If you have a spouse who is 65 or older and is covered under your health plan, the Fund must provide the same coverage you select for your spouse until you retire or leave employment.

3. Retired Persons Aged 65 or Older

When, after age 65, you cease active employment, Medicare shall automatically become the primary payer after your eligibility by way of hours worked in covered employment runs out, and the Fund will be secondary.

DEPENDENTS ON MEDICARE

If you are eligible by way of hours worked in covered employment, the Fund will be the primary payer of benefits to your dependent who is on Medicare because of age or disability. Special rules apply to a person with end stage renal disease (ESRD) under Medicare. Check with the Fund Office or your local Social Security office for additional information on this.

COORDINATION WITH MEDICAID

For participants and dependents eligible for Medicaid benefits, the Fund will reimburse Medicaid payments made to participants and dependents as required under state Medicaid laws, the Fund will ignore Medicaid eligibility when enrolling a participant or dependent or making any benefit payment determination, and the Fund will comply with any subrogation rights required under state Medicaid laws.

If you or your dependents are entitled to Medicaid at the same time you are eligible for benefits from the Fund, the Fund will be the primary payer of benefits.

COORDINATION OF BENEFITS/NON-DUPLICATION OF BENEFITS

Coordination of Benefits, or COB, is how health care carriers coordinate benefits when you are covered by more than one group health care plan. Under COB, carriers work together to make sure you receive the maximum benefits available under all health care plans. Your health care plan requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans. COB ensures that the level of payment, when added to the benefits payable under another group plan, will cover up to 100 percent of the eligible expenses as determined between carriers. In other words, COB can reduce or eliminate health care plan out-of-pocket costs for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for your care.

How COB works

If you are covered by more than one group plan, COB guidelines determine which carrier pays for covered services first.

- Your primary plan is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.
- Your secondary plan is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by both carriers.

Note: To the extent that the services covered under your health care plan are also covered and payable under another group health care plan, BCBSM will combine the BCBSM payment with that of the other plan(s) to pay the maximum amount BCBSM would routinely pay for covered services.

Guidelines to determining primary and secondary plans

The following guidelines are used to determine which plan pays first:

- (1) If the other health and welfare plan, fund, policy, contract or program has not adopted coordination of benefit provisions, it shall be required to pay first.

- (2) If the other plan has adopted coordination of benefit provisions, then
- (a) the one in which the participant or dependent is covered as an employee shall pay as primary, and the health plan in which the participant or dependent is covered as a dependent shall pay as secondary.
 - (b) the one in which the participant or dependent is covered as an active employee or a dependent of an active employee (not as a retiree) shall pay as primary, and the one in which the participant or dependent is covered as a retiree or a dependent of a retiree shall pay as secondary.
 - (c) if the participant or dependent is covered by more than one health plan but one of the health plans covers the person pursuant to COBRA, then the COBRA coverage is secondary to the other plan.
 - (d) where the claim is for an eligible dependent child, the following order of priority shall be followed in determining which health and welfare plan, fund, policy, contract or program shall pay first:
 - (i) for children of parents not separated or divorced, or children of legally separated, divorced or never married parents with joint physical custody:
 - A. the one covering the parent who has the earlier birth date anniversary in the calendar year, or
 - B. if both parents have the same birth date, the one that covered the child for the longer period of time.
 - (ii) for children of legally separated, divorced or never married parents without joint physical custody:
 - A. the one covering the parent with physical custody of the child,
 - B. then the one of the spouse of the parent with physical custody of the child, or
 - C. then the one of the parent or spouse of the parent without physical custody of the child.

However, if a court decree, such as a judgment of divorce, states that **one** parent is financially responsible for the health care expenses of the child, and the health plan has been advised of that legal responsibility, then that health plan is primary for the child and the health plan of the other parent would be secondary. If a court decree states that **both** parents are responsible for providing health coverage, then the two health plans would be of the same priority level and the rules of subparagraph (i), above, would apply.

- (e) where the covered person is both a dependent child under this Plan and a dependent spouse under the plan of his or her spouse, the following order of priority shall be followed in determining which health and welfare plan, fund, policy, contract or program shall pay as primary:
 - (i) the one covering the covered parent or covered spouse who has the earlier birth date anniversary in the calendar year shall be primary, or
 - (ii) if both the covered parent and the covered spouse have the same birth date anniversary, the one that covered the child/spouse for the longer period of time shall be primary.
- (3) If a participant and/or beneficiary is eligible for benefits under a 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 if such individual fails to comply with the requirements of such policy or plan, then he shall not be eligible for benefits hereunder, pursuant to the Coordination of Benefits provision. Only if a participant and/or beneficiary is denied benefits under another health care plan, after complying with all its requirements for eligibility and/or coverage will that person become eligible for coverage under this Plan pursuant to the Coordination of Benefits provision.

Filing secondary COB claims

In most instances when you go to a PPO network or Blues participating provider, your provider will bill the primary and secondary carrier directly. However, if you receive services from a non-participating provider, and the provider will not file your claim, you will need to file.

Ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or your provider can then submit the claim along with the primary carrier's payment statement to BCBSM. When you submit claims to BCBSM for payment of the balance, follow these steps:

1. Obtain an EOB from the primary carrier. Make sure the EOB matches the receipts being submitted.
2. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.
3. If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.
4. Make sure the provider's name and complete address are on all receipts.
 - a. If the provider's office is in Michigan, include the provider's BCBSM Provider Identification Number (PIN).
 - b. If the provider's office is located outside of Michigan, include the provider's tax ID number.

3. Keep copies of all statements, receipts and forms for your personal files. Enclose the original billing statement with your claim form.
4. Mail all claims and receipts to:

Blue Cross Blue Shield of Michigan
COB Department
600 East Lafayette – Mail Code 0526
Detroit, MI 48226-2998

Important: If any required information is missing, claims processing may be delayed.

Updating COB information is your responsibility

You can avoid claims-processing delays if you keep your COB information updated. View your current COB information online. Go to bcbsm.com and log in to Member Secured Services. If there are any changes in coverage information for you or your dependents, notify the Fund Office immediately. BCBSM may periodically ask you to update your COB information through a letter of inquiry. Please help BCBSM serve you better by responding to requests for COB information quickly.

SUBROGATION AND REIMBURSEMENT

In the event of any payments of services to or on your and/or your eligible dependents' behalf, the Fund shall, to the extent of such payments, be subrogated to all rights of recovery by you (or your representative(s)) arising out of any claim or cause of action which may accrue against a third party, including any occupationally related claim or cause of action covered by the Michigan Workers' Disability Compensation Act or Occupational Disease Act or similar federal or state statutes. You (or your representative(s)), by acceptance of benefits provided by this Fund, hereby agrees to reimburse the Fund for any benefits so paid hereunder out of monies recovered, fully or partially, from such third party as the result of judgment, settlement or otherwise, irrespective of how differentiated, without any offset for expenses, including legal fees, you (or your representative(s)) may owe, and before you (or your representative(s)) pay any other individual, organization or entity out of that full or partial recovery (i.e., **the Fund has first priority with respect to its rights under this provision**). Such monies recovered shall be deemed to be held in constructive trust for the benefit of the Fund, regardless of who holds those monies. You (or your representative(s)) may take no action which would prejudice the Fund and/or any of the Fund's designees' rights, and hereby agree to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Trustees may require to facilitate the enforcement of the Fund's rights. The Fund and/or any of the Fund's designees will not be responsible for attorney's fees or costs incurred and/or paid by or on your behalf unless the Fund and/or any of the Fund's designees has agreed in writing to pay such fees or costs or some portion thereof.

If the Fund and/or any of the Fund's designees pays benefits on your or your eligible dependents' behalf and you (or your representative(s)) receive a settlement, you (or your representative(s)) must repay the Fund and/or any of the Fund's designees up to the amount of benefits it/they have paid. If you (or your representative(s)) do not do so, the Fund and/or any of the Fund's designees has the right to treat the amount of benefits paid as your debt to the Fund and/or any of the Fund's designees and may pursue recovery of said amount from you (or your representative(s)) and/or reduce any future benefits payable to or on your and your eligible dependents' behalf until this debt has been cancelled.

Subrogation regarding BCBSM Benefits

The Fund's contract with BCBSM contains subrogation language that delegates to BCBSM the responsibility to recover the Fund's payments from responsible third parties. If you file a lawsuit or an insurance claim, or if there is a settlement, subrogation allows the Fund to hold a party that caused an injury to be responsible for payment of the medical expenses related to the injury.

Example: A participant is injured in a store, or other commercial property, due to negligence on the part of the store or property. The Fund pays for the services to the injured person, as required by the Plan. Later, the participant sues the store. The BCBSM subrogation unit would attempt to recover the money paid for medical services related to the injury in that lawsuit.

This is the Fund's right of recovery. The Fund is entitled to its right of recovery even if you are not "made whole" for all of your damages in the money you receive. The Fund's right of recovery is not subject to reduction of attorney's fees, costs, or other state law doctrines such as common fund.

The types of cases of third party responsibility BCBSM generally pursues fall into the following categories:

- Workers' compensation
- Personal injury
- Medical malpractice

In the event that you are injured and a third party is responsible:

- Your right to recover payment from the third party is transferred to the Fund.
- You are required to do whatever is necessary to help the Fund enforce its right of recovery.
- If you receive money through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse the Fund. However, this does not apply if the funds you receive are from additional coverage you purchased in your name from another insurance company.

You agree to:

- Cooperate and do what is reasonably necessary to assist the BCBSM subrogation unit in the pursuit of the Fund's right of recovery.
- Not take action that may prejudice the Fund's right of recovery.
- Permit the BCBSM subrogation unit to initiate recovery on your behalf if you do not seek recovery for illness or injury.
- Contact the BCBSM subrogation unit promptly if you seek damages, file a lawsuit, file an insurance claim or demand, or initiate any other type of collection for your illness or injury.
- Provide updates both periodically and at BCBSM's request, regarding the status of any third party recovery matters.

- Upon resolution or settlement of any a lawsuit, insurance claim or demand, or any other type of collection, you or your attorney must notify the Fund no more than three business days after such resolution or settlement has been reached. Upon notification of a settlement or proposed settlement, the Fund or the BCBSM subrogation unit will provide a final subrogation lien total as soon as practicable.
- Upon receipt of a recovery from a third party, you or your attorney must hold the entire amount in a trust account so that the recovery proceeds are segregated from your and your attorney's general assets until the Fund has been reimbursed up to the amount of benefits the Fund has paid. You *may not* comingle the recovery proceeds with your general assets or spend such proceeds until any disputes regarding the amount due of the Fund's right of recovery have been resolved and final payment is disbursed to the Fund.

Please remember that if you hire an attorney to represent you in such a situation, you should always have your attorney call BCBSM at (517) 322-8177.

The Fund and/or BCBSM may pursue a claim against you (or your beneficiaries) and your attorney/representative if any of the following occur:

- Notice of settlement is not provided to the Fund within three (3) business days of resolution between the parties; or
- The proceeds of the settlement or resolution are comingled with (i.e., not segregated from) your general assets; or
- You spend any portion of the proceeds prior to reimbursing the Fund and/or BCBSM for benefits it paid that are related to the underlying cause of action.

The Fund and/or the BCBSM subrogation unit may:

- Seek first priority lien on proceeds of your claim in order to fulfill the Fund's right of recovery.
- Request you to sign a subrogation and/or reimbursement agreement.
- Delay the processing of your claims until you provide a signed copy of the subrogation and/or reimbursement agreement.
- Offset future benefits to enforce the Fund's right of recovery.

The Fund will pay the costs of any covered services you receive that are in excess of any recoveries made.

RESTITUTION WHERE BENEFITS IMPROPERLY RECEIVED

The Fund and its Board of Trustees shall have the right to pursue restitution from any person who receives benefits of any description from the Fund to which such person was not entitled, whether by virtue of the ineligibility of such person at the time services were rendered, by virtue of receipt of excluded benefits or otherwise.

EXCLUSIONS AND GENERAL LIMITATIONS

In addition to the exclusions and limitations listed earlier in the Summary and except as may be provided under the Fund's agreements with BCBSM or specifically provided for under the terms of the Plan, the Plan shall not provide benefits for the following, except Life Insurance Benefits and Accidental Death and Dismemberment, unless otherwise noted:

The Plan will **NOT** provide Weekly Disability Benefits if you are unable to work because of an accident involving an automobile or other motor vehicle licensed to be on the road.

The Plan will **NOT** provide for treatment of injuries resulting from causes other than sickness, accidental injury or disease. However, the Plan will provide for treatment of injuries resulting from domestic violence. The Board of Trustees may require details describing the incident, including a copy of the police report where available.

The Plan will **NOT** provide for expense incurred if the person is engaged in any unlawful act.

The Plan will **NOT** provide for benefits for injuries that you receive while working for pay or profit.

The Plan will **NOT** provide for loss or expense from sickness, or disease that entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law, or as a result of any accidental bodily injury that arises out of or in the course of employment.

The Plan will **NOT** provide Weekly Disability Benefits if you are unable to work because of an accident occurring on the job or an illness connected with employment.

The Plan will **NOT** provide for services that would not be charged if there were no insurance.

The Plan will **NOT** provide for services for which a charge is not customarily made, services for which the patient is not obligated or services available without cost.

The Plan will **NOT** provide for treatment of a condition caused by military action or war or determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

The Plan will **NOT** provide for care and services available at no cost in a veteran's, marine or other federal hospital or any hospital maintained by any state or governmental agency.

The Plan will **NOT** provide for care and services payable by government-sponsored health care programs such as Medicare. However, the Plan will provide for prescription drugs that are payable by a Medicare Part D prescription drug plan.

The Plan will **NOT** provide for payment of surcharge or non-resident tax levied by community hospitals, except where required by law.

The Plan will **NOT** provide for medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location.

The Plan will **NOT** provide for services and supplies that are not medically necessary according to accepted standards of medical practice (including cosmetic surgery solely for improving appearance), except that coverage will be provided for reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast for symmetrical appearance and prostheses and physical complications in all stages of mastectomy.

The Plan will **NOT** provide prescription drug coverage for age-related appearance or weight loss purposes.

The Plan will **NOT** provide for services, care, devices or supplies considered experimental or investigative, except as required by section 2709 of the Public Health Services Act, as added by the Patient Protection and Affordable Care Act.

The Plan will **NOT** provide for hospital care and medical services and supplies provided **prior** to the effective date of coverage or **after** the coverage termination date.

The Plan will **NOT** provide 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.

The Plan will **NOT** provide for charges for hospital rooms in excess of the hospital's regular charges.

The Plan will **NOT** provide for television, telephone, guest trays or other non-essential personal items and services, including take-home prescription drugs and supplies.

The Plan will **NOT** provide for court ordered hospital confinements and treatment required by court orders, which is the result of an order of any court of law to any participant or dependent, even when prescribed by a physician.

The Plan will **NOT** provide 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.

The Plan will **NOT** provide for installation of air conditioning units, sun lamps, 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, exercycles, bicycles, etc.

The Plan will **NOT** provide for psychological tests for vocational guidance or counseling.

The Plan will **NOT** provide for hospital confinement or medical expense due to pregnancy of dependent children.

The Plan will **NOT** provide for expense incurred for family planning, semen analysis, fertility and infertility analysis and diagnostic expense or in vitro-fertilization or artificial insemination.

The Plan will **NOT** provide for treatment for temporomandibular joint syndrome (TMJ) and related jaw joint problems by any method other than as set forth in the Fund's policies of insurance, group enrollments, coverage agreements, administrative services agreements or other documentation with its service provider(s).

The Plan will **NOT** provide for annual physical examinations (except as provided in the Preventive Services Benefit); routine physical examinations for dependent children or for the employee and spouse; pre-marital examinations; physical examinations and neuropsychological evaluations for litigation purposes; school physicals or camp physicals, immunization injections (except to age 16), or any examination not necessary by reason of sickness, injury or disease.

The Plan will **NOT** provide for drugs that require a prescription by state law, but not Federal law.

The Plan will **NOT** provide for administration of drugs or any drug consumed at the time and place of the prescription order.

The Plan will **NOT** provide for refills not authorized by a physician.

The Plan will **NOT** provide for more than a 34-day supply of prescription drugs (except for specified maintenance drugs that are covered for 90 days or a 100-unit dose, whichever is greater).

The Plan will **NOT** provide for refills dispensed after one year from the date of the original prescription.

The Plan will **NOT** provide for comprehensive nutritional programs or for visits with specialists in endocrinology when required solely for the purpose of weight loss or for treatment of obesity only or for expense incurred for dietary supplements, nutritional lectures, or weight loss programs and clinics, unless such benefits are provided in connection with covered cardiac rehabilitation services.

The Plan will **NOT** provide for drugs for fertility and infertility treatment.

The Plan will **NOT** provide for acupuncture services.

The Plan will **NOT** provide for smoking cessation treatment, except as provided under the prescription drug benefits provisions.

The Plan will **NOT** provide coverage for reversal of sterilization.

The Plan will **NOT** provide coverage for compounded medications made from bulk powders or chemicals (that is, made with any ingredient that does not have an NDC code).

The Plan will **NOT** provide coverage for weight loss/weight control drugs.

The Plan will **NOT** provide coverage for allergens (may be covered under medical coverage).

The Plan will **NOT** provide coverage for blood product (may be covered under medical coverage).

The Plan will **NOT** provide coverage for over the counter allergy medications

The Plan will **NOT** provide coverage for medications covered under the specialty drug step therapy requirements, drugs considered “step 2” therapy, prior to meeting the requirements for coverage.

LEGAL NOTICES

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). “Loss of eligibility” includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It does not include a loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim. However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at 700 Tower Drive, Suite 300, Michigan Glass and Glazing Industry Welfare Insurance Plan, P.O. Box 966, Troy, MI 48099-0966, (248) 641-4957.

ERISA RIGHTS

As a participant in the Michigan Glass and Glazing Industry Welfare Insurance Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Fund Office and at other specified locations, such as worksites and the union hall, all Plan documents including collective bargaining agreements and copies of all documents filed by the Fund with the United States Department of Labor, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Board of Trustees, the Plan Administrator. The Fund will, however, make a reasonable charge established by the Board of Trustees for furnishing the copies.
3. Receive a summary of the Plan’s annual financial report. The Board of Trustees 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. See page 25 of this Summary on the rules governing your COBRA continuation coverage rights.

5. Reduction or elimination of the exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage for another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. *This requirement ended December 31, 2014.*

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, who are 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, the union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you may be entitled or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why and to receive a written explanation of the reason for the denial, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Fund’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 the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim to be frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-EBSA (3272). The web site address for the Employee Benefits Security Administration of the Department of Labor is <http://www.dol.gov/ebsa>.

You can read the materials listed above by making an appointment at the Fund Office during normal business hours. In addition, copies of the materials will be mailed to you if you send a written request to the Fund Office. There will a per-page charge for copying some of the materials. Before requesting materials, call

the Fund Office and find out the cost. If a charge is made, your check must be attached to your request for the material.

WOMEN’S HEALTH AND CANCER RIGHTS ACT NOTICE

If you or your dependent has had or is going to have a mastectomy, you or your dependent may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (“WHCRA”). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, contact the Fund Office at 700 Tower Drive, Suite 300, P.O. Box 966, Troy, MI 48099-0966, (248) 641-4957.

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT NOTICE

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

NOTICE OF PRIVACY PRACTICES

This Notice Describes How HEALTH Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully And Contact the Fund’s PRIVACY OFFICER If You Have Any Questions.

The Michigan Glass & Glazing Industry Welfare Insurance Fund (“Plan”) is required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) to make sure that health information that identifies you is kept private to the extent required by law.

The Plan is also required to give you this Notice regarding

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

The term “Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic) and, when applicable, includes “genetic information.” De-identified information, which does not identify an individual and that cannot reasonably be expected to be used to identify an individual, is not PHI.

This Notice and its contents are intended to conform to the requirements of HIPAA. Please be advised that other entities that provide services to you related to your participation in the Plan have issued or may issue separate notices regarding disclosure of PHI that is maintained on the Plan’s behalf by those entities.

How the Plan May Use and Disclose PHI About You

The following categories describe different ways that the Plan uses and discloses PHI. Not every use or disclosure in each category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories. Except for the purposes described in the categories below, we will use and disclose PHI only with your written authorization. You may revoke such authorization at any time by writing to the Plan’s Privacy Officer.

Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

For Payment. The Plan may use and disclose PHI about you for payment purposes such as to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. The Plan may also share PHI with a utilization review or precertification service provider. Likewise, the Plan may share PHI with another entity to assist with the coordination of benefit payments.

For Health Care Operations. The Plan may use and disclose PHI about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use PHI in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Plan administrative activities. The disclosure of PHI that is genetic information for underwriting purposes is prohibited and the Plan will not disclose any of your genetic information for such purposes.

To Inform You About Treatment, Treatment Alternatives or Other Health Related Benefits. The Plan may use your PHI for treatment purposes and other related benefits. The Plan may use your PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination, or (4) recommended alternative treatments, therapies, health care providers, or settings of care. For instance, the Plan may forward a communication to a participant who is a smoker regarding a smoking-cessation program.

For Disclosure to the Fund’s Board of Trustees. The Plan may disclose your PHI to the Plan’s Board of Trustees (Plan Sponsor) for plan administration functions performed by the Plan Sponsor on behalf of the Plan including, but not limited to, reviewing appeals. The Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or for modifying, amending or terminating the group health plan. “Summary health information” is information that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health

benefits under a group health plan and from which identifying information has been deleted in accordance with federal regulations.

Business Associates. The Plan may disclose PHI to its business associates that perform functions on the Plan's behalf or provide the Plan with services if the information is necessary for such functions or services. For example, the Plan may use another company to perform billing services on its behalf. All of the Plan's business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in their agreement with the Plan.

Other Uses and Disclosures for Which Consent, Authorization or Opportunity to Agree or Object is Not Required

When Legally Required. The Plan will disclose your PHI when it is required to do so by any federal, state or local law.

For Public Health Activities. The Plan may disclose your PHI for public health activities such as the reporting of vital events such as birth or death or the tracking of products regulated by the Food and Drug Administration.

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

To Conduct Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, the Plan may not disclose your PHI if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, the Plan may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to you of the request or, if such assurance is not forthcoming, if the Plan has made a reasonable effort to notify you about the request or to obtain an order protecting your PHI.

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your PHI to a law enforcement official for certain law enforcement purposes, including the reporting of certain types of wounds, upon the request of a law enforcement official for locating a suspect, fugitive, material witness, missing person, or crime victim, to report a death, to report a crime on the premises and to report a crime in a medical emergency. A disclosure of information about an individual who is or is suspected to be a crime victim may be made only if a) the individual agrees to the disclosure or the Plan is unable to obtain

the individual's agreement because of emergency circumstances, b) the law enforcement official represents that the information is not intended to be used against the individual and the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and c) the Plan determines disclosure is in the best interest of the individual as determined by the exercise of its best judgment.

To Coroners, Medical Examiners and Funeral Directors. The Plan may release PHI to coroners or medical examiners for duties authorized by law or to funeral directors consistent with applicable law.

Organ and Tissue Donation. If you are an organ donor, the Plan may release PHI to organizations that handle organ procurement or transplantation.

For Research. The Plan may disclose your PHI for research subject to certain conditions regarding the manner in which the research is conducted.

In the Event of a Serious Threat to Health or Safety. The Plan may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person when consistent with applicable law and standards of ethical conduct and the Plan in good faith believes such use or disclosure is necessary.

For Specified Government Functions. In certain circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans affairs, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Workers' Compensation. The Plan may release your PHI to the extent necessary to comply with laws related to workers' compensation or similar programs.

Other Uses and Disclosures

The Plan will not (1) supply confidential information to another entity for its marketing purposes in violation of the privacy regulations, or (2) sell your confidential information in violation of the privacy regulations.

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to the Plan will be made only if you provide a written authorization.

The Plan asks you to complete an authorization form if you would like someone, such as a spouse, to be able to have access to your PHI. If you need an authorization form, please contact the Fund Office at (248) 641-4957.

If you provide the Plan with written authorization to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures that the Plan has already made with your permission.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

You have the following rights:

The right to request restrictions or limitations on the PHI the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. The Plan is not, however, required to agree to your request with the exception of a request for a restriction of a disclosure of PHI pertaining solely to a health care item or service for which the health care provider involved has been paid out of pocket that is for purposes of carrying out payment or health care operations (and not for the purposes of carrying out treatment).

To request restrictions, you must make your request in writing to the Plan's Privacy Officer. In your request, you must tell the Plan (1) what information you want to limit, (2) whether you want to limit the Plan's use, disclosure or both; and (3) to whom the limits apply.

The right to request to receive confidential communication of your PHI by an alternative means or at an alternative location if a disclosure of your PHI could endanger you. The request must be made in writing to the Plan's Privacy Officer and must specify the alternative location or other method of communication that you prefer (for example, using an alternate address). Your request must include a statement that the restriction is necessary to prevent a disclosure that could endanger you. The Plan does not refuse to accommodate such a request unless the request imposes an unreasonable administrative burden. If the request is granted, the documentation of your request will be placed in your record.

The right to access documents regarding your eligibility, payment of claims, appeals or other similar documents in your Designated Record Set for inspection and/or copying. If the information you request is in an electronic health record, you may request that these records be transmitted electronically. Your request for access to documents with your PHI must be in writing to the Plan's Privacy Officer. When a request for access is accepted (in whole or in part), you will be notified of the decisions and you may then inspect the PHI, copy it, or both, in the form or format requested at a time and place convenient to you and the Plan. If you would like, you may receive a summary of the requested PHI instead of your entire record, for a reasonable fee. You may also receive a copy of your PHI by mail if you prefer. (The Plan charges a reasonable, cost-based fee for copying, including labor and supplies [for instance, paper, computer disks] and for postage if you request that the information be mailed. No fee is charged for retrieving or handling the PHI or for processing the participant's request for access.)

If a request for access is denied (in whole or in part), the Plan will grant access to PHI for which there are no grounds to deny access. The Plan will also inform you why your request for access was denied, how to appeal the denial (if the denial is reviewable), and how to file complaints with the Plan and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, the Plan will designate a licensed health care professional, not involved in the original denial decision, to serve as a reviewing official, and will notify you in writing of the reviewing official's determination.

The right to request to amend your PHI if it is inaccurate or incomplete. You may request that your PHI be amended. That request must be in writing to the Fund's Privacy Officer and include a reason why your PHI should be amended. If you do not include a reason, the Plan will not act on the request. When a request for amendment is accepted (in whole or in part), the Plan will inform you that your request for amendment has been accepted. The Plan will request from you permission to contact other individuals or health care entities that you identify that need to be informed of the amendment(s), and will inform them and other entities with whom the Plan does business who may rely on the disputed PHI to your detriment. The Plan

will identify the record(s) that are the subject of the amendment request and will append the amendment to the record.

If a request for amendment is denied, you will be notified why the request was denied (e.g., the information requested was not created by the Plan, is accurate and complete, is not part of the record, or may not legally be changed such as information compiled in anticipation of a civil, criminal or administrative proceeding), how to file a statement of disagreement or a request that the Plan provide the request for amendment and the denial in any future release of the disputed PHI, and how to file a complaint with the Plan or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, the Plan may write a rebuttal statement and will provide a copy to the participant, and the Plan will include the request for amendment, denial letter, statement of disagreement, and rebuttal (if any), with any future disclosures of the disputed PHI. If you do not choose to write a statement of disagreement with the denial decision, the Plan is not required to include the request for amendment and denial decision letter with future disclosures of the disputed PHI unless you request the Plan to do so. When the Plan receives notification that your PHI has been amended, the Plan will ensure that the amendment is appended to your records, and will inform entities with whom it does business that may use or rely on your PHI of the amendment and require them to make the necessary corrections.

The right to obtain an accounting of disclosures of your PHI. The right to an accounting extends to disclosures, other than disclosures made (1) for the purposes of treatment, payment or health care operations, including those made to business associates (vendors), (2) to an individual (or personal representative) about his or her own PHI, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for national security or intelligence purposes and (8) to correctional institutions or law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to the Plan's Privacy Officer. Your request must specify a time period, which may not be longer than six (6) years. You may request and receive an accounting of disclosures once during any twelve (12) month period for no charge. If you request more than one accounting within the same twelve (12) month period, a reasonable, cost-based fee may be charged. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You also have the right to an accounting of disclosures of electronic health records for purposes of payment, treatment and health care operations. The right to such an accounting depends on whether the Plan maintains such electronic health records and, if so, when the electronic health records were acquired by the Plan and when the disclosure occurred.

The right to receive a paper copy of this Notice and any revisions to this Notice. You may request a copy of this Notice in writing to the Plan's Privacy Officer at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

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

- a power of attorney for health care purposes;
- a court order of appointment of the person as the conservator or guardian of the individual; or

- a birth certificate identifying the parent of a minor child.

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

LEGAL DUTIES OF THE MICHIGAN GLASS & GLAZING INDUSTRY WELFARE INSURANCE FUND REGARDING YOUR HEALTH INFORMATION

The Plan is required by law to maintain the privacy of your PHI as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. If your PHI is improperly accessed, acquired, used, or disclosed, the Plan will notify you, as required by law. That notification may include a description of what happened, the information involved, and the steps you can take to protect yourself.

The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI the Plan has about you as well as any information the Plan receives in the future. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

Minimum Necessary Standard

When using, disclosing or requesting PHI, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose. However, the minimum necessary standard will not apply in the following situations:

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

YOUR RIGHT TO FILE A COMPLAINT

You have the right to express complaints to the Michigan Glass & Glazing Industry Welfare Insurance Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Michigan Glass & Glazing Industry Welfare Insurance Fund should be made in writing to the Fund's Privacy Officer. The Michigan Glass & Glazing Industry Welfare Insurance Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

FOR MORE INFORMATION CONTACT THE PRIVACY OFFICER

For questions about this Notice, to exercise your privacy rights, or to file a complaint, contact the Plan's Privacy Officer, Michigan Glass & Glazing Industry Welfare Insurance Fund, P.O. Box 966, Troy, MI 48099-0966, (248) 641-4957.

SOCIAL SECURITY NUMBER PRIVACY POLICY

The Michigan Glass and Glazing Industry Welfare Insurance Fund is required by Michigan law to make sure that your Social Security number and the Social Security numbers of your family members are kept private as set forth in that law.

The law permits the Fund to use Social Security numbers to verify your identity and the identities of your family members and to perform other functions related to providing health and welfare benefits under the Fund's Plan. Therefore, the Fund will continue to require Social Security numbers on application and enrollment forms. When your employer pays contributions on your behalf, the law permits your employer to provide the Fund with your Social Security number so that the Fund may determine your eligibility status. The law also permits the Fund to use Social Security numbers when authorized or required to do so by state or federal statute, by court order, or pursuant to legal discovery or process. The Fund will ensure to the extent practicable the confidentiality of those Social Security numbers.

In order to protect your privacy and in compliance with the law, the Fund will use alternate identification numbers wherever feasible, including on benefits cards and explanations of benefits. The Fund does not print Social Security numbers on the exterior of any envelope or package sent through the mail or in a manner that can be seen from the exterior of such envelope or package. The Fund's website is secure and permits participants to access information through use of a password other than their Social Security number.

Only Fund employees and Fund service providers may access the Social Security numbers of Fund participants and family members and only as necessary to provide services to the Fund. The Fund uses practical means to limit access to written and electronic records in its possession that contain Social Security numbers to those Fund employees and service providers whose job duties require such access, such as securing areas where Social Security number information is located when not in use and requiring the use of passwords for access to electronic files containing Social Security numbers. The Fund disposes of documents that contain Social Security numbers that the Fund is not actively using or is not otherwise obligated to retain by shredding and other processes that protect the confidentiality of the Social Security numbers. Fund employees must not disclose Social Security numbers by publicly displaying more than four sequential digits of a Social Security number or in any other manner prohibited by law.

The Fund notifies all service providers that they must ensure, to the extent practicable, the confidentiality of all Social Security numbers related to Fund participants and their families as required by law. The Fund may take action regarding service providers who fail to protect adequately the confidentiality of those Social Security numbers, including the termination of contracts.

The Fund disciplines its employees who violate this Policy, up to and including termination.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by a nonparticipating provider at a participating hospital or ambulatory surgical center, you are protected from balance or surprise billing.

What is balance billing?

Balance billing – sometimes called surprise billing – is when you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance or deductible. You may have

other costs or have to pay the entire bill if you see a provider or visit a health care facility that doesn't participate with your health plan.

"Nonparticipating" describes providers and facilities that haven't signed a contract with your health plan. Nonparticipating providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – such as when you have an emergency or schedule a visit at a participating facility but are unexpectedly treated by a nonparticipating provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from a nonparticipating provider or facility, the most the provider or facility may bill you is your plan's in-network out-of-pocket amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Depending on your plan, you may have additional protections under Michigan law if you receive post-stabilization services from a nonparticipating provider when you're in a participating facility. If your plan is governed by Michigan law, those providers can't balance bill you even if you give written consent.

Certain services at a participating hospital or ambulatory surgical center

When you get services from a participating hospital or ambulatory surgical center, certain providers there may be nonparticipating. In these cases, the most those providers may bill you is your plan's in-network out-of-pocket amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these participating facilities, nonparticipating providers **can't** balance bill you unless you give written consent and give up your protections. **You're never required to give up your protections from balance billing. You also aren't required to get care from a nonparticipating provider. You can choose a provider or facility in your plan's network.**

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (such as copayments, coinsurance and deductibles that you would pay if the provider or facility was in network). Your health plan will pay nonparticipating providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization)
 - Cover emergency services by nonparticipating providers

- Base what you owe the provider or facility (out-of-pocket costs) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits
- Count any amount you pay for emergency services or services rendered by nonparticipating providers in the circumstances outlined above toward your deductible and out-of-pocket limit

If you believe you've been incorrectly billed, contact the No Surprises Help Desk at 1-800-985-3059. Visit <http://michigan.gov/difs> for more information about your rights under Michigan law.

SUBROGATION AGREEMENT

ASSIGNMENT OF ACKNOWLEDGMENT OF LIEN FOR THE BENEFIT OF THE MICHIGAN GLASS and GLAZING INDUSTRY WELFARE INSURANCE FUND

I, _____ (Name of Participant), hereby make this Acknowledgment of Lien for the Benefit of the Michigan Glass and Glazing Industry Welfare Insurance Fund (hereafter the "Assignment"), as stated below.

WHEREAS, I and/or my dependent(s) have made application to Michigan Glass and Glazing Industry Welfare Insurance Fund (hereinafter referred to as the "Fund") for benefits, which may include payment of hospital and other medical expenses and weekly disability benefits (hereinafter collectively referred to as the "benefits") arising from a medical condition commencing on _____; and

WHEREAS, the condition giving rise to the benefits may have been caused by a third party who maintains liability for payment of the expenses and benefits ("third party") and for all related medical and hospital expenses, as well as weekly compensation benefits, causing the Fund to maintain no liability to pay such benefits; and

WHEREAS, a third party has refused to pay my and/or my dependent's(s') medical and hospital bills and has refused to pay weekly compensation benefits,

NOW, THEREFORE, in consideration for the advancement of the disability benefits/weekly wage replacement benefits which I have not received and/or medical and hospital expenses by the Fund which arise from my or my dependent's(s') medical condition and/or disability, I agree for myself and on behalf of my dependent(s) that I am indebted to the Fund and that I will reimburse or cause to be paid to the Fund all proceeds from any settlement, judgment or other recovery, whether a full or partial recovery, up to the amount of any expenses paid by the Fund, including payments made from an insurance carrier or money paid toward settlement of my or my dependent's(s') third-party claim, irrespective of any determination of who is at fault, and, further, that I will pay the Fund before I pay any other party out of those proceeds or recovery, whether full or partial. I acknowledge that any proceeds shall be deemed to be held in constructive trust for the benefit of the Fund, regardless of who holds those proceeds. I acknowledge that the Fund has first priority with respect to its rights set forth in this document. I agree for myself and on behalf of my dependent(s) to pursue any viable claim or a lawsuit against a third party and I hereby assign to the Fund (to the extent of the total amount of benefits which shall be paid to me or on my behalf or to my dependent(s) or on my dependent's(s') behalf) all right, title and interest in any money which I or my dependent(s) will receive or recover by trial, settlement, arbitration, redemption, voluntary payment or otherwise, and agree that I am and my dependent(s) is (are) subject to the assignment provisions. I understand that this Assignment is applicable to any person who succeeds to my or my dependent's(s') right of recovery, including my and/or my dependent's(s') estate, any person who serves as my or my dependent's(s') personal representative, guardian, next friend or heir and any other successor in interest to my or my dependent's(s') rights.

I hereby authorize and direct any insurance carrier, attorney and any other person now in possession of such proceeds or who comes into possession of such proceeds to pay the proceeds directly to the Fund.

I further understand and agree that the intent of this assignment is to assure the Michigan Glass and Glazing Industry Welfare Insurance Fund that I will reimburse to the Fund 100% of the amount paid to me or on my behalf arising from the medical condition giving rise to my claim against a third party, whether or not I or my dependent(s) recover in full or only partially. I understand and agree that the Fund does not have any financial responsibility with respect to the cost of legal services or other costs in connection with my or my dependent's(s') claims(s). I agree that the Fund shall maintain a lien on my or my dependent's(s') recovery from any third party, whether I/my dependent(s) recover money through civil lawsuit, arbitration, or other proceeding, pursuant to the Subrogation and Reimbursement section of the description of benefits provided by the Fund which has been distributed to me.

I will provide a copy of this Assignment to my or my dependent's(s') attorney if I/my dependent(s) have/has retained an attorney. If I/my dependent(s) have/has not yet retained an attorney or if I/my dependent(s) retain a new attorney to pursue claims arising from the medical condition described above, I agree to notify the Fund of the name and address of my/my dependent's(s') attorney within ten days of the retention of the attorney and provide a copy of the Assignment to any such attorney.

I agree that if I and/or my dependent(s) fail to pursue a claim against a third party, my employer or any other person who maintains liability to pay expenses on my or my dependent's(s') behalf and compensation to me/my dependent(s) within 90 days from the date of this Assignment and Acknowledgment of Lien, I on my own behalf and on behalf of my dependent(s) assign and subrogate to the Fund all of my/my dependent's(s') right, claims and interest any claim which I/my dependent(s) maintain and authorize the Fund, at its discretion, to sue, compromise or settle in my/my dependent's(s') name all such claims and to execute releases, endorse checks or drafts paid in settlement of such claim in my name and/or my dependent's(s') name(s), with the same force and effect as if I/my dependent(s) executed or endorsed them. I agree on my behalf and on behalf of my dependent(s) to cooperate fully with the Fund in the prosecution of such claims and testify at the Fund's request.

I also grant the Fund a security interest in any proceeds I/my dependent(s) receive as described above and agree to sign any additional documents requested by the Fund to perfect its security interest or to otherwise secure the Fund's subrogation rights to the proceeds.

I HEREBY AGREE to notify the Fund at least thirty (30) days prior to the date, time and location of any settlement conference, trial or redemption hearing on any lawsuit\claim of mine or my dependent(s), at the following address:

Michigan Glass and Glazing Industry Welfare Insurance Fund
P.O. Box 966
Troy, MI 48099-0966
(248) 641-4957

I further understand and agree that if I do not reimburse the Fund or otherwise comply with my obligations under this Assignment as agreed, the Fund may take all appropriate steps to recover money it paid me or on my behalf or to my dependent(s) or on his/her/their behalf, including filing suit against me, deducting the balance owed by refusing to honor future claims of my family and me, or cutting off eligibility for benefits for my family and me.

Signature: _____

Date: _____

Social Security Number: _____

Address: _____

Telephone Number: (_____) _____

Signature: _____

Subscribed and sworn to before me

this _____ day of _____, 20 _____.

Notary Public, _____

County, State of _____

If you have retained an attorney, the following information must be provided and the enclosed Acknowledgment of Lien by Attorney must be completed and returned to our office for approval by the Board of Trustees before any claims will be considered in connection with this medical condition.

Attorney's Name: _____

Address: _____

Telephone Number: (_____) _____

ACKNOWLEDGMENT OF LIEN BY ATTORNEY

Dated: _____

Regarding Client: _____
(Please Print)

The undersigned attorney hereby acknowledges and recognizes a lien on behalf of the Michigan Glass and Glazing Industry Welfare Insurance Fund (“Fund”) for all payments made by the Fund to or on behalf of the attorney’s above-named Client(s) in connection with the Client’s(s’) injuries, including payments made for medical claims and wage loss.

The undersigned attorney hereby agrees to take steps to withhold sufficient money out of any proceeds of settlement, suit, or otherwise in connection with the Client’s(s’) claims when they are resolved, whether or not the Client(s) is/are made whole, to satisfy the lien, and after verification from the Fund as to the actual and then-current lien amount, agrees to take steps to effect disbursement of such money out of the Client’s(s’) proceeds through redemption, trial or otherwise, however they are designated and including proceeds allocated to medical expenses, lost wages, compensatory damages, attorneys’ fees, costs and interest, irrespective of any finding of liability of a third party.

I acknowledge that any money recovered shall be deemed to be held in constructive trust for the benefit of the Fund, regardless of who holds such money.

ATTORNEY’S SIGNATURE

DATE: _____

NOTES

NOTES

NOTES

