Iron Workers' Local No. 25 Fringe Benefit Funds
P.O. Box 99219
Troy, MI 48099-9219
Phone: (248) 347-3100 Toll Free: (800) 572-8553 Fax: (248) 813-9898
Website: www.iw25fringe.org

Dear Participant,

This enrollment package was sent to you because you are or will be eligible for health care coverage. To better understand the benefits that are available to you, it is important that you carefully read all of the information included. It is equally important that you fully and legibly complete and return all required documents as soon as possible. Any missing information or incomplete forms, will delay the processing of your medical and/or dental claims

Enclosed please find:

Vital Information Form:
This form needs to be completely filled out and returned to the Fund office. The front of the document is for the employee's personal information, dependent information, and beneficiary information. The beneficiary is the person that will receive any death benefits that may be payable upon your death. **You must complete the beneficiary portion of this form or it will be returned to you to be completed.** The back of the form is for other insurance information. Please be advised that both sides of this document must be completed.

Dependent Letter:
This explains what documents you will need to submit in the event you are adding your spouse, dependent child(ren), step child(ren), and/or adopted child(ren). **You must provide a copy of your marriage certificate to add your spouse and birth certificate to add dependent child(ren).**

Blue Cross Blue Shield Benefit at a Glance:
Customer Service Number: (877) 790-2583 or www.bcbsm.com

Sav-Rx Benefits at a Glance:
Customer Service Number: (888) 662-IRON (4766) or www.savrx.com

Delta Dental Benefits at a Glance:
To locate a provider in your area, call 1-800-524-0149 or www.deltadentalmi.com.

DENCAP Dental Benefits at a Glance:
To locate a provider in your area, call 1-800-451-5918 or www.dencap.com.

Notice of Privacy Practices (HIPAA) and Authorization Form:
Please read the enclosed HIPAA Privacy Notice, which explains your rights, along with how and when medical information may be disclosed. Effective April 2003, you are no longer able to

over

receive health care information over the phone for any member of your family other than yourself or your minor child (under age 18), **unless a signed authorization form is on file at the Fund Office. Please complete and sign the enclosed Authorization for Release of Protected Health Information form and return it to the Benefit Office.**

Notice of COBRA Continuation Coverage Rights:
Please read this information, as it contains important information regarding your rights to COBRA Continuation Coverage. COBRA is a temporary extension of coverage under your plan in the event of your termination.

Summary Plan Description:
This booklet contains the rules of the Plan, along with a description of the benefits available to you and your eligible dependents.

YOU MUST PROVIDE A COPY OF YOUR MARRIAGE CERTIFICATE TO ADD YOUR SPOUSE AND BIRTH CERTIFICATES TO ADD DEPENDENT CHILDREN.

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VITAL INFORMATION FORM

MEMBER Information: *(Please Print)*

Last: _____ First: _____ Middle: _____

Address/City/State/Zip:_____

Social Security Number: _____-_____-_____ Telephone Number: (_____)_____

Date of Birth: _____/_____/_____ Gender: (*circle one*) Male Female

Marital Status: *(circle one)* Single Married Divorced Separated Widowed
Date of Marriage/Divorce/Separation: _____

Current Status: *(circle one)* Active Retired Disabled COBRA

DEPENDENTS: - Include Spouse (If additional space is needed, please use 2nd sheet)

FULL NAME	RELATION	BIRTH DATE	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please include the required Marriage License and Birth Certificate when adding dependents

BENEFICIARY(ies): (Death Benefits-Medical)

If a minor is named as beneficiary, insurance proceeds can only be paid to a legally appointed/qualified guardian.

NAME	RELATION	BIRTHDAY	S.S. #	ADDRESS/CITY/STATE/ZIP	%
_____ (Primary)	_____	___/___/___	____-___-____	_____	_____
_____	_____	___/___/___	____-___-____	_____	_____
_____ (Secondary)	_____	___/___/___	____-___-____	_____	_____
_____	_____	___/___/___	____-___-____	_____	_____

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

_____ _____

MEMBER SIGNATURE **Date**

(OVER)

OTHER INSURANCE INQUIRY

Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage.

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____)_____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active? _____

Termination date if applicable: _____

Coverage is: (*circle one*) Single Family

Children are covered until age: _____

Type of coverage: (*circle all that apply*) Medical Dental Vision Prescription

List covered dependents: _____

_____

_____

Member Statement:

*The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I **must** notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.*

Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

_____ _____

Member Signature **Date**

IMPORTANT!

Instructions for Vital Information Form and Authorization for Release of Protected Health Information

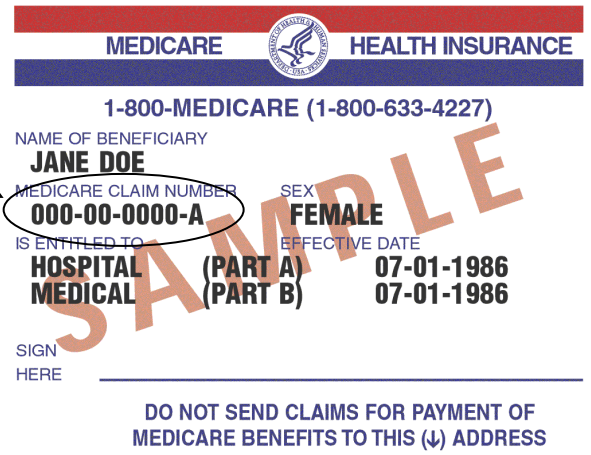
It is necessary for you to complete and return the attached forms entitled *Vital Information Form* and *Authorization for Release of Protected Health Information*.

Instructions for *Vital Information Form*

All the information on the front of the form must be completed and the form must be signed. Please complete the back of the form regarding *Other Insurance* that you, your spouse, or any of your dependents may have.

If you, your spouse, or your covered dependents are age 65 or older or eligible for Medicare disability benefits, it is extremely important that you complete the line on the form regarding Medicare Claim Numbers. The illustration below shows where the number is located on the Medicare card.

Medicare Claim Number including the letter(s)



Instructions for *Authorization for Release of Protected Health Information*

Privacy regulations require the Fund Office to have authorization to discuss health care and eligibility information over the phone. The Authorization for Release of Protected Health Information allows you to permit the Fund Office to discuss health care and eligibility information with the person(s) you designate on the form. If you so choose, the form also permits you to limit the release of health information to yourself only.

If the Authorization Form is not completed and returned, discussions regarding health care will be limited to yourself and any minor children enrolled under your coverage. This means that if your spouse calls the Fund Office with a question about a benefit paid on your behalf, we will not be able to release the information. Similarly, if your spouse does not give authorization for us to talk to you, you will not be able to inquire about a claim paid on your spouse.

Please review the instructions for completing the *Authorization for Release of Protected Health Information* that are located on the back of the form.

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DEPENDENT COVERAGE

PLEASE DO NOT SEND ORIGINAL DOCUMENTS

Please read the following information carefully! This letter explains the necessary requirements and documentation needed to add dependents to your health care coverage. Please refer only to the situation which applies to you and forward the required information to the Benefit Office.

SPOUSE - Coverage for a spouse can be provided for any eligible active participant. You are required to complete a Vital Information Form for verifying any other active insurance coverage. When adding a new spouse to your policy a copy of your marriage certificate is required before coverage will be activated.

CHILDREN - The active participants' natural dependent children and legally adopted children are eligible to be added to your policy. When adding eligible dependents to your policy a copy of each child's birth certificate is required before coverage will be activated.

STEPCHILDREN – Please be advised stepchildren are not automatically eligible dependents. If you are 100% responsible for the stepchildren, and their non-custodial parent has relinquished all legal claims and rights to said children, please forward the child's birth certificate and the legal documents to the Benefit Office for review. If action has not been pursued by the dependent's custodial parent, the Fund cannot be responsible for their Primary Health Care coverage. However, you may submit for review, any legal documents such as a prior divorce decree, or a Paternity affidavit, a copy of your taxes showing you claim the child as a dependent.

DEPENDENTS AGE 19 – 26 - In accordance with the Patient Protection and Affordable Care Act (PPACA also known as Healthcare Reform) health care plans that offer coverage for dependent children must provide coverage for adult children of covered employees until the age of 26. It is no longer a requirement that a dependent child over the age of 19 be a full-time student. Therefore, your children may be eligible for coverage until they attain age 26, regardless of; their student or marital status; whether your home is their principal place of residence or whether you support them. A copy of the child's birth certificate must be sent in before coverage will be activated.

The Summary of Benefits and Coverage (SBC) will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage and costs, you can get the complete terms in the policy or plan document at the Fund Office of the Iron Workers Health Fund of Eastern Michigan Benefit Plan, P.O. Box 99219, Troy, MI 48099-9219 or by calling (800) 572-8553.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-Network: $250** Individual / **$500** Couple or Family **Out-of-Network: $500** Individual/ **$1,000** Couple or Family	Generally, you must pay all the costs from **providers** up to the **deductible** amount before this plan begins to pay. If you have other family members on the policy, the overall family **deductible** must be met before the plan begins to pay. Check your policy or plan document to see when the **deductible** starts over. See chart on page 2 for how much you pay for covered services after you meet the **deductible**. Out-of-network amounts also apply toward in-network deductible. In-network amounts do not apply toward out-of-network deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care services are covered before you meet your deductible.	You will have to meet the deductible before the plan pays for any services. As required by law, certain services are covered 100%, i.e. no deductible. These are primarily preventive care services.
Are there deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services, but see Common Medical Event chart on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**OOP: Medical In-Network $2,250** Individual /**$4,500** Couple or Family; **Medical Out-of-Network $12,700** Individual/ **$25,400** Couple or Family; **Rx: $4,900** Individual **/ $9,800** Couple or Family	The **OOP** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. By law, the Overall OOP for deductibles, co-payments, and co-insurance on in-network essential benefits is: Medical 2024: $9,450 Individual/ $18,900 Couple or Family Medical 2025: $9,200 Individual/ $18,400 Couple or Family In-network coinsurance amounts do not count toward the out-of-network coinsurance maximum. Out-of-network coinsurance amounts do count toward the in-network coinsurance maximum.
What is not included in the out–of–pocket limit?	Self-payments, balance-billed charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. Please see page 7 under Contact Information for the toll-free number to call to obtain a list of participating **providers**.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use a non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your in-network provider may use an out-of-network provider for some services. See the chart starting on page 2 for how this plan pays different kinds of **providers**. For additional information see Contacts on page 7.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission (referral) from this plan.

Self-payments. The Fund requires monthly self-payments by participants to participate in the Fund. The monthly self-payment for this Option1 is $418 for single; $586 for 2 person; and $615 for family. Group Number 0070040310000 – Non-Medicare

Questions: Call the Fund Office (800) 572-8553, the number on your BCBSM ID card, or go to www.bcbsm.com. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform. See pg. 7 for additional contact information.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	20% co-insurance after deductible.	---none---
	Specialist visit	$20 co-pay; no co-pay for chiropractor visit; 10% co-insurance after deductible-xray during visit.	20% co-insurance after deductible.	Chiropractor: 26 visits per member per calendar year for spinal manipulations. Out-of-network or for services other than spinal manipulation deductible/co-insurance apply.
	Preventive care/screening/ immunization	No Charge	20% co-insurance after deductible	Wellness exam subject to annual visit limitation. Routine preventive care generally limited to annually; subsequent related care subject to deductible and percent copay. Well-baby/Well-childcare visits; 8 visits, birth to 12 months; 6 visits, 13 months to 35 months; 2 visits, 36 months to 47 months You may have to pay for services that aren't preventative. Ask your provider if the services you need are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance after deductible	20% co-insurance after deductible.	---none---
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible	20% co-insurance after deductible.	May require preauthorization.

Questions: Call the Fund Office (800) 572-8553, the number on your BCBSM ID card, or go to www.bcbsm.com. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform. See pg. 7 for additional contact information.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition For more information about **prescription drug coverage** contact the Fund or OptumRx.	Generic drugs	Retail - $10 co-pay Mail - $20 co-pay (90 day supply)	Retail - $10 co-pay Mail - $20 co-pay (90 day supply)	Does not cover prescriptions filled at Sam's Club or Walmart. Generic women's contraceptives covered without copay; formulary brand name contraceptives covered without copay if suitable generic unavailable.
	Formulary brand-name (preferred brand) drugs	Retail - $15 co-pay Mail - $30 co-pay (90 day)	Retail - $15 co-pay Mail - $30 co-pay (90 day)	Does not cover prescriptions filled at Sam's Club or Walmart. For information visit: www.OptumRx.com or call: 1-866-328-2005
	Nonformulary brand-name (non-preferred brand) drugs	Retail - $30 co-pay Mail - $60 co-pay (90 day)	Retail - $30 co-pay Mail - $60 co-pay (90 day)	Does not cover prescriptions filled at Sam's Club or Walmart.
	Specialty drugs	Retail - $30 co-pay Mail - $60 co-pay (90 day)	Retail - $30 co-pay Mail - $60 co-pay (90 day)	Must be obtained from OptumRx Specialty Pharmacy. See pg. 7 for contact information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fees	10% co-insurance after deductible	20% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room services	10% co-insurance after deductible	10% co-insurance after deductible	---none---
	Emergency medical transportation	10% co-insurance after deductible	10% co-insurance after deductible	---none---
	Urgent care	$20 co-pay; 10% co-insurance after deductible on any services rendered such as x-ray, etc.	$20 co-pay; 20% co-insurance after deductible	---none---

Questions: Call the Fund Office (800) 572-8553, the number on your BCBSM ID card, or go to www.bcbsm.com. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform. See pg. 7 for additional contact information.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance after deductible	20% co-insurance after deductible	Preauthorization is required.
	Physician/surgeon fee	10% co-insurance after deductible	20% co-insurance after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health/ Substance Abuse outpatient services	10% co-insurance after deductible	10% co-insurance after deductible (mental health and behavioral health) 20% co-insurance after deductible (substance abuse)	Your cost share may be different for services provided in an office setting. Outpatient substance abuse disorder treatment covered at approved facilities only.
	Mental/Behavioral health/ Substance Abuse inpatient services	10% co-insurance after deductible	20% co-insurance after deductible	Preauthorization is required.
If you are pregnant	Office Visits	Pre-natal: covered 100% Post-natal: covered100%	20% co-insurance after deductible	Pre-natal care only, covered for dependent children.
	Childbirth/delivery professional services	10% co-insurance after deductible	20% co-insurance after deductible	Pre-natal care only, covered for dependent children.
	Childbirth/delivery facility services	10% co-insurance after deductible	20% co-insurance after deductible	Pre-natal care only, covered for dependent children.
If you need help recovering or have other special health needs	Home health care	10% co-insurance after deductible	10% co-insurance after deductible	Must be medically necessary and provided by a participating home health care agency.
	Rehabilitation services	10% co-insurance after deductible	20% co-insurance after deductible	Services at nonparticipating outpatient physical therapy facilities are not covered.
	Habilitation services	10% co-insurance, after deductible for ABA	10% co-insurance, after deductible for ABA	Applied behavioral analysis (ABA) treatment for Autism – subject to preauthorization
	Skilled nursing care	10% co-insurance after deductible	10% co-insurance after deductible	Must be in a participating skilled nursing facility and preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
	Durable medical equipment	10% co-insurance after deductible	10% co-insurance after deductible	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice service	No Charge	No Charge	Subject to pre-hospice counseling. Hospice coverage for four 90-day periods provided. After reaching a certain dollar maximum, member transitions into individual case management. Physician certification required.
If you or your child needs dental or eye care	Eye exam Safety Glasses or Contacts – Eye Exam	$5 co-pay None – see limitation below.	Reimbursement up to $50 less $5 co-pay that applies to all charges (member responsible for any difference)	Blue Vision benefits are provided by Vision Service Plan (VSP) Once per covered person per calendar year.
	Glasses Lenses Frames Safety Glasses Contact Lenses – Medically necessary Contact Lenses – Elective	100% In-Network $130 allowance Covered up to 100% of Approved Amount Lenses and Frames Covered up to 100% of Approved Amount $150 Allowance for Exam & Contact Lenses	Reimburse up to approved amount Reimburse up to $45 for frames. Not covered. Reimbursement up to $210 per pair. $105 Allowance for Exam & Contact Lenses	Prescription glasses or contact lenses, not both. One pair of lenses, with or without frames, per calendar year. One frame per calendar year. One per member per calendar year. Applicable to Medically Necessary or Elective Contacts: Allowance for prescription glasses or contact lenses, not both, Participant pays balance after Approved Amount. 15% off 1x per year eye exam for medically necessary elective contacts.

Questions: Call the Fund Office (800) 572-8553, the number on your BCBSM ID card, or go to www.bcbsm.com. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform. See pg. 7 for additional contact information.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
	Dental check-up (oral exam)	No Charge	Covered at Delta Dental's approved PPO Dentist Schedule.	Delta Dental: Frequency limitations; $1,200 annual maximum, N/A children up to age 18. DENCAP Dental see benefit guide.

To see examples of how this plan might cover costs for a sample medical situation, see the examples on page 8.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy/plan document for other excluded services.)

Long-term care	Infertility treatment	Weight loss programs
Routine foot care		
Cosmetic surgery	Expenses arising from motor vehicle or motorcycle accidents	Expenses incurred due to an on-the-job injury

Other Covered Services (This isn't a complete list. Check your policy/plan document for other covered services/your costs for these services.)

Bariatric surgery	Chiropractic care	Hearing aids
Non-emergency care when traveling outside the United States - see http://provider.bcbs.com	Private-duty nursing	Acupuncture treatment
Routine eye care		Dental care

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or co-insurance, or benefits not otherwise covered.

Contact Information (If you need additional information, please contact the Fund Office at 1-800-572-8553 or Customer Service as listed below).

For Medical and Vision (for a list of participating providers go to www.bcbsm.com and view the list of Participating Traditional/PPO Providers):
BCBSM, Customer Service, P.O. Box 2888, Detroit, Michigan 48231 | Toll-free (877) 790-2583

For Prescription Drugs:
OptumRx, 1-866-328-2005, P.O. Box 29044, Hot Springs, AR 71903-9044
OptumRx Specialty Pharmacy, 1-866-218-5445

For Dental Benefits:

For individuals enrolled in the Delta Dental Plan, contact Delta Dental at P.O. Box 9085, Farmington Hills, MI 48333 | Toll-free (800) 482-8915
For individuals enrolled in the DENCAP Dental Plan, contact DENCAP Dental Plan at 45 E. Milwaukee, Detroit, MI 48202 | Toll-free (800) 451-5918 | For a list of participating dentists, please contact the dental program that you are enrolled in at the related toll-free number.

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a self-payment which may be significantly higher than the self-payment you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the Fund Office at 1-800-572-8553. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-696-6775 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Fund Office at 1-800-572-8553 or Blue Cross Blue Shield of Michigan by calling 1-877-790-2583. For grievances and appeals regarding prescription drug or dental coverage, see the contact information listed above.
Or, you can contact Michigan Office of Financial and Insurance Regulation at **www.michigan.gov/ofir** or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.
This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.
Not Applicable

———————— To see examples of how this plan might cover costs for a sample medical situation, see the next section. ————————

Questions: Call the Fund Office (800) 572-8553, the number on your BCBSM ID card, or go to www.bcbsm.com. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform. See pg. 7 for additional contact information.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$250
■ Specialist *copayment*	$20
■ Hospital (facility) *[cost sharing after deductible]*	10%
■ Other *[cost sharing after deductible]*	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)* (12/9 months)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$11,300**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,120**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$250
■ Specialist *copayment*	$20
■ Hospital (facility) *[cost sharing after deductible]*	10%
■ Other *[cost sharing after deductible]*	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)* (12/ per year)
Diagnostic tests *(blood work)*
Prescription drugs (12 months at $10 copay)
Durable medical equipment *(glucose meter)*

Total Example Cost	**$2,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments – Primary Care/Rx	$120
Coinsurance	$70
What isn't covered	
Limits or exclusions	$400
The total Joe would pay is	**$840**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$250
■ Specialist *copayment*	$20
■ Hospital (facility) *[cost sharing after deductible]*	10%
■ Other *[cost sharing after deductible]*	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$40
Coinsurance	$200
What isn't covered	
Limits or exclusions	$400
The total Mia would pay is	**$890**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Tips to Reduce Drug Cost and Maximize Medication Efficiency

Review Medications Every Quarter
Keep a single, updated list of all your medications and ensure that each of your healthcare providers has a copy. This helps reduce the risk of unnecessary drugs, side effects, and interactions. Regularly review this list with your physician or pharmacist.

Talk with Your Doctor about Cost
Let your doctor know that cost and therapeutic effectiveness both matters. Ask if there is a generic or lower-cost substitute available.

Use the Patient Portal to Compare Prices
Sav-Rx Patient Portal will give you cost comparison of medications.

Avoid Free Samples
Free samples are usually brand name and more expensive in the long run.

Ask your Pharmacist for Information
For information on generic medications, consult your pharmacist. Discuss the cost and efficacy of generic alternatives with your doctor.

Ask for Smaller Amounts of New Meds
Ask your doctor for a smaller quantity of a new medication until you know it is right for you. This is especially helpful if you are paying cash or have a high copay.

Call Sav-Rx at 888-662-(IRON) 4766
Call Sav-Rx for assistance in reducing your overall drug costs. There will be a live representative available to take your call 24 hours a day, 7 days a week, and 365 days a year.

Patient Portal

Use the QR code below or visit app.savrx.com/login to use our secure patient portal!

Use the Portal to:

Access your electronic ID card

Compare medication costs with the drug price lookup tool

Download your entire prescription claim history

Maintain your profile and payment method

Order your medications from the mail order pharmacy

Track your current order status

Receive notifications when mail order refills are due

View your mail order prescriptions

For More Information, Visit savrx.com

PRESCRIPTION SAV-RX SERVICES EST. 1968

Pharmacy Benefit Management Guide

Iron Workers Local 25 Health Care Trust Fund

25

Medication Coverages

- Most maintenance medications are covered by your Plan.
- Certain prescription drug classes are excluded from coverage, such as:
  - Fertility
  - Weight Loss
  - Cosmetic
- Some medications may be subject to quantity limitations or require prior authorization to determine coverage.
- Please refer to your Summary Plan Description for specific coverage rules.

Call 888-662- IRON (4766)

Speak with a LIVE Sav-Rx Union representative 24/7/365

Where to Use the Benefit

Sav-Rx Mail Order Pharmacy

Benefits

- **Cost-effective**, convenient solution for long-term maintenance and specialty medications
- **Free shipping** directly to your door

How It Works

1. Send in your prescription
2. Pay at the time of order
3. Get your medication delivered to your door
4. Enjoy **easy refills** by phone, online, or through the Sav-Rx Patient Portal

How to Send in Prescriptions (3 Options)

1. Ask your doctor to **send it electronically** to Sav-Rx in Fremont, NE.
2. Ask your doctor to **fax** it to 402-753-2890.
3. Call Sav-Rx with your prescription details and your doctor's information – **we'll handle the rest!**

Sav-Rx Retail Pharmacy Network

How to Make Use of the Network

- To locate a pharmacy near you, visit savrx.com and enter the Group from your ID card and your zip code.
- Present your Sav-Rx ID card at your pharmacy.
- **Walmart & Sams Club are not included in this network.**

Your Sav-Rx Benefit

Retail Pharmacy *(Up to 30 Days' Supply)*	
Generic	$15
Formulary	$25
Non-Formulary	$50
Brand with Generic	$50 + Difference in Cost

Sav-Rx Mail Order & Retail 90-Day Pharmacy *(Per 90 Days' Supply)*	
Generic	$30
Formulary	$50
Non-Formulary	$100
Brand with Generic	$100 + Difference in Cost

Specialty Pharmacy	
30 Day Supply	25% $250 Maximum
60 Day Supply	25% $500 Maximum
90 Day Supply	25% $500 Maximum

Maximum Out-of-Pocket	
Individual $4,900	**Family $**9,800

DELTA DENTAL®

Delta Dental PPO (Standard)
Summary of Dental Plan Benefits
For Group# 9830-3000, 4000, 5000
Iron Workers' Health Fund of Eastern Michigan

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays*	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	100%	100%	100%
Endodontic Services – root canals	100%	100%	100%
Occlusal Guards/Adjustments – bite guards and occlusal adjustments	100%	100%	100%
Oral Surgery Services – extractions and dental surgery	100%	100%	100%
Major Restorative Services – crowns	100%	100%	100%
Other Basic Services – misc. services	100%	100%	100%
Relines and Repairs – to bridges, implants, and dentures	100%	100%	100%
Periodontic Services – to treat gum disease	75%	75%	75%
TMD Treatment – treatment of the disorder of the temporomandibular joint, including related films	75%	75%	75%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	100%	100%	100%
Orthodontic Services			
Orthodontic Services – braces	75%	75%	75%
Orthodontic Age Limit –	No Age Limit		

* When you receive services from a Delta Dental Premier or Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's PPO Dentist Schedule (or the Nonparticipating Dentist Fee) that will be paid for those services. This amount may be less than what the dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Diagnostic casts are Covered Services without limitation.

- Additional prefabricated posts (same tooth) are Covered Services.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Inlays (any material) are Covered Services.
- Gold foils are Covered Services.
- Porcelain and resin facings on crowns are Covered Services on posterior teeth.
- Provisional splinting is a Covered Service.
- Biopsy of hard and soft tissue are Covered Services.
- Benefits for Temporomandibular Disorders (TMD) are limited to those services normally provided by a dentist to relieve oral symptoms associated with malfunctioning of the temporomandibular joint. This does not include services that would normally be provided under medical care.
- Full and partial dentures are payable once in any five-year period. Reline and rebase of dentures are payable once in any two-year period.
- Pediatric partial dentures are Covered Services.
- Implants and implant related services are payable once per tooth in any five-year period.
- Occlusal guards are payable once in any three-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,200 per person total per Benefit Year on periodontics (excluding occlusal guards and occlusal adjustments). $1,200 per person total per Benefit Year on all services, except periodontics (excluding occlusal guards/adjustments), implants, and orthodontic services. $1,500 per person total per lifetime on orthodontic services. $6,000 per person total per lifetime on implants.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to 30% of Delta Dental's stated Copayment of the Maximum Allowed Amount for Orthodontic Services as set forth in the Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 75% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – None.

Waiting Period – Subscribers who are eligible for Benefits are covered once they have met the eligibility requirements as outlined by the Iron Workers' Health Fund of Eastern Michigan.

Eligible People – All active eligible Subscribers of IW25 (3000), retirees of IW25 (4000) and Medicare Retirees of IW25 (5000) of the Fund who are eligible under the terms of the Iron Workers' Health Fund of Eastern Michigan plan document "The Plan" and choose the Delta Dental option, and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, as applicable. Please note that if there are any inconsistencies between the terms of The Plan and the dental care certificate, the terms of The Plan control.

Also eligible are your legal spouse and your children to the end of the month in which they turn 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Subscribers, you may be enrolled as both a Subscriber on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease on the last day of the month in which the employee is terminated.

The Maximum Payments (except for Orthodontic Services) are waived for children up to age 18.

This plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. This plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

This plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)

This plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call 1-800-524-0149 (TTY users call 711).

If you believe that this plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the civil rights coordinator at PO Box 9089, Farmington Hills, MI 48333-9089; by phone at 1-800-524-0149 (TTY users call 711) or fax to 517-706-3513. You can file a grievance by mail, fax or phone. If you need help filing a grievance, the civil rights coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-524-0149 (TTY: 711).

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل على الهاتف رقم 1-800-524-0149 (رقم الطابعة الهاتفية: 711).

মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে ভাষাগত সহায়তা পরিষেবাগুলি, আপনার জন্য বিনামূল্যে পাওয়া যাবে। ফোন করুন 1-800-524-0149 (TTY: 711)।

သတိပြုရန်- သင် မြန်မာဘာသာစကား ပြောဆိုပါကဘာသာစကားအကူအညီဝန်ဆောင်မှုများကိုအခမဲ့ရရှိနိုင်ပါသည်။ခေါ်ဆိုရန် 1-800-524-0149 (TTY- 711)။

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-524-0149 (TTY：711)。

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-524-0149 (TTY: 711).

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-524-0149 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-524-0149 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-524-0149 (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। कॉल करें 1-800-524-0149 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-524-0149 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-524-0149 (TTY: 711)
まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-524-0149 (TTY: 711) 번으로 전화해 주십시오.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਇੱਥੇ ਕਾਲ ਕਰੋ 1-800-524-0149 (TTY: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-524-0149 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-524-0149 (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-524-0149 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-524-0149 (телетайп: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-524-0149 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-524-0149 (TTY: 711).

يرجى الانتباه: إذا كنت تتحدث اللغة العربية السورية، تتوفر لك خدمات المساعدة اللغوية المجانية. يرجىالاتصال بالرقم: 1-800-524-0149 (الهاتف النصي: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-524-0149 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-524-0149 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-524-0149 (TTY: 711).

DELTA DENTAL®

Consumer Toolkit®

A fast, free way to check your dental benefits coverage

Looking for information about your Delta Dental coverage? Our free online Consumer Toolkit gives you easy access to a wealth of information 24/7.

This secure service lets you:

- Verify your eligibility
- Review up-to-date benefits information (such as your coverage levels for specific services, how much of your yearly benefit has been used to date, and how much is still available)
- Check your claims and see what's been paid
- Search directories of participating dentists
- Print ID cards and claim forms
- Sign up for electronic delivery of Explanation of Benefits (EOB) statements

Delta Dental's Consumer Toolkit is just one of the many ways we're working to better serve you. Register and log on at:

www.consumertoolkit.com

OVER

All users must first register to gain access to the Consumer Toolkit. Privacy of your online benefit information is assured through highly secure encryption technology.

Get started today

To start taking advantage of this innovative tool, follow these simple steps:

1. Visit **www.consumertoolkit.com**.
2. Click the **Register Now** link.
3. Complete the required fields and follow the on-screen instructions to register as a new user.

   NOTE: You will need the subscriber's (the person whose name is on the benefit package) member ID. The member ID is an assigned number unique to the subscriber. In many cases, the member ID is the same as the subscriber's Social Security number.
4. Select your own username and password to access the site.

Additional help topics can be accessed through the Help menu or by clicking the question mark icon at any time within the Toolkit. If you need further assistance, contact Toolkit support at 866-356-0301.

Delta Dental of Arkansas, Indiana, Kentucky, Michigan, New Mexico, North Carolina, Ohio, and Tennessee.

DELTA DENTAL®

Teledentistry FAQ

What is teledentistry?

Teledentistry is a part of telemedicine, and it's a way for patients to receive health care evaluations or advice remotely using videoconference technology. It can be a helpful service for people who live far from a dental office, or in the case of the COVID-19 pandemic, when people are staying home to avoid exposure.

How does teledentistry work?

If you have a dental emergency, your dentist may ask you to take a picture of the outside and the inside of your mouth to email to text. Or you may connect over the phone or through video chats such as FaceTime or Skype.

What code will my dentist use to bill for teledentistry?

Your dentist should be familiar with how to bill for teledentistry, but if not, it's code D0140: Problem focused examination.

Will I have a copay?

That depends on your particular dental plan. However, for most plans this is covered under prevention and diagnostics with no copay.

Where is this covered within my dental plan?

In the prevention and diagnostics section.

How do I know if my dentist has teledentistry capability? Does it state that in the online directory?

You should ask your dentist if teledentistry is an option. This information is not included in the directory.

What equipment or devices do I need for a teledentistry call?

If your dentist wants to see inside your mouth, you may need a smartphone, tablet with internet connection, or a computer with a camera. Sometimes taking a picture, emailing it or texting it to your dentist, and then talking on the phone may also be beneficial.

Benefits Summary
Iron Workers Local 25

The below summary of the Iron Workers Local 25 Plan Benefits is additional information to your Certificate of Coverage. If the information in this document is different from your Certificate of Coverage, this document applies. The percentages noted are applied to DENCAP's Dental allowance for each service and may vary based on your dentist's current fees.

Covered Services:
Annual Maximum: $1,800
Deductible: None
Waiting Period: None

	DENCAP DHMO Benefit
Office Visit	$10.00
Diagnostic and Preventive – performed by a general dentist	
Exams, X-Rays, Cleanings	100%
Complete Series (D0210) & Panoramic (D0330)	100%
Sealants (1st and 2nd Molars only – once in lifetime up to age 14)	100%
Space Maintainers (Up to age 19, primary teeth only)	100%
Fluoride Treatment (Up to age 19)	100%
Basic – performed by a general dentist	
Amalgam Fillings	100%
Composite Fillings D2330-D2335 (anterior only)	100%
Root Canals	100%
Routine Extractions	90%
Major – performed by a general dentist	
Periodontics	75%
Crowns (D2751/D2791 only)	90%
Bridges, Dentures, Partials, Repairs to Appliances	90%
Specialty Care	
Oral Surgery, Endodontics, Periodontics, Pedodontics	75%
Orthodontics - Lifetime Maximum, Comprehensive Case Only	
Up to age 19	$1,800 discount
Over age 19	$1,200 discount

DENCAP CUSTOMER SERVICE or CLAIM STATUS
800-451-5918

DENTAL OFFICES, SUBMIT CLAIMS TO:
DENCAP Dental Plans
P.O. Box 2819 Detroit, MI 48202-3231

45 E. Milwaukee St. | Detroit, MI 48202 | f: (844) 919-1601 | dencap.com

DENCAP Dental Plans Request Form - New ENROLLMENT

Clear Data

- Complete the "Employee Section" of this form including employee signature, then return to your group administrator.
- This form is NOT for making changes to existing subscribers. Please use the Change/Delete form if making changes to an already enrolled employee.
- For participating network dental locations, visit dencap.com
- Your Member I.D. Card will be mailed within 2 weeks of receipt of form.
- Contact your group administrator to make changes to your coverage.

TODAY'S DATE: ____/____/ 20____

EMPLOYEE SECTION: *Required information, this section MUST be completed*

LAST NAME (Print)	FIRST	INITIAL	DATE OF BIRTH MONTH DAY YEAR	SEX	SOCIAL SECURITY NUMBER
STREET ADDRESS		Apt#		☐ M ☐ F	– –
CITY	STATE	ZIP	PHONE NUMBER:		
For DHMO Only Dental Office Selection *(Enter 3 digit number from Provider Directory)* ☐☐☐			E-MAIL:		

LIST ALL DEPENDENTS TO BE COVERED BELOW. INCLUDE LAST NAME IF DIFFERENT FROM SUBSCRIBER		DATE OF BIRTH MONTH DAY YEAR	Qualified Disabled Dependent	SEX	SOCIAL SECURITY NUMBER
SPOUSE				☐ M ☐ F	– –
DEPENDENT			YES ☐	☐ M ☐ F	– –
DEPENDENT			YES ☐	☐ M ☐ F	– –
DEPENDENT			YES ☐	☐ M ☐ F	– –
DEPENDENT			YES ☐	☐ M ☐ F	– –

EMPLOYEE SIGNATURE:_____ **DATE:** _____

GROUP ADMINISTRATOR SECTION: *Required information, this section MUST be completed*

COMPANY NAME *OR* GROUP NUMBER: _____

PLAN SELECTION:_____

DESIRED EFFECTIVE DATE:

Please START coverage on the FIRST DAY of MONTH: _____ **YEAR:**_____

To ensure that your addition will be effective for the current month, please submit by the 10th of the current month. In some cases, enrollments can be processed for the current month when received later than the 10th of the month, but are not guaranteed. If an invalid date or no date is entered in the desired effective date field, the earliest date possible will be used.

ADMINISTRATOR SIGNATURE:_____ **TITLE:** _____ **DATE:** _____
REQUIRED

Group Administrator: Please retain a copy of completed form for your records

- If submitting electronically, type your name in the administrator signature box.
(Your e-mail to DENCAP serves as a binding signature.)

Email This Form

f5-V.12.06.21

Return this form to: DENCAP Dental Plans, Inc., 45 E. Milwaukee St., Detroit, MI 48202. Or fax to 844-919-1601. Or email to enrollments@dencap.com

dencap DENTAL PLANS

DENCAP EMERALD NETWORK DIRECTORY – April 2024

City	ID	Name	Address	Location Details	Zip	Phone
Allen Park	**251**	**Great Expressions Dental Center**	6760 Allen Rd Suite 101	bet Southfield & Ecorse Rds	48101	313-928-2500
Ann Arbor	**184**	**Great Expressions Dental Center**	2360 E Stadium Blvd Suite 14	near the Lamp Post Inn	48104	734-677-0793
Belleville	**3834**	**Accurate Dental - Denture Inc**	781 Sumpter Road	in Belle Park Plaze	48111	734-697-5477
Brighton	**211**	**Great Expressions Dental Center**	7743 Grand River Ave Suite 202	N of Hacker Rd	48116	810-229-0303
Burton	**3854**	**Hamilton Community Health**	G-3375 S. Saginaw Street	Hemphill Rd and Saaginaw St	48529	810-743-6830
Canton	**218**	**Great Expressions Dental Center**	5958 Canton Center Rd Suite 400	Essex Centre/N of Ford Rd	48187	734-451-9570
Chelsea	**4138**	**Chelsea Painless Dentistry**	1414 Main Street Ste 2	at Main St & Old Manchester Rd	48118	734-475-8800
Clinton Township	**280**	**Great Expressions Dental Center**	35939 Moravian Dr	E of Utica Rd	48035	586-790-8668
Clinton Township	**225**	**Great Expressions Dental Center**	18557 Canal Rd Suite 5	bet Garfield & Romeo Plank	48038	586-228-1050
Dearborn	**572**	**Dearborn Dental**	1308 Monroe St	between Beech St & Park St	48124	313-561-4431
Dearborn	**120**	**Great Expressions Dental Center**	23157 Michigan Ave	at Outer Dr in Wesborn Plz	48124	313-561-9500
Dearborn	**219**	**Great Expressions Dental Center**	2021 Monroe St Suite 204	in Dearborn Professional Bldg	48124	313-565-5586
Dearborn	**14**	**Care Dental PLLC**	5237 Oakman Blvd Suite A	Oakman and Hartwell	48126	313-945-9977
Dearborn	**4246**	**I Care Dental**	7911 Wyoming Street	at Tireman Ave & Wyoming St	48126	313-834-5000
Dearborn	**217**	**Great Expressions Dental Center**	23401 Ford Rd	bet Telegraph & Outer Dr	48128	313-561-3367
Detroit	**409**	**Advantage Health Centers**	101 E Alexandrine St	at Alexandrine & Woodward	48201	313-416-6262
Detroit	**313**	**Great Expressions Dental Center**	3670 Woodward Ave Suite 101 B	bet Mack & Parsons	48201	313-355-1665
Detroit	**129**	**Lucas-Perry Dental Group**	4727 St Antoine St Suite 408	in Hutzel Professional Bldg	48201	313-833-7309
Detroit	**406**	**Waller Health Center**	60 E Warren Ave	in the Waller Healthcare Center	48201	313-416-6262
Detroit	**399**	**Detroit Dental Care**	511 W 8 Mile Rd	SB side of 8 Mile, W of John R	48203	313-454-4800
Detroit	**392**	**Team Wellness Center**	3646 Mt Elliott St	bet Mack Ave & Gratiot Ave	48207	313-626-2400
Detroit	**367**	**Detroit Sterling Dental**	17200 E Warren Ave	E of Cadieux	48224	313-882-6635
Detroit	**258**	**Warren/Bedford**	5024 Bedford Rd	at E Warren	48224	313-882-8010
Detroit	**4167**	**Downtown Detroit Dental PC**	645 Griswold Suite 224	Fort St & Griswold	48226	313-263-0230
Detroit	**293**	**Shadows Bedell, DDS**	15101 Plymouth Rd Suite 1	at Coyle	48227	313-273-3171
Detroit	**198**	**Shadows Bedell, DDS**	15101 Plymouth Rd Suite 2	bet Joy & W Chicago	48227	313-272-6500
Detroit	**397**	**Detroit Dental Care**	20720 Plymouth Rd	W of Greenfield	48228	313-342-1997
Detroit	**46**	**Robert Hoffman, DDS**	19600 W Warren Ave	E of Greenfield	48228	313-271-5555
Detroit	**197**	**Shadows Bedell, DDS**	19600 Van Dyke Rd	at Lantz	48234	313-892-9148
Detroit	**396**	**Advantage Health Centers**	15400 W McNichols Rd	E of Greenfield Rd	48235	313-835-5990
Detroit	**407**	**Advantage Health Center of Hope**	1355 Oakman Blvd	bet La Salle Blvd and 14th St	48238	313-416-6262
Detroit	**45**	**Denise Coleman, DDS**	10040 Puritan	W of Wyoming	48238	313-341-2868
Detroit	**398**	**Detroit Dental Care**	15510 Livernois Ave	At the Lodge Fwy & Livernois	48238	313-863-2800
Eastpointe	**128**	**Eastland Dental Group ***	20960 Kelly Rd	Bet 8&9 Mile across from mall	48021	313-521-2070
Eastpointe	**228**	**Great Expressions Dental Center**	16555 E Ten Mile Rd	at Gratiot in Riviera Plaza	48021	586-778-3838
Farmington	**3173**	**Jacquelyn Chu, DDS**	32905 W 12 Mile road Suite 350	W 12 Mile and Farmington Roads	48334	248-489-7008
Farmington	**4198**	**Comfort Dental Spa**	33966 W Eight Mile Road	at 8 Mile & Farmington Roads	48335	248-474-6434
Farmington	**376**	**Art Dental Center**	23023 Orchard lake Rd	bet Grand River & Shaiwassee	48336	248-476-4619
Farmington Hills	**503**	**Dental Spot**	31487 Northwestern Hwy Suite B	W of Middlebelt Rd	48334	248-539-7781

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dencap DENTAL PLANS

DENCAP EMERALD NETWORK DIRECTORY – April 2024

City	ID	Name	Address	Location Details	Zip	Phone
Farmington Hills	**292**	**Great Expressions Dental Center**	25882 Orchard Lake Rd Suite 209	S of 11 Mile Rd	48336	248-474-0600
Flint	**3856**	**Hamilton Community Health**	5399 N. Saginaw Street	W Harvard Ave & Saginaw St	48505	810-785-0863
Flint	**3855**	**Hamilton Community Health**	2900 N. Saginaw Street	E Dartmouth & Saginaw St	48505	810-789-9141
Flint- East	**220**	**Great Expressions Dental Center**	2483 S Linden Rd Suite 100	N of Lennon Rd	48532	810-733-7470
Grand Blanc	**279**	**Great Expressions Dental Center**	8185 Holly Rd Suite 15	in Ridge Plaza	48439	810-695-0842
Grosse Pointe	**271**	**Great Expressions Dental Center**	17700 Mack Ave	on the corner of University	48224	313-882-2211
Lathrup Village	**504**	**Dental Spot**	18161 W 12 Mile Rd Ste 3	W of Southfield Rd	48076	248-539-7781
Lathrup Village	**232**	**Great Expressions Dental Center**	28550 Southfield Rd	bet 11 & 12 Mile Rds	48076	248-557-5557
Livonia	**222**	**Great Expressions Dental Center**	9134 Middlebelt Rd	at Joy & W Chicago	48150	734-261-1920
Livonia	**282**	**Great Expressions Dental Center**	37625 Ann Arbor Rd	W of Newburgh Rd	48150	734-464-6774
Livonia	**4268**	**Awesome Dental Care**	36000 Five Mile Road	Golfview St & Five Mile Rd	48154	734-464-3430
Monroe	**214**	**Great Expressions Dental Center**	530 S Monroe St	near 5th St	48161	734-242-1500
Novi	**255**	**Great Expressions Dental Center**	39555 W Ten Mile Rd Suite 306	W of Haggerty	48375	248-442-7305
Oak Park	**272**	**Great Expressions Dental Center**	13231 W Ten Mile Rd	E of Coolidge	48237	248-547-3323
Okemos	**306**	**Great Expressions Dental Ctr ***	1869 Grand River Ave	E of Marsh Rd	48864	517-349-3175
Oxford	**314**	**Great Expressions Dental Center**	129 S Washington St	N of Lincoln St	48371	248-628-3700
Pontiac	**80**	**Great Expressions Dental Center**	667 N Martin Luther King Blvd	Near Victory St	48342	248-334-9912
Rochester Hills	**281**	**Great Expressions Dental Center**	1428 N Rochester Rd	S of Tienken Rd	48307	248-651-1594
Roseville	**136**	**Great Expressions Dental Center**	26298 Gratiot Ave	Eastgate Ctr at 10 1/2 Mile	48066	586-776-5015
Royal Oak	**383**	**Antonino S. Abate, DDS PC**	1228 Catalpa Dr	E of Woodward	48067	248-542-8200
Saint Clair Shores	**354**	**James F. Skoney, DDS PC ***	22726 Harper Ave	S of 9 Mile Rd	48080	586-775-7080
Saint Clair Shores	**343**	**Gentle Dental - Shores**	26210 Harper Ave Suite 100	N of 10 Mile Rd	48081	586-779-0150
Shelby Township	**215**	**Great Expressions Dental Center**	5106 23 Mile Rd	E of Shelby Rd	48317	586-726-6688
Southfield	**262**	**Great Expressions Dental Center**	28626 Telegraph Rd	bet 11 & 12 Mile Rds	48034	248-647-7550
Southfield	**13**	**Freemans Family Dentistry**	20905 Greenfield Rd Suite 204	N of 8 Mile Rd	48075	313-535-5050
Southfield	**502**	**Roxann Baker, DDS**	20905 Greenfield Rd Suite 208	just N of 8 Mile Rd	48075	248-569-3490
Southfield	**385**	**James A. Watson, DDS**	20307 12 Mile Rd Suite 106	W of Evergreen	48076	248-355-9800
Southgate	**287**	**Great Expressions Dental Center**	15312 Trenton Rd	S of Eureka Rd	48195	734-282-8600
Sterling Heights	**265**	**Great Expressions Dental Center**	2041 15 Mile Rd	at Dequindre Rd	48310	586-268-0900
Sterling Heights	**190**	**Waleed Mammo, DDS**	35450 Dequindre Rd Suite 101	N of 15 Mile Rd	48310	586-264-6550
Taylor	**108**	**United Dental Center***	21925 Van Born Rd	at Monroe	48180	313-563-5010
Troy	**216**	**Great Expressions Dental Center**	6535 Rochester Rd	bet Square Lk & South Blvd	48084	248-879-5557
Walled Lake	**288**	**Great Expressions Dental Center**	1080 E West Maple Rd	W of Novi Rd	48390	248-668-9419
Walled Lake	**379**	**The Dentist West**	2390 S. Commerce Rd.	N of Oakshade St	48390	248-438-6421
Warren	**408**	**Detroit Healthcare for Homeless**	4669 E 8 Mile Road	at 8 Mile Rd & Cunningham St	48091	313-416-6262
Warren	**330**	**Ryan Dental Group**	26620 Ryan Rd	bet 10 & 11 Mile Rds	48091	586-755-4770
Warren	**144**	**Sunshine Dental Center**	21761 Ryan Rd	bet 8 & 9 Mile Rds	48091	586-758-3620
Warren	**3797**	**Creative Dental Ctr-Apple Dental**	28225 Hoover Road	at Hoover Road & Martin Road	48093	586-751-6868
Warren	**337**	**Gentle Dental - Warren**	29753 Hoover Rd Suite B	S of Common Rd	48093	586-573-0011

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DENCAP EMERALD NETWORK DIRECTORY – April 2024

City	ID	Name	Address	Location Details	Zip	Phone
Warren	**224**	**Great Expressions Dental Center**	11885 E 12 Mile Rd Suite 303B	Macomb Professional Bldg	48093	586-574-9800
Waterford	**226**	**Great Expressions Dental Center**	4216 Pontiac Lake Rd	inside Pinetree Plaza	48328	248-674-1009
Wayne	**213**	**Great Expressions Dental Center**	38110 Michigan Ave	W of Newburgh Rd	48184	734-728-1700
Westland	**315**	**Rita Patel, DDS ***	8010 N Wayne Rd	bet Joy & Warren Rds	48185	734-522-6128
Westland	**328**	**Gentle Dental - Wayne**	825 S Wayne Rd	S of Cherry Hill	48186	734-722-5630
Westland	**57**	**Great Expressions Dental Center**	38959 Cherry Hill Rd.	at Hix Road	48186	734-326-2010
Wixom	**387**	**Great Expressions Dental Center**	49701 Grand River Ave	W of Wixom Rd	48393	248-864-2378
Woodhaven	**312**	**Great Expressions Dental Center**	22003 Allen Rd	bet King & West Rds	48183	734-692-1920
Wyandotte	**193**	**Great Expressions Dental Center**	1805 Fort Street	bet Merrill & Stewart	48192	313-383-2270

Write Office ID on application or contact DENCAP to select dental office before seeing the dentist.

Up to date Directory and Locator available at ***www.dencap.com***

What if I have a dental emergency?

Dental emergencies can be handled by your DENCAP Primary Care Dentist. Often times, there are after-hour emergency numbers given on a dentist's answering service. If you are unable to get a hold of your DENCAP Dentist after hours, please call DENCAP at 888-98-TEETH.

What if I have an emergency out of town?

If you are out of the DENCAP service area (50 or more miles away from your Primary Care Dentist), DENCAP will reimburse you or your covered dependent for 50% of the amount up to $100.00 for those emergency services which relieve severe pain or discomfort and are covered benefits.

Directory Key Emerald Network
****Cannot Service New Patients***

• 45 E. Milwaukee St., Detroit, MI 48202 • 888-988-3384 toll free • 313-972-4662 fax • info@dencap.com • Printed 4/1/2024

Iron Workers' Local No. 25 Fringe Benefit Funds

P.O. Box 99219
Troy, MI 48099-9219
Phone: (248) 347-3100 Toll Free: (800) 572-8553 Fax: (248) 813-9898
Website: www.iw25fringe.org

NOTICE OF THE PRIVACY PRACTICES OF THE IRON WORKERS' LOCAL NO. 25 HEALTH FUND

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.

We are 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. We are also required to give you this notice regarding (1) the uses and disclosures of health information that may be made by the Plan of the Iron Workers' Local No. 25 Health Fund, and (2) your rights and the Plan's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA. Please be advised that Blue Cross Blue Shield of Michigan and/or Blue Care Network HMO have issued or may issue separate Notices regarding disclosure of health information that is maintained on the Plan's behalf by those entities.

How We May Use and Disclose Health Information About You

The following categories describe different ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose health information about you 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, we may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. We may also share health information with a utilization review or precertification service provider. Likewise, we may share health information with another entity to assist with the coordination of benefit payments.

For Health Care Operations. We may use and disclose health information about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use health information 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.

To Inform You About Treatment Alternatives or Other Health Related Benefits. We may use your health information 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 for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. For instance, we may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.

For Disclosure to the Fund's Trustees. We may disclose your health information to the Fund's Trustees for plan administration functions performed by the plan sponsor on behalf of the Fund including, but not limited to, reviewing appeals. We may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. We also may disclose to the plan sponsor information on whether you are participating in the Fund.

When Legally Required. We will disclose your health information when it is required to do so by any federal, state or local law.

For Public Health Activities. We may disclose your health information 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.

To Conduct Health Oversight Activities. We may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, we may not disclose your health information 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, we may disclose your health information 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 we receive 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 we have made a reasonable effort to notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, in an emergency to report a crime.

To Coroners, Medical Examiners and Funeral Directors. We may release health information 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, we may release health information to organizations that handle organ procurement or transplantation.

In the Event of a Serious Threat to Health or Safety. We may disclose your health information 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.

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

For Workers' Compensation. We may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

For Other Purposes. Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only if you provide a written authorization. If you provide us with written authorization to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made with your permission.

We may use or disclose your health information for other purposes not set forth in this Notice which we are permitted to do so without your written authorization or consent.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

You have the following rights:

The right to request restrictions or limitations on the health information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Fund's Privacy Officer. In your request, you must tell us (1) what information

you want to limit, (2) whether you want to limit our use, disclosure or both; and (3) to whom the limits apply.

The right to request to receive confidential communication of your health information by an alternative means or at an alternative location if a disclosure of your health information could endanger you. The request must be made in writing to the Fund'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. We do 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 for inspection and/or copying. Your request for access to documents with your health information must be in writing to the Fund'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 health information, copy it, or both, in the form or format requested at a time and place convenient to you and us. If you would like, you may receive a summary of the requested health information instead of your entire record, for a reasonable fee. You may also receive a copy of your health information by mail if you prefer. (We charge 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 health information or for processing the participant's request for access.) When a request for access is denied (in whole or in part), we will grant access to health information for which there are no grounds to deny access. We 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 us and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, we 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 health information if it is inaccurate or incomplete. You may request that your health information be amended. That request must be in writing to the Fund's Privacy Officer and include a reason why your health information should be amended. If you do not include a reason, we will not act on the request. When a request for amendment is accepted (in whole or in part), we will inform you that your request for amendment has been accepted. We 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 Fund does business who may rely on the disputed health information to your detriment. We will identify the record(s) that are the subject of the amendment request and will append the amendment to the record. When 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 Fund, 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 we provide the request for amendment and the denial in any future release of the disputed health information, and how to file a complaint with us or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, we may write a rebuttal statement and will provide a copy to the participant, and we will include the request for amendment, denial letter, statement of disagreement, and rebuttal (if any), with any future disclosures of the disputed health information. If you do not choose to write a statement of disagreement with the denial decision, we are not required to include the request for amendment and denial decision letter with future disclosures of the disputed health information unless you request we to do so. Receipt of notification of amendment: When we receive notification from that your health information has been amended, we 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 health information of the amendment and require them to make the necessary corrections.

The right to obtain an accounting of disclosures of your health information. 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, (2) to individual about their own health information, (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; (8) to correctional institutions or law enforcement officials; and (9) those made prior to April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Fund'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. We 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.

The right to receive a paper copy of this Notice and any revisions to this Notice. You may request a copy of this Notice is writing to the Fund'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.

LEGAL DUTIES OF THE IRON WORKERS' LOCAL NO. 25 HEALTH FUND REGARDING YOUR HEALTH INFORMATION

The Iron Workers' Local No. 25 Health Fund is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Iron Workers' Local No. 25 Health Fund is required to abide by the terms of this Notice, which may be amended from time to time. Iron Workers' Local No. 25 Health Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information we have about you as well as any information we receive in the future. If the Iron Workers' Local No. 25 Health Fund changes its policies and procedures, the Iron Workers' Local No. 25 Health Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Iron Workers' Local No. 25 Health 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 Iron Workers' Local No. 25 Health Fund should be made in writing to the Fund's Privacy Officer. The Iron Workers' Local No. 25 Health 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.

CONTACT PERSON

For questions about this Notice, to exercise your privacy rights, or to file a complaint, contact the Fund's Privacy Officer, Iron Workers' Local No. 25 Health Fund, P O BOX 368, Troy, Michigan 48099-0368 or 1-248-641-4902.

EFFECTIVE DATE

April 14, 2003

Instructions for completing the

Authorization for Release of Protected Health Information

There is a section for the Participant/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

Participant Section /Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or-
   If you are not married or **you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself". **Please sign and date below the box**.

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (participant/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse).
   If you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. **Please sign and date form below the box**.

Dependent(s) over the age of 18 Section

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).
   If want to give someone other than your parents authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. **Please sign and date form below the box.**

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I,_____SS# _____ authorize the Iron Workers' Local No. 25 Health Fund (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

IRON WORKERS' LOCAL NO. 25
P.O. BOX 99219
TROY MI 48099-9219

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Plan cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member/Retiree_____**Date Signed:** _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Member/Retiree_____**Date Signed:** _____

SPOUSE SECTION

I, the **spouse** (**Name, Please Print**) _____, (**Spouse's Social Security #**) _____of the above named Member/Retiree, have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse_____**Date Signed**: _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Spouse _____**Date Signed**: _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the **dependent child(ren)** over the age of 18 (**Name, Please Print)**_____,**(Social Security #)** _____have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, except at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent_____**Date Signed**: _____

OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Dependent _____**Date Signed**: _____

NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Fund Office. If you have any questions, please contact the Fund Office at 248-347-3100 or toll free at 800-372-8553

Iron Workers' Local No. 25 Fringe Benefit Funds
P.O. Box 99219
Troy, MI 48099-9219
Phone: (248) 347-3100 Toll Free: (800) 572-8553 Fax: (248) 813-9898
Website: www.iw25fringe.org

****General Notice of Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan, the Iron Workers' Local No. 25 Health Fund. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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 doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- 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 parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

A child born to or placed for adoption with an employee receiving COBRA continuation coverage shall be considered a qualified beneficiary entitled to COBRA continuation coverage. You must notify the Plan Administrator within 30 days of the birth or adoption in order for the child to be eligible for COBRA coverage.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If your employer files a proceeding in bankruptcy court, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse, an employee or qualified beneficiary becoming disabled, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Iron Workers' Local No.25 health Fund; P.O. Box 99219, Troy, MI, 48099-9219, 1-800-572-8553.

Failure to elect COBRA continuation coverage within the time specified, will result in termination of the Participant's or Dependant's group health care coverage, as of the date of the qualifying event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. 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 is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security Administration to be disabled within 60 days of the date of the commencement of COBRA continuation coverage and the Disabled Participant notifies the Plan Administrator of the Social Security Administration's determination, the Disabled Participant as well as any family member who is a qualified beneficiary in connection with the same qualifying event may be entitled to get up to an additional 11 months of coverage, for a total of 29 months of COBRA continuation coverage. You must notify the Plan Administrator within 60 days of the disability determination in order to receive an extension of COBRA continuation coverage.

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

If your family experiences another qualifying event during the first 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Qualified beneficiaries must notify the Plan Administrator within 60 days after the second qualifying event occurs in order to become eligible for extended COBRA coverage. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first

qualifying event not occurred. In no event, shall COBRA continuation coverage exceed three (3) years from the date of the first qualifying event.

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 your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator: Iron Workers' Local No. 25 Health Fund, P.O. Box 99219, Troy, MI, 48099-9219, 1-800-572-8553.

Iron Workers' Local No. 25 Fringe Benefit Funds
P.O. Box 99219
Troy, MI 48099-9219
Local: (248) 347-3100 Toll Free: (800) 572-8553
Website: www.iw25fringe.org

Enhanced Member Benefit Website
www.iw25fringe.org

Dear Member:

The Trustees of the Iron Workers' Local No. 25 Fringe Benefit Funds are pleased to announce a new enhanced member benefit website, www.iw25fringe.org. This website has been fully updated to provide you with a more effective way to access and manage your benefits.

The website enables you to obtain basic benefit information about the Plan, review answers to frequently asked questions, access your personal benefit information, and communicate with the Benefit Office via e-mail. You can also find helpful links regarding benefits provided by the Plan.

To access your personal benefit information, such as your benefit elections, work history detail, forms, and Plan documents, you need to register as a new user by clicking the *Create an Account* link at the top right hand corner in the Login box. More detailed instructions are shown on the back of this letter. Once you are registered, you can access your personal benefit information by entering your ***User Name*** and ***Password***, so please keep these confidential. **Please note, only one user name and password is permitted per email address. If more than one person in your family requires website access, each must use a different email address.**

Please contact the Benefit Office at (800) 572-8553 if you encounter any difficulty logging in, or if you have any questions regarding the Member Benefit website. You can also email the Benefit Office directly by using the "Contact Us" section of the website.

Please visit the enhanced Member Benefit website soon and see all that it has to offer!

Board of Trustees,

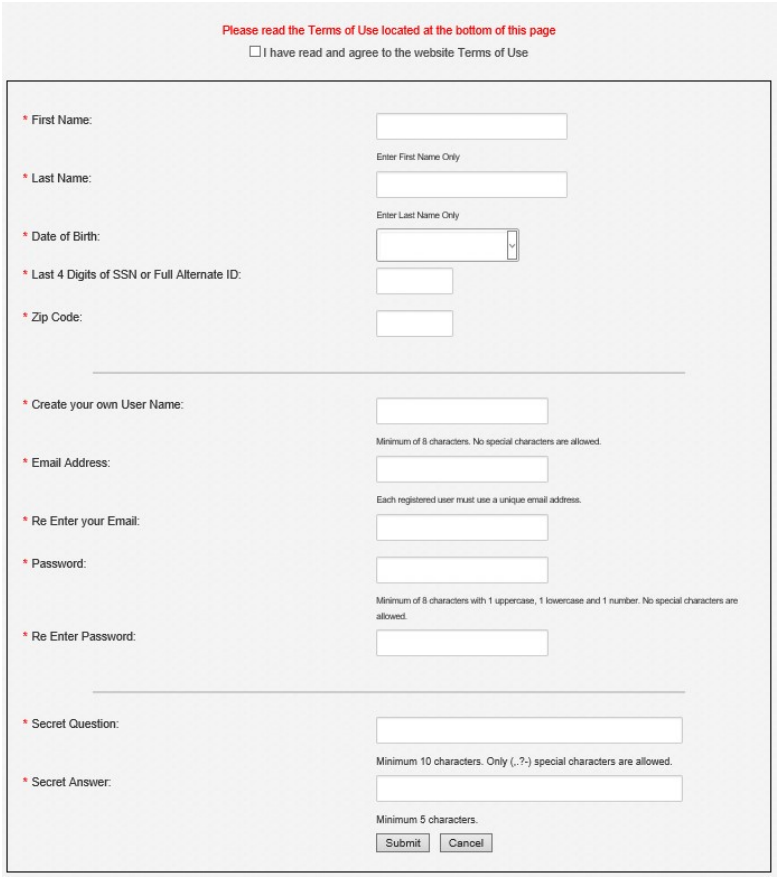
Iron Workers' Local No. 25 Fringe Benefit Funds

HOW TO REGISTER ON THE WEBSITE

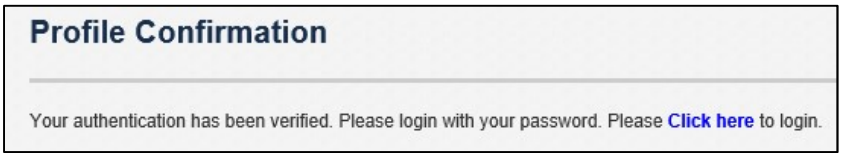
When registering for the first time, please follow these instructions:

1) From your computer or mobile device, connect to the website listed on the front page of this letter.
2) Locate the Login box in the upper right-hand corner of the screen.
3) Click on "Create an Account" to get started.

4) The Registration Screen will display next. Please enter all information, as all fields are required. Once all information has been entered, please click "Submit" on the bottom of the screen.



5) After registering you will receive an email notification with a link to confirm your registration. Your email address will also be used in the event you forget your user name and password.



SUMMARY PLAN DESCRIPTION

IRON WORKERS' HEALTH FUND
OF EASTERN MICHIGAN BENEFIT PLAN

2013

SUMMARY PLAN DESCRIPTION
IRON WORKERS' HEALTH FUND OF EASTERN MICHIGAN BENEFIT PLAN

Preface

The Board of Trustees of the Iron Workers' Health Fund of Eastern Michigan (Fund) defines its health care plan by the official Iron Workers' Health Fund of Eastern Michigan Benefit Plan document (Plan). This document is the summary plan description ("SPD") of the Plan. It is a summary of the official Plan document.

- The Fund is a health care plan intended to be maintained for the exclusive benefit of employees and maintained on an indefinite basis. It is intended that the Plan will serve to describe the benefits of the Fund. It is also intended that the Plan will conform to the requirements found in the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, as it applies to employee welfare benefit plans. If any portion of the Plan now, or in the future, conflicts with ERISA or applicable federal regulations, ERISA and/or such regulations will govern. **If any portion of this SPD conflicts with the official Plan document, the Plan will control.**

- **Although the Trustees expect and intend to continue the Fund indefinitely, they reserve the right to change or terminate the Fund at any time and for any reason, for any group or class of Participants as well as for all Participants. Correspondingly, the Trustees may change the level of benefits provided, eliminate an entire category of benefits, or change self-payment requirements at any time and/or for any reason. THERE ARE NO VESTED BENEFITS UNDER THIS PLAN.**

- Eligibility for benefits and payment of benefits are subject to all terms, provisions and limitations stated on the following pages and in the Plan.

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ARTICLE 1 – DEFINITIONS

As used in this document, the following words are defined as follows:

Active Employee means a Journeyman, Apprentice, Union Employee, Apprenticeship Fund Employee, Fund Office Employee, or other person on whose account an Employer has made Contributions to the Fund or who is eligible for benefits as provided under the eligibility rules of the Fund.

Active Participant means an Active Employee entitled to coverage under the Fund.

Apprenticeship Fund means the Iron Workers' Apprenticeship Fund of Eastern Michigan.

Apprenticeship Fund Employee means an instructor or other employee of the Apprenticeship Fund on whose behalf the Apprenticeship Fund makes Contributions to the Fund.

Association means the Great Lakes Fabricators and Erectors Association, Inc., the Associated General Contractors of America, Detroit Chapter, Inc., the Michigan Conveyer Manufactures Association, Inc., the Resteel Contractors Association, Inc., and any successors to these entities.

Bank means the total cumulative Credited Employer Contributions made to the Fund on behalf of a Participant subject to any maximum plan limit on such amounts.

Beneficiary is the person(s) designated as such in the Fund Office records in accordance with the Participant's election. Any change in Beneficiary must be made by changing the election form in the Fund Office. This may be done at any time, without the consent of any previously designated Beneficiary. Any change in Beneficiary shall not take effect until the request for the change is received by the Fund Office. Any other documents purporting to change the beneficiary, such as divorce or separation orders, shall not be considered in determining a Participant's Beneficiary. If no Beneficiary is named or if the designated Beneficiary predeceases the Participant, Beneficiary shall mean in the following order: (1) Spouse; (2) Children; (3) Parents; (4) Brothers and Sisters; and (5) Estate.

Children or Child means a person who qualifies under (a), (b), or (c) below:

(a) Any person up until the first of the month following the month in which he/she turns age 26 and either:

(1) is a Participant's natural child or adopted child;

(2) has been placed with a Participant for adoption; or

(3) is a Participant's step-child, which means the child of the Participant's Spouse.

(b) A person who would qualify as a "child" under paragraph (a) but for the age limitations, who by reason of mental or physical handicap is incapable of sustaining employment and the Participant has submitted proof of such to the Fund Office prior to December 31 of the year in which the child would otherwise cease to be a dependent under the terms of this Plan.

(c) An alternate recipient under a Qualified Medical Child Support Order of a Participant.

Children under the guardianship of the Participant and foster children are not included in the definition of Children and are not covered by the Plan.

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

Contributions means payments made or required to be made to the Fund by an Employer as required under a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act. Contributions become vested Plan assets at the time they become due and owing to the Fund. An Employer shall have no right, title or interest in the Contributions owing to or made to the Fund.

Credited Employer Contributions means the actual Contributions received and credited to a Participant's Bank for purposes of determining eligibility for coverage and benefits.

Co-payment means the amount of the claim for which the Covered Person is responsible.

Covered Person means a Participant and Dependent, unless otherwise indicated in any section of this Plan explaining a particular benefit.

Dependents mean Participant's Spouse and Children, if any.

Disability means a physical or mental condition resulting from an injury or illness, which in the opinion of a physician satisfactory to the Trustees, prevents a person from engaging in any regular occupation or employment for remuneration or profit as an ironworker and which requires the regular care and attendance of a legally qualified physician or surgeon; provided, that no person shall be deemed to have a Disability if such incapacity was contracted, suffered or incurred while he was engaged in an illegal activity or from service in the Armed Forces of any country.

Employer means:

(a) a member of the Association who is bound by the terms of a Collective Bargaining Agreement between the Union and the Association to make Contributions to the Fund;

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

(c) the Union to the extent, and solely to the extent, that it acts in the capacity of an employer of its business agents or other employees on whose behalf it makes Contributions to the Fund; and

(d) the Board of Trustees, to the extent and solely to the extent that it acts in the capacity of an employer of administrative employees on whose behalf Contributions are made to the Fund.

Fund Office means the administration office located at 25130 Trans X Drive, Novi, Michigan 48375; mailing address is P.O. Box 8006, Novi, MI 48376-8006, telephone number (248) 347-3100 or 1-800-

572-8553.

Fund or Health Fund means the Iron Workers' Health Fund of Eastern Michigan.

Journeyman/Journeymen means persons designated as such pursuant to the terms of a Collective Bargaining Agreement.

Owner-Member means any person who performs work covered by a Collective Bargaining Agreement who has a financial interest in an Employer, direct or indirect, whether or not that interest shall be as sole proprietor, partner, shareholder or similar financial interest. An eligible Owner-Member is entitled to benefits as an Active Participant unless otherwise set forth in this Plan.

Participant means an Active Employee or Covered Retiree entitled to coverage under the Fund.

Plan or Plan Document means this document, i.e. the Iron Workers' Health Fund of Eastern Michigan Benefit Plan.

Plan Administrator means the Trustees of the Fund.

Plan Year means the fiscal period that begins on May 1st each year and ends on April 30th of the following year.

Retiree or Covered Retiree means a person who has been granted an early, normal, or disability pension by Iron Workers' Local No. 25 Pension Fund and entitled to coverage under the Fund.

Spouse means the Participant's legal spouse.

Surviving Spouse means that person who was married to the Participant on the date of the Participant's death.

Trustees means the Trustees of the Iron Workers' Health Fund of Eastern Michigan.

Union means Iron Workers Local No. 25 of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers, AFL-CIO.

Union Employee means a business agent or other employee of the Union on whose behalf the Union makes Contributions to the Fund.

ARTICLE 2 - ELIGIBILITY

2.1 Eligibility Requirements for Active Employees

Eligibility shall be based upon a "Bank System" comprised of the Active Employees' Credited Employer Contributions. The cost of coverage shall be deducted from the Active Employee's Bank in an amount determined periodically by the Trustees. The "Bank System" shall operate as follows:

(a) Periodically, the Trustees will determine in their sole discretion the monthly benefit cost per Active Participant. This monthly benefit cost shall be computed to include the cost of

all benefits provided by the Fund, administrative expenses, and retiree benefits subsidy (if any).

(b) For Owner-Members, monthly contributions must be made in an amount equal to the greater of: (i) 160 hours of work or (ii) the actual number of hours worked, at the current Journeyman's rate. No contributions will be owed for any month in which no work was performed, provided that the Owner-Member has notified the Trustees seven days before the first of each month that no work will be performed.

(c) A record of each Participant's Credited Employer Contributions as received from the Employer(s) will be kept by the Trustees.

(d) All Credited Employer Contributions received will be added together to form the Participant's Bank.

(e) The Trustees will deduct the monthly benefit cost from the Participant's Bank for each month's eligibility.

(f) A Participant's Bank will be limited to 12 times the current monthly benefit cost. When a Participant's Bank reaches the maximum limit, any additional Credited Contributions will be placed in the general assets of the Fund.

Notwithstanding, any Participant whose Bank exceeds 24 but is less than 48 times the current monthly benefit cost as of May 1, 2001, or exceeds 12 but is less than 24 times the current monthly cost as of September 1, 2006, said contributions shall not revert to the general assets of the Fund. However, as the Participant draws on these excess contributions he will not be permitted to replace them.

(g) When an Employer declares Chapter 7 or Chapter 11 bankruptcy, has manpower withdrawn by the Union, or where lien proceedings have been instituted by legal counsel, the Participants involved will be credited with the contributions due the Fund for the month in which the delinquency occurs, plus the previous month's delinquency, if any. The applicable contributions will be credited based on the employer report (if received), pay stubs, and/or audit.

2.2 Initial Eligibility for Active Employees

An Active Employee will become an Active Participant and be eligible for benefits under the Fund the first day of the third month following the month in which his Bank is equal to or greater than 3 times the required monthly benefit cost.

The chart below illustrates the relationship between Credited Employer Contributions and eligibility:

Credited Employer Contributions for Work Month of:	Provide Eligibility for Month of:
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March
January	April
February	May
March	June
April	July

With Trustee approval, this section may be waived to grant immediate coverage for any employee organized by the Union.

2.3 Continuing Eligibility

A Participant will remain eligible for benefits provided his Bank is equal to or greater than his required monthly benefit charge. Notwithstanding, if an Active Participant becomes and remains ineligible for 12 or more consecutive months, he must satisfy the initial eligibility requirements for Active Participants before again becoming eligible for benefits.

2.4 Self-Payment for Active Participants

When a Participant's Bank is not sufficient to meet the monthly benefit cost the Participant will be billed by the Fund Office for the difference between what he has in his Bank and the current monthly cost.

Any Active Participant shall be allowed to make 3 consecutive self-payments to the Fund to maintain his eligibility provided he is not working for a non-contributing employer in the industry. If verification by an area Union business agent is received that the Participant is actively seeking employment in the jurisdiction of the Union, he will be allowed to make 3 additional regular self-payments. If no verification is given by a union business agent, or if the maximum time allowed for self-payment is exhausted, the Participant shall be offered COBRA.

When a request for a self-payment is issued and the Participant elects not to make the required self-payment, his coverage will terminate. Any monies standing to his credit will remain in his Bank for 12 months and thereafter revert to the general assets of the Fund.

No Owner-Member shall be entitled to maintain eligibility by way of self-payment. Once an Owner-Member's Bank is not sufficient to meet the monthly benefit cost, he will be offered COBRA.

A Retiree who returns to work cannot make self-payments to maintain coverage.

2.5 Eligibility and Coverage for Active Participants Working Outside the Jurisdiction of Local No. 25

If the Active Participant becomes employed as an Ironworker outside the jurisdiction of the Union, and becomes eligible for health and welfare benefits under another Ironworker health and welfare plan, he may elect to freeze his Bank and/or suspend his self-payment status. The Active Participant who elects coverage under another Ironworker health and welfare plan must provide the Plan Administrator confirmation in writing from the other plan as to his date of eligibility in the other plan. The Active Participant's Bank will not be frozen nor will his self-payment status be suspended until such confirmation is received by the Plan Administrator.

The Active Participant may resume coverage under this Plan either by resuming self-payment status, if eligible, or by directing the Plan Administrator to commence deductions from his Bank to cover the current monthly benefit costs. Prior to reinstatement of coverage and eligibility under this Plan, the Active Participant must provide the Plan Administrator with a copy of the other Ironworker plan. The Active Participant will be permitted to reinstate his eligibility in the month following the last month he was eligible in the other Ironworker plan.

2.6 Absence Due to Military Duty

If coverage under the Plan is terminating due to military service, the Participant may elect to continue the health plan coverage under the Plan for up to 24 months after the absence begins, or for the period of military service, if shorter. The Participant must notify the Fund Office as soon as he volunteers for or is called to active duty. The maximum premium that will be charged is 102% of the full premium for the coverage. However, if the military service is for 30 or fewer days, the maximum premium will be the self-payment amount.

Upon termination for military duty, a Participant's eligibility shall be frozen, with reinstatement under that same status upon his discharge from the military. Exclusions and waiting periods will not be imposed upon re-employment provided coverage would have been afforded had the person not been absent for military service, unless there are disabilities that the Veterans Administration determines to be service related. For these benefits to apply, however, the period of service must be less than five years and a Participant must return to work as an iron worker under the Collective Bargaining Agreement within the following time frames:

- For uniformed service of less than 31 days, by the next work day after the end of service plus eight hours, or as soon as possible after the end of the eight-hour period if reporting earlier is impossible through no fault of the Participant.
- For service of more than 30 days but less than 181 days, within 14 days of completing the service, or the next full calendar day if returning earlier is impossible through no fault of the Participant.
- For service of more than 180 days, within 90 days after completion of the service.

2.7 Self-Payments for Disabled Participants

An Active Participant who becomes Disabled while eligible to participate in the Fund shall be permitted to continue his eligibility at a reduced monthly benefit cost. This reduced rate remains in effect for 24 months. At the end of this 24 month period, the self-payment rate for a Disabled Participant is the same as the cost for an Active Participant, i.e. the amount deducted from an Active Participant's Bank.

Notwithstanding the foregoing, coverage under this section is subject to the following:

(a) To be eligible for the reduced monthly benefit cost, the Participant must have been eligible for 12 consecutive months, including the month in which Disability occurs, prior to becoming Disabled. In addition, an Active Participant must be disabled on the first of the month in for which the reduced benefit cost is requested and the Disability must have lasted for at least 2 weeks. The reduced monthly benefit cost shall be determined by the Trustees in their sole discretion.

(b) The reduced monthly benefit cost will be deducted from the disabled Participant's Bank until his Bank is insufficient to cover the monthly reduced benefit cost.

(c) When a Disabled Participant's Bank is insufficient to cover the monthly reduced benefit cost, the Disabled Participant will be required to make monthly self-payments in order to continue his eligibility.

(d) The Disabled Participant may continue his eligibility while disabled for a maximum of 24 consecutive months. In no event shall the Disabled Participant's reduced benefit cost and required monthly self-payments, or any combination thereof, exceed 24 months in duration. Thereafter, the Disabled Participant shall be required to meet the monthly benefit cost for an Active Participant in order to maintain his eligibility.

(e) Disabled Participants who request that their coverage under the Fund be cancelled because they have returned to work on a full or part-time basis and now have coverage through their current employer shall not be allowed to reinstate their coverage under the Fund.

The Trustees may request written medical verification to substantiate the Participant's Disability, or request that a Disabled Participant submit to an IME, at any time. Failure to furnish such evidence or submit to an IME upon request will result in the forfeiture of eligibility under this section.

2.8 Retirees

(a) Eligibility

When an Active Participant is approved for a Normal, Early, Special Retirement Benefit or a Disability Benefit from the Iron Workers' Local No. 25 Pension Fund (as those terms are defined in that plan), he will become a Retiree under the Fund.

So long as there is a balance of Credited Employer Contributions in his Bank, the Fund will deduct the appropriate monthly benefit cost for an Active Participant to continue his eligibility. Beginning with the first of the month for which such Bank is completely depleted, a Retiree will have to make a self-payment to maintain coverage in an amount determined by the Trustees from time to time.

A Retiree is not eligible for coverage unless he/she consents to have such self-payment automatically deducted from his monthly pension check from the Iron Workers' Local

No. 25 Pension Fund.

(b) Other Coverage

If after becoming a Retiree, the Retiree desires to cancel coverage because he wishes to be covered under his Spouse's insurance or has returned to work on a full or part-time basis and now has coverage through his employer, he must notify the Fund Office in writing of such intent. At that time, the Fund will allow the Retiree to terminate his coverage under the Fund; however, if at some future date the Retiree wishes to resume his coverage, he must provide the Fund Office with a written statement requesting reinstatement of coverage, accompanied by proof of other health coverage since date of retirement. (The other coverage may be any group or individual health coverage. Medicare does not qualify as other coverage for purposes of this section.)

Coverage under the Plan will be reinstated the first of the month following a 90 day waiting period which begins the date the written request for reinstatement is received. During such 90 days, the Retiree must continue to maintain the other health coverage referenced above.

If the Retiree wishes to terminate his coverage again at some time in the future, he will not be permitted to resume coverage a second time.

(c) Special Election Period

A Retiree may cancel coverage under the Plan because he has other health coverage. The other coverage may be any group or individual health coverage. Medicare does not qualify as other coverage for purposes of this section. The Retiree will thereafter be allowed to reinstate coverage under the Plan only if a written request for reinstatement, and proof of health coverage since he cancelled Plan coverage, is received by the Fund Office on or before December 20, 2013. Coverage under the Plan will be reinstated the first of the month following a 90 day waiting period which begins the date the written request for reinstatement is received. Reinstatement of coverage under this provision will be allowed one time only.

(d) COBRA

In lieu of Retiree coverage, at the time of retirement a Retiree and his eligible Dependents shall be offered COBRA continuation coverage which, if selected, shall exclusively govern the terms and conditions of coverage. This is a one-time election which cannot be changed or rescinded.

(e) Continued Eligibility for Retirees Who Return to Work

When a Retiree returns to work, he becomes eligible for Active Participant benefits when he satisfies the initial eligibility requirements for an Active Participant. Prior to satisfying the initial eligibility requirements for an Active Participant, the working Retiree will continue to make Retiree self-payments to the Fund to continue his Retiree coverage.

Once a working Retiree satisfies the initial eligibility requirements for an Active Participant, he is eligible for benefits provided to Active Participants, subject to the following:

(a) A Retiree who returns to work will maintain eligibility via his Bank, like an Active Participant. However, if his Bank is not sufficient to cover the current Active Participant monthly benefit cost, he will be required to make a Retiree self-payment to maintain coverage for any such month.

(b) A Retiree who returns to work is only eligible for loss of time benefits under section 3.3 if: (1) his Disability began during the period of time he returned to work, and (2) he was eligible for Active Participant benefits in the month in which the injury occurred based on the prior month's contributions.

(c) A Retiree who returns to work is only entitled to death benefits under section 3.1 for Active Participants provided:

(a) The Retiree notifies the Fund Office (prior to his return to work) that he will be returning to work;

(b) The Retiree forfeits his pension benefit from the Iron Workers' Local No. 25 Pension Fund as a result of his return to work; and

(c) The Retiree maintains his coverage under the Health Fund through his Bank.

2.9 Self-Payment for Surviving Spouse

When a Participant dies, the eligibility of his covered Dependents shall continue so long as their eligibility would have continued had the Participant not died based on the balance of Credited Employer Contributions in the deceased Participant's Bank.

Thereafter, upon payment of the required monthly self-payment, Surviving Spouses and Children continue to be covered under the Fund, provided they were covered under the Fund prior to the date of the Participant's death.

If a Surviving Spouse is receiving benefits from the Iron Workers' Local No. 25 Pension Fund, she must elect to have the self-payment deducted from such pension benefit to continue coverage as a Surviving Spouse. If a Surviving Spouse elects not to continue coverage by self-payment, she must notify the Fund Office in writing, and he/she will thereafter be offered COBRA.

If upon the death of a Participant, a Surviving Spouse elects not to continue coverage under this section, COBRA applies to the extent required by law.

2.10 Dependent Coverage

(a) Dependents are eligible for coverage under the Fund when the Participant upon whom they are dependent is eligible and the Participant has completed and submitted to the Fund Office a completed enrollment card for such Dependents.

(b) A new enrollment card must be submitted to the Fund Office for each new Dependent. A Participant must notify the Fund Office within 31 days of the date the Participant acquires a new Dependent family member - such as through marriage, birth, placement for adoption, or adoption - to establish Dependent coverage. This time period applies to both Active Participants and Retirees who enroll their family members. Coverage for a Spouse shall be effective as of the date of marriage. Coverage for a new Child shall be effective the date of birth, adoption, or placement for adoption, or the date such individual qualifies as a Child under Article 1 of the Plan. If a Dependent is not timely enrolled under this section, he/she will not be able to enroll until the next open enrollment period, as set forth below in (c).

(c) During the open enrollment period from April 1-30, Participants will have the opportunity to enroll eligible Dependents who were not previously enrolled.

If during open enrollment the Participant states in writing that the reason for declining coverage for a Dependent is because such Dependent has Other Coverage (as defined in this section), then if the Other Coverage involuntarily terminates during the Plan Year, the Dependent may enroll in the Plan the first of the month following the date a request to enroll is received, provided this request is made within 30 days of such termination. For purposes of this section:

(1) Coverage involuntarily terminates when:
   (i) The other coverage was COBRA coverage and it has been exhausted; or
   (ii) The Other Coverage was non-COBRA coverage and it has been terminated as a result of loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of the plan for similarly situated individuals, cessation of dependent status, or employer contributions toward such coverage were terminated and the Dependent Child had no control over such termination of contributions).

(2) "Other Coverage" is coverage under a group health plan or health insurance coverage, not including accident or disability only policies, coverage issued as a supplement to liability insurance, liability insurance, workers compensation or similar insurance, automobile medical payment insurance, credit only insurance, coverage for on-site medical clinics, or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits.

(d) A Participant may voluntarily terminate his Dependent's coverage.

(1) If proof of Other Coverage is provided for such Dependent at the time of voluntary termination of coverage, the Participant will be permitted to reenroll the Dependent within 30 days of the loss of such Other Coverage.
(2) If no proof of Other Coverage is provided at the time of voluntary termination of coverage, or if reenrollment is not requested within 30 days of the loss of such Other Coverage, such Dependent will be permitted to reenroll no sooner than the next open enrollment.

(3) To reenroll a Dependent, a new enrollment card must be completed and the Dependent must meet the eligibility requirements for Dependent coverage.

Notwithstanding the foregoing, a Dependent of a Retiree may only be reenrolled if he/she provides proof of continuous coverage from the date coverage terminated. If such Dependent's Fund coverage under the Fund terminates again, he/she will not be permitted to reenroll. Voluntary termination of coverage is not a COBRA qualifying event.

(e) In the event of the death of a Participant, a Dependent Child who is not the dependent of a Surviving Spouse of the Participant may continue coverage until the Participant's Bank is exhausted (at the monthly cost charged Active Participants) and thereafter elect to continue coverage either:

(1) Under COBRA, as set forth in Article 9; or

(2) By self-paying at the monthly rate charged to Surviving Spouses until the earlier of: (a) the month in which such self-payments are not timely received by the Fund Office, or (b) first of the month following the month the Dependent Child reaches age 26.

If coverage is not timely elected under either option, it cannot thereafter be elected. Once elected, when coverage terminates under either option, it cannot be reinstated.

(f) Personal data on each Participant and Dependent shall be maintained by the Plan Administrator. The following data shall be required: marriage license, birth certificates, adoption papers, divorce decree, Social Security number, and any other documents to show actual dependency. Appropriate forms shall be furnished upon request in order to change or correct the Fund's information and data records. A Participant must notify the Fund Office, in writing, of any change of address.

2.11 Termination of Coverage

The coverage for benefits provided by this Plan shall terminate the earlier of:

(a) On the date the Plan is terminated; or
(b) On the date the Covered Person ceases to be eligible for coverage under the terms of the Plan.

ARTICLE 3 - BENEFITS

3.1 Death and Accidental Death and Dismemberment

(a) Active Participants

A fully insured Death benefit in the amount of $100,000 and an Accidental Death and Dismemberment benefit in the amount of $100,000 are provided for Active Participants. This benefit is fully insured under a life insurance policy issued by United Mutual of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska, 68175, 1-800-775-8805. Further information, including limitations and exclusions to coverage and

beneficiary designations, is set forth in the life insurance policy which is available upon request at the Fund Office. In the event of any discrepancy between any terms of this Plan and the insurance policy, the terms of the insurance policy control.

(b) Retirees

A self-insured death benefit in the amount of $5,000 is payable to a Retiree upon the death of his/her Spouse. A copy of the Death Certificate of the Spouse of an eligible Covered Retiree must be presented to the Fund Office for payment of this benefit. The death benefit is payable ONLY to the surviving Covered Retiree. **If the Covered Retiree predeceases his Spouse, no benefit is payable.**

3.2 Burial Benefit

(a) Active Participants

A self-insured burial benefit is payable upon the death of an Active Participant or an Active Participant's Spouse in the amount of $5,000.00.

Notwithstanding, the benefit will be paid even if eligibility is lost in the following circumstances:

(1) an individual who loses coverage as an Active Participant because he becomes employed by the International Association of Bridge, Structural, Ornamental, and Reinforcing Iron Workers of America, AFL-CIO, a building or construction trades council, a metal trades council, a central labor union, a state federation of labor, state or federal department of labor, the American Federation of Labor-Congress or Industrial Organization or any of its departments, shall continue to be eligible for the Burial Benefit so long as he remains employed in such capacity; or

(2) an individual who dies as a result of on-the-job injuries suffered when he was an Active Participant, even though he/she was not eligible at the time of death; or

(3) upon the death of an Active Employee who was not eligible for benefits at the time of his death, provided he was eligible for benefits in at least one month out of the three month period immediately prior to his death.

The Fund will pay for burial expenses upon receipt of proper notification of death. The Fund will pay the burial expenses directly or to the individual who paid such expenses upon receipt of paid bills. If the burial expenses are less than $5,000, the difference will be paid to the Participant's Beneficiary or in the case of the death of a Participant's Spouse, the difference will be paid to the Participant. Before the Fund pays such difference, it must be satisfied that all burial expenses have been incurred and paid.

(b) Retirees

A self-insured burial benefit is payable upon the death of a Retiree in the amount of $5,000.00.

The burial benefit is payable upon the death of a Covered Retiree provided that at the time of his death he was receiving either (1) a Normal, Early, Special or Disability pension benefit from the Iron Workers' Local No. 25 Pension Fund, or (2) a pension from

the International Association of Bridge, Structural Ornamental, and Reinforcing Iron Workers of America, AFL-CIO, and his eligibility for such international pension benefit was predicated primarily on his participation in such plan while he was under the jurisdiction of the Union.

The Fund will pay for burial expenses upon receipt of proper notification of death. The Fund will pay the burial expenses directly or to the individual who paid such expenses upon receipt of paid bills. If the burial expenses are less than $5,000, the difference will be paid to the Retiree's Beneficiary. Before the Fund pays such difference, it must be satisfied that all burial expenses have been incurred and paid.

3.3 Loss of Time Benefits (Weekly Disability)

(a) Amount

Loss of Time benefits are available for Active Participants in the amount of $324.85/week (subject to F.I.C.A. withholding).

(b) Loss of Time Benefits - Non-Occupational

An Active Participant may receive the current weekly benefit for each week of Disability for the first 13 weeks of Disability, even if he otherwise loses his eligibility during this 13 week period, provided he was eligible for benefits at the time of application and at the time the injury occurred or the illness commenced. If still disabled, an additional 13 weeks of Disability will be paid provided he/she is an Active Participant at the outset of such extension and was also eligible under the Plan sometime in each of the three preceding Plan Years.

Benefits under this section are also payable to female Participants who are unable to work due to pregnancy.

A Participant may receive a maximum of 26 weeks of benefits in a 24 month period.

(c) Loss-of-Time Benefits - Occupational

An Active Participant is eligible for six weeks of Disability for the same injury or illness.

(d) Loss-of-Time Benefits – Occupational - Apprentices Who Are Not Active Participants

An Apprentice, not otherwise eligible, is eligible for occupational Disability for six weeks provided he is indoctrinated into the Iron Workers Local 25 Apprenticeship Program and remains an apprentice in good standing.

(e) Payment of Loss-of-Time Benefits

In order for payment of Loss-of-Time Benefits to begin, the Fund must receive written verification from the Participant's doctor that he is Disabled. The Trustees have the right

to condition the commencement or continuation of benefits on an independent medical examination at any time, to be paid for by the Fund.

Benefits begin with the first day of Disability due to injury. Benefits begin with the eighth day of Disability due to illness or pregnancy, unless the member is hospital confined during the first seven days, then benefits commence with the first day of hospitalization.

If a Participant received non-occupational weekly Loss-of-Time Benefits and it is subsequently determined that the period of claimed Disability was the result of injury or illness arising out of or in the course of the Participant's employment, the Fund shall be entitled to recover the Loss-of-Time Benefits paid for such period. This right to reimbursement shall be exercised in accordance with the applicable provisions of the Michigan Workers' Disability Compensation Act.

If a Participant with an occupational Disability is denied workers' compensation, he: (1) must retain the services of an attorney and file his claim with the Workers' Compensation Bureau, and (2) sign an assignment to the Fund confirming that he will repay the Iron Workers' Health Fund of Eastern Michigan for any benefits paid on his behalf as a result of his work-related injury.

Loss-of-Time benefits are not payable for: (1) an accident with a motorized vehicle licensed by any state; or (2) an attempted suicide or any intentionally self-inflicted injury or illness, unless it was the result of a physical or mental condition. Loss-of-Time benefits will not be paid if the Participant owes money to the Fund.

3.4 Medical Coverage

(a) Medical

Self-insured medical benefits, including hospitalization, are provided for Participants and their Covered Dependents. These benefits are administered by Blue Cross Blue Shield of Michigan (BCBSM), 600 E. Lafayette, Detroit, MI 48226, (877) 790-2583. An on-line Benefit Guide and Summary of Group Health Care Benefits ("BCBSM Documents") is available at www.bcbsm.com. You will be required to log into Member Secured Services.

(b) Exclusions and Limitations

In addition to any exclusion and/or limitation set forth in the BCBSM Documents, the following services and benefits are not covered by the Fund:

(1) Services provided before the effective date of coverage.

(2) Services provided after the effective date of termination of coverage.

(3) Charges that exceed reasonable and customary level.

(4) Services or supplies that are not medically necessary.

(5) Physical examinations that are considered premarital or for pre-employment, school, sports, etc.

(6) Charges for use of any treatment, supply, device or facility which (a) does not have required governmental approval, or (b) is found to be experimental, investigative or not a generally accepted medical practice.

(7) Services that are not health care services (personal and convenience, completion of forms, cost of transportation except covered ambulance services).

(8) Services, care, supplies or devices not prescribed by a physician and not directly related to the diagnosis or treatment of illness or injury.

(9) Services by persons not qualified or licensed.

(10) Charges for services rendered by a Covered Participant's immediate family (i.e., Spouse, brother, sister, parent, or child). Charges that the Covered Participant or Retiree has no obligation to pay are also excluded, but not the cost of services or supplies provided by a state's Medicaid program.

(11) Any part of the normal charges for services or supplies which the provider offers to waive, such as part that would not be paid by Fund due to its deductible or co-payment provisions.

(12) Services for which a charge would not have been made had no coverage existed; services that the Covered Participant or Retiree is not legally obligated to pay.

(13) When a private room is occupied, benefits are limited to the semi-private room rate.

(14) Care and treatment billed by a hospital for non-emergency admissions on Friday or Saturday. This exclusion does not apply if surgery is performed within twenty-four (24) hours of admission.

(15) Services provided by Employer facilities.

(16) Services available without cost.

(17) An injury or illness for which the Covered Participant is eligible for benefits under any workers' compensation plan.

(18) Medical, hospital, surgical or loss-of-time benefits resulting from a motorcycle or motor vehicle accident.

(19) An elective abortion performed when the mother's life would not be in danger if the fetus were carried to term. This does not exclude coverage for medical complications which arise from and after such abortion.

(20) Maternity benefit is limited to the Covered Participant or Covered Participant's

Spouse.

(21) Pregnancy expenses relating to surrogate mothers, including coverage for medical complications which arise from and after such pregnancy.

(22) Amniocentesis and/or genetic counseling will be approved on an individual basis in situations where the attending physician recommends that such procedure is a medical necessity; based on age, etc.

(23) Artificial insemination, in-vitro fertilization or embryo transfer, and any charges for infertility testing.

(24) Surgery to reverse voluntary sterilization.

(25) Charges for oral contraceptives, contraceptive materials, devices and infertility drugs which are not approved by the FDA and required to be covered by law.

(26) Services, supplies or treatment related to sex transformation.

(27) Charges for surgical removal of silicone breast implants unless medically necessary.

(28) Cosmetic surgery, which means surgery performed to improve appearance rather than to correct a functional disorder. Functional disorders do not include mental or emotional distress related to a physical condition but do include the correction of a newborn child's birth defect.

(29) Reconstructive surgery unless due to (a) an injury sustained while under this Plan, (b) an illness, such as breast cancer, or (c) a newborn child's birth defect.

(30) Care and treatment for male pattern baldness.

(31) Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages, devices for simulating natural female body contours, except for post-mastectomy surgery, non-prescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

(32) Non-Essential home installed conveniences even when prescribed by a physician.

(33) Charges for services or supplies not medically necessary.

(34) Charges for food supplements and vitamins, other than those required to treat metabolic disease.

(35) Hypnosis, except when performed by a physician in lieu of anesthesia.

(36) Custodial care, which means care furnished to aid in the activities of a normal daily life, such as help to walk, bathe, eat or dress.

(37) An injury or illness arising out of the commission of a felony by the Covered Participant, Retiree or Dependent; however, this exclusion shall not operate to deny coverage for injuries that result from an act of domestic violence. No benefits will be provided for services or supplies prohibited by law. Also excluded from coverage is an injury or illness resulting from war, whether or not a declared war. Charges in a hospital owned and operated by the United States Government and any services and supplies eligible for payment by a governmental or charitable program, except as required by law, are also excluded.

(38) Charges incurred in connection with any intentionally self-inflicted injury or illness, unless it was the result of a physical or mental condition. This exclusion does not apply to Death and Burial Benefits, as set forth under Article 3, when either a Participant, Retiree or their Spouse commits suicide.

(39) Charges for travel outside the United States without Plan approval if sole purpose is to obtain medical services, supplies or drugs.

(40) Weight loss programs.

(41) Radial keratotomy, photo-refractive keratotomy, or other eye surgery to correct nearsightedness.

(42) Hospital and professional services for dental treatment, other than repair of accidental injuries, are limited to multiple extractions, removal of one or more unerupted teeth, alveloplasty or gingivectomy, and only when performed in a hospital when a concurrent hazardous medical condition exists.

(43) Charges for non-drug supplies.

(44) Out-of-network ambulance service providers shall be covered at the in-network rate only if there are no in-network ambulance service providers available.

(45) No benefits are payable under this Plan unless the claim is incurred while the Covered Participant or his Dependent is eligible under the Plan. However, in a situation where a Covered Person is hospitalized while eligible under the Plan, is receiving benefits, and becomes ineligible while hospitalized, the Plan will continue to provide benefits until such time as the hospitalization confinement is ended.

(46) Any claims that are incurred a year or more prior to date that they are submitted for payment will not be eligible for payment.

(c) Medicare Eligibility and Coverage

(1) Medicare Eligibility

All Participants who are covered by Medicare must provide the Fund office with a photocopy of their Medicare card at the time of receipt.

Medicare Parts A and B

In order for a Covered Retiree, or his Spouse, who is age 65 years or older to obtain maximum health benefits, he or she must apply for and obtain Parts A and B of Medicare. (Part A is for hospitalization benefits. Part B is for medical insurance.) This is because upon attainment of age 65, even if Medicare has not been obtained, medical coverage under the Fund is limited as set forth below in section (2). Thus, it is strongly recommended that a Retiree, his Spouse, or an Active Employee contemplating retirement, contact the Social Security Administration at least 4 months before they will reach age 65.

Disability

An individual becomes eligible for Medicare, regardless of age, after receiving Social Security Disability payments for 2 years. Any Participant or Dependent who is eligible to apply for Medicare due to disability is required to do so. Once Medicare eligibility could have been obtained, even if it is not, medical coverage under the Fund is limited as set forth below in section (2). Thus, it is strongly recommended that the Social Security Administration be contacted as soon as possible regarding Social Security Disability payments.

Dialysis

After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Participant or Dependent receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once Medicare eligibility could have been obtained, even if it is not, the Plan will be primary (i.e. will provide benefits) only to the extent required by the Medicare's Secondary Payer rules. The Plan will not pay benefits which otherwise would have been paid by Medicare once the Participant or Dependent would have otherwise been eligible for Medicare.

(2) Coverage for Medicare Eligible Participants and Dependents

In lieu of medical benefits provided under section 3.4(a), Supplemental Coverage only is provided to Medicare eligible Participants and Dependents. These benefits are administered by Blue Cross Blue Shield of Michigan (BCBSM), 600 E. Lafayette, Detroit, MI 48226, (877) 790-2583. An on-line Benefit Guide and Summary of Group Health Care Benefits ("BCBSM Documents") is available at www.bcbsm.com. You will be required to log into Member Secured Services.

Supplemental Coverage is also subject to the exclusions set forth in section 3.4(b).

3.5 Prescription Drug Benefit

The Fund provides self-funded prescription drug benefits administered by EnvisionRxOptions, 2181 E. Aurora Rd., Twinsburg, Ohio 44087, (800) 361-4542. The Fund covers only legally prescribed Federal Legend Drugs.

(a) Co-payments

	Non Formulary Brand	Formulary Brand	Generic
Retail	$30	$15	$10
Mail	$60	$30	$20

Formulary Brands are those drugs provided through the Envision Drug Formulary.

The co-pay charges for Mail prescriptions are based on a 3-month supply. The co-pay for Retail prescriptions are for prescriptions not exceeding a one month supply.

(b) Exclusions

The following is excluded from prescription drug coverage:

(1) Any drug prescribed for any of the reasons set forth in the Medical exclusions, see section 3.4(b).

(2) Any drug purchased at Sam's Club or Wal-Mart.

(3) Any drug which is not a Federal Legend Drug.

(4) Sexual dysfunction drugs are only covered if a Participant presents documentation from a physician, in addition to a prescription, stating that the drugs are medically necessary, in which case they will be covered with a quantity limit of 10 pills per 30 days. Notwithstanding, sexual dysfunction drugs will be covered if medically necessary to treat a condition other than ED.

(5) Over the counter medications, other than over the counter preventive medications required to be provided under the Affordable Care Act.

(6) Weight loss drugs.

(7) Fertility drugs.

(8) Cosmetic drugs.

3.6 Dental Benefits

(a) Choice of Dental Plans

The Plan provides Participants with a choice between a traditional self-insured dental plan administered by Delta Dental Plan of Michigan, P.O. Box 30416, Lansing, Michigan 48909, (800) 482-8915, or a fully insured DMO plan provided by Golden Dental Plans, 29377 Hoover Rd., Warren, Michigan 48093, (800) 451-5918

Participants will only be allowed to change Plans one time annually.

(b) Traditional Dental Plan (Delta Dental)

(1) Coverage

The annual maximum dental benefit per individual is $1,200.00. This annual limit does not apply to Children up to the age of 18.

All dental procedures set forth below will be paid in accordance with the prevailing schedule under the Delta Dental Plan.

IMPLANT

A maximum benefit per dental implants of $1,500, to include anesthesia/sedative and any hospital charges, but in no event shall such benefit exceed a lifetime maximum per eligible dependent and Participant of $6,000. (All claims for dental implants must be submitted to either Delta Dental or Golden Dental for pre-approval.) Effective May 1, 2011, this lifetime limit does not apply to Children up to the age of 18.

ORTHODONTIC SERVICES OR SUPPLIES

A benefit equal to 75% of reasonable and customary charges made for such services and supplies which are rendered while the individual is eligible, but in no event shall such benefits exceed a lifetime maximum of $1,500.00 per eligible Participant and Dependent.

PERIODONTIC SERVICES OR SUPPLIES

A benefit equal to 75% of reasonable and customary charges made for such services and supplies which are rendered while the individual is eligible with maximum annual benefit per individual of $1,200. Effective May 1, 2011, this annual limit does not apply to Children up to the age of 18.

ALVELOPLASTY

A benefit equal to 100% of reasonable and customary charges up to a maximum of $150 per quadrant with an extraction and 100% of reasonable and customary charges up to a maximum of $644 if there is no extraction.

CANCER TREATMENT

Crowns will be covered where teeth need to be crowned to prevent infections during cancer treatment.

NO OTHER BENEFITS ARE PAYABLE FOR TRADITIONAL DENTAL PLAN SERVICES THAT ARE NOT SPECIFICALLY LISTED IN THIS SECTION.

(2) Exclusions and Limitations

Coverage is not provided for the following:

(i) Charges for full mouth X-ray series with bitewings shall be allowed only to the extent of one such series every five years.

(ii) Charges for bitewings and all other X-rays shall be allowed only to the extent of one every 12 months.

(iii) Charges for oral examinations shall be allowed only to the extent of one every six months.

(iv) Charges for prophylaxis shall be allowed only to the extent of one such treatment every six months.

(v) Charges for biopsy of oral tissue shall be allowed only to the extent of those charges made for the actual excision.

(vi) Charges for relining procedures in connection with full or partial dentures shall be allowed only to the extent of one such procedure per denture every two years.

(vii) Charges for a full or partial denture shall be allowed only once every five years.

(viii) Occlusal Guard payable once every three years.

(ix) Charges for replacement of teeth on persons less than age 19 shall be allowed only to the extent that they are made for the replacement of anterior teeth.

(x) Charges for topical application of fluoride shall be allowed every six months prior to the age 19.

(xi) A prosthodontic appliance, crown or bridge is not payable more than once in a five year period. This five year period will be measured from the date on which the existing appliance was last supplied.

(xii) Any procedure for which medical coverage would be denied under section 3.4(b).

(c) Golden Dental

All information regarding coverage and benefits is set forth in the Golden Dental Plan Benefits Guide, available at the Fund Office upon request.

3.7 Vision Benefits

The Fund provides participants with self-insured vision benefits. These benefits are administered by Blue Cross Blue Shield of Michigan (BCBSM), 600 E. Lafayette, Detroit, MI 48226, (877) 790-2583. An on-line Benefit Guide and Summary of Group Health Care Benefits ("BCBSM Documents") is available at www.bcbsm.com. You will be required to log into Member Secured Services.

3.8 Retiree Benefit Options

Retirees may elect the following options, for which a lower self-payment rate will be charged:

(a) Medical-Only Option

Medicare and non-Medicare Retirees may elect:

(1) Medical benefits under section 3.4;
(2) NO Dental coverage under section 3.6; and
(3) NO Prescription Drug coverage under section 3.5.

(b) Coordinated Medicare HMO Option

Medicare eligible Retirees may elect a Medicare HMO coordinated policy offered by the Fund in lieu of medical benefits and prescription drug benefits under sections 3.4 and 3.5. Information regarding such benefits is set forth in the HMO guides. This option may only be elected if the Retiree and all his eligible Dependents are Medicare eligible.

Any Dependent of a Retiree is covered under the same option elected by the Retiree.

ARTICLE 4 - COORDINATION OF BENEFITS

4.1. Application

No duplication of benefits will be paid under the Plan for any Covered Person who is eligible for benefits under any other insurance program. The coordination of such benefits is governed by the provisions below. The provisions of this Article shall not apply to individual insurance purchased by an Active Participant.

4.2. Coordination

Plan rules regarding coordination:

(a) Another plan without a coordinating provision shall always be deemed to be the primary Plan.

(b) If another plan has a provision that makes this Plan primary, then:

(1) The plan covering the patient directly rather than as a dependent is primary and the other is secondary.

(2) If a child is covered under both parents' plans, the plan that covers the parent whose birthday occurs earlier in the calendar year shall be considered the primary plan.

(3) If neither (1) nor (2) applies, the plan covering the patient longest is primary.

(c) With respect to dependents of divorced parents, the following rule applies:

(1) if there is a court decree, the plan that covers the dependent of the parent with responsibility to do so pursuant to such decree shall be primary;

(2) if (1) does not apply:

(A) the plan covering the parent with custody of the dependent shall be considered the primary plan;

(B) the plan covering the spouse, if any, of the parent with custody of the dependent will be secondarily liable; then

(C) the plan covering the parent without custody shall be considered last.

(3) if neither (1) nor (2) apply, coordination of benefits shall be determined in accordance with the Michigan Coordination of Benefits Act (MCL 550.251, et seq.), or any successor law.

(d) Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) Rules when applicable.

The following addresses specific situations where MSP Rules are applicable:

(1) Coordination with Coverage By Virtue of Current Employment Status

In the event a Medicare-eligible Covered Person is eligible under one plan as a dependent (for example, a dependent of an actively employed spouse) and another plan other than as a dependent (for example, a Retiree under this Plan), and as a result of the Medicare Secondary Payer Rules, Medicare is

(A) Secondary to the plan covering the Covered Person as a dependent, and
(B) Primary to the plan covering the Covered Person other than as a dependent,

then benefits of the plan covering the Covered Person as a dependent are primary to those of the plan covering the Covered Person other than as a dependent. For example, if a Retiree is covered as a dependent under a plan covering his/her Spouse as an active employee, then the benefits of the Spouse's plan are primary to the benefits provided by this Plan (and in no event will this Plan pay more than the benefits otherwise provided by the Plan in the absence of any other coverage).

(2) End Stage Renal Disease

After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Participant or Dependent receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e. will provide benefits) only to the extent required by Medicare's Secondary Payer rules.

(e) With respect to a Participant or Dependent on COBRA Continuation of Coverage from any other plan, this plan will be secondary.

(f) This Plan is primary when Medicaid is involved as the other carrier.

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

Any person claiming benefits under the Plan shall (1) furnish to the Plan Administrator such information as may be necessary to administer the coordination provisions and (2) abide by his or her primary Plan's rules and requirements before a claim may be submitted to the Fund.

Whenever payments have been made by the Plan with respect to allowable expenses in a total amount which is at any time in excess of the maximum amount of payment necessary at that time to satisfy the requirements of this provision, the Fund has the right to recover such excess payments from among one or more of the following: any persons to or for, or with respect to whom, such payments were made (subject to Article 15); any insurance companies; or any other organizations.

ARTICLE 5- THIRD PARTY LIABILITY

5.1 Subrogation

(a) Application

Subrogation means the Plan has the right to recover from a Participant or Dependent those amounts paid by the Plan for medical care or other expenses due to an injury caused by a third party (for example, another person or company). To the extent benefits are

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

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

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

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

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

(b) Conditions to Payment of Benefits

If a Participant or Dependent sustains an injury caused by a third party, or is being denied workers compensation as there is a dispute as to whether the claims are work related, the Plan will pay benefits related to such injury (provided such benefits are otherwise properly payable under the terms and conditions of the Plan), provided all the following conditions are met:

(1) As soon as reasonably possible, the Participant or Dependent must notify the Fund Administrator that he or she has an injury caused by a third party.

(2) Prior to the receipt of benefits for such injury, the injured Participant or Dependent must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the injury. If such assignment is not made before the receipt of benefits, then the receipt of benefits automatically assigns to the Plan any rights the Participant or Dependent may have to recover payments from any third party or insurer. (If the recovery so assigned exceeds the benefits paid by the Plan, such excess shall be delivered to the Participant or Dependent or other person as required by law.)

(3) The Participant or Dependent does not take any action that would prejudice the Plan's subrogation rights.

(4) The Participant or Dependent cooperates in doing what is necessary to assist the Plan in any recovery, which includes but is not limited to executing and delivering all necessary instruments and papers.

(c) Right to Pursue Claim

The Plan's subrogation rights allow the Plan to directly pursue any claims the Participant or Dependent has against any third party, or insurer, whether or not the Participant or Dependent chooses to pursue that claim.

(d) Enforcement

- If it becomes necessary for the Plan to enforce this provision by initiating any action against the Participant or Dependent, the Participant or Dependent agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome. The Plan shall be entitled to enforce this provision by way of an equitable restitution, constructive trust, or any other equitable remedy.
- At the Plan's option, it may enforce this provision by deducting amounts owed from future benefits, to the extent allowed by law.

5.2 Workers' Compensation

The Plan does not pay any claims covered by Workers' Compensation. The Plan will only cover those claims which:

(a) Workers' Compensation denies because they are not work related; and
(b) Are covered under the terms of the Plan.

If a Participant or Dependent receives any benefits under this Plan that are properly payable by workers' compensation, then this Plan must be indemnified by the Participant or Dependent for the amount paid by the Plan for such benefits. The Plan shall be indemnified out of the proceeds received from the Participant or Dependent in settlement of any workers' compensation claim. The Participant must complete any forms required by the Fund to preserve its rights under this section.

ARTICLE 6 - RECIPROCITY

The Plan is authorized to enter into and abide by reciprocity agreements.

ARTICLE 7 – INTERNAL CLAIMS AND APPEALS PROCESS

For benefits provided under the fully insured policies, such as life insurance, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits, and not by the provisions of Articles 7 and 8.

7.1 Types of Claims Covered

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

- Urgent health claims: claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;

- Pre-service health claims: for example, pre-certification of a hospital stay or predetermination of dental coverage;
- Post-service health claims: for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician; and
- Concurrent claims: claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by plan amendment or plan termination.
- Rescission of Coverage: retroactive cancellation of coverage.

7.2 Initial Submission of Claims

Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, claims should be submitted to Blue Cross Blue Shield of Michigan, the prescription benefit manager, or the dental network provider as applicable. All other claims for benefits should be submitted to the Plan Office. A claimant should contact the Plan Office for applicable forms.

7.3 Notice That Additional Information is Needed to Process Claim

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

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

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

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

7.4 Avoiding Conflicts of Interest

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

7.5 Initial Decision on a Claim

(a) Additional Evidence

(1) The Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the

adverse benefit determination is required to be provided under (b), below, to give the Claimant a reasonable opportunity to respond prior to that date; and

(2) Before the Fund can issue an initial benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), to give the claimant a reasonable opportunity to respond prior to that date.

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

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

7.6 Adverse Benefit Determination

Notice of an adverse benefit determination will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- the internal rule or similar guideline relied upon in denying the claim;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of available internal appeal process and how to initiate the external review process for an adverse benefit determination which involves a medical condition of the claimant for which the timeframe for completion of the internal appeal would jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function;

- if applicable, a statement of the Claimant's right to bring a civil action after further denial on appeal or external appeal; and
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272, or the Michigan Office of Financial and Insurance Regulation, MiCHAP, P.O. Box 30220, Lansing, Michigan 48909, (877) 999-6442.

7.7 Internal Appeals

(a) Adverse Benefit Determinations

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

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

(b) Submission of Internal Appeals

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

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

The Plan will continue to provide coverage pending the outcome of an internal appeal.

The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Appeals should be submitted as follows:

Appeals Regarding Benefits Administered By Blue Cross Blue Shield:

For those claims administered by BCBSM, submit appeals to the address set forth on the BCBSM denial. However, appeals involving eligibility for benefits under the terms of the Plan should be submitted to the Plan Office.

Appeals Regarding Benefits Not Administered by Blue Cross Blue Shield:

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

(c) Time for Submitting Internal Appeals

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

- For Urgent Health Claims – 180 days after receiving denial.
- For Pre-Service Health Claims - 180 days after receiving denial.
- For Post-Service Health Claims – 180 days after receiving denial.
- For Concurrent Claims – Claimant must be given enough time to appeal decision before termination effective.
- For Disability Claims – 180 days after receiving denial.

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

(d) Notice of Decision on Internal Appeal

The notice of a decision on appeal will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- the internal rule or similar guideline relied upon in denying the claim;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of the external review process, including information regarding how to initiate the external review process;
- a statement of the Claimant's right to bring a civil action after a further denial on appeal or external appeal, if applicable; and
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272, or the Michigan Office of Financial and Insurance Regulation, MiCHAP, P.O. Box 30220, Lansing, Michigan 48909, (877) 999-6442.

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

- For Urgent Health Claims – 72 hours after receiving appeal.
- For Pre-Service Health Claims – 30 days after receiving the appeal.
- For Post-Service Health Claims: The Trustees shall decide the appeal at a Board Meeting.*

- For Concurrent Claims – Prior to termination of previously approved course of treatment.
- For Disability Claims – The Trustees shall decide the appeal at a Board Meeting.*

  * Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third board meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees decision on appeal no later than 5 days after the decision is made.

7.8 Deemed Exhaustion of Internal Claims and Appeals Processes

If the Plan fails to adhere to all of the requirements in this Article 7 with respect to a claim, the Claimant is deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Article 8. The Claimant is also entitled to pursue any available remedies under Section 502(a) of ERISA, or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. Notwithstanding, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.

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

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

7.9 Discretion of Trustees

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

7.10 Limitations of Actions

For adverse benefit denials not subject to external review, no action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal. For adverse benefit denials subject to external review, a request for external review must be made within the time limitations provided in Section 8.2. In the event a Claimant does not abide by these time limitations, he/she waives his/her right to any further review of an adverse determination, including waiving his/her right to have the determination reviewed in a court of law.

ARTICLE 8: EXTERNAL REVIEW PROCESS

8.1 Eligibility for External Review

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

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

Claims administered by BCBSM will be handled through the BCBSM External Review Process.

8.2 Request for External Review

A Claimant must file a request for an external review with the Fund within 4 months after receipt of a notice of the final internal appeal. If he/she fails to do so, he/she waives the right to an external review or review in a court of law. The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an external review.

8.3 Preliminary Review

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

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

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

8.4 Referral to Independent Review Organization

(a) The Fund must assign an independent review organization (IRO) to conduct the external review.

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

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

(c) Within five business days after the date of assignment, the Fund will provide to the IRO documents and any information considered in making the final decision on internal appeal, but failure to do so will not delay the conduct of the external review. If the Fund fails to timely provide this information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination and notice of such decision will be provided by the IRO to the Claimant and Fund within one business day.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1) The Claimant's medical records;
2) The attending health care professional's recommendation;
3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;
4) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the

Federal government, national or professional medical societies, boards, and associations;

6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(e) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and deliver its decision to the Claimant and the Fund.

(f) The IRO's decision notice will contain:

1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
2) the date the IRO received the assignment and the date of the IRO decision;
3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
6) A statement that judicial review may be available to the Claimant; and
7) Current contact information, including phone number, for any applicable state office of health insurance consumer assistance or ombudsman established under PHS Act §2793.

(g) The external reviewer's decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law. The Plan must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

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

8.5 Expedited External Review

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

(a) An adverse benefit determination which involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

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

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

Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO as outlined in Section 13A.4, above. The Plan must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

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

8.6 Discretion of Trustees

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

8.7 Limitations of Actions

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

ARTICLE 9 - COBRA

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

9.2 Nature of COBRA Continuation Coverage

(a) COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A Participant, his Spouse, and dependent Children could become qualified beneficiaries if coverage under the Fund is lost because of the qualifying event. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

(b) A Participant will become a qualified beneficiary if coverage is lost under the Fund because either one of the following qualifying events happens:

(1) Hours of employment are reduced such that hours are insufficient to maintain eligibility, or
(2) Employment ends for any reason other than gross misconduct.

(c) The Spouse of a participant will become a qualified beneficiary if coverage is lost under the Fund because any of the following qualifying events happens:

(1) Death of spouse;
(2) Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;
(3) Spouse's employment ends for any reason other than his or her gross misconduct;
(4) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
(5) Divorce from the participant.

(d) Dependent Children become qualified beneficiaries if coverage is lost under the Fund because any of the following qualifying events happens:

(1) The parent-participant dies;
(2) The parent-participant's hours of employment are reduced such that dollars in the dollar bank are insufficient to maintain eligibility;
(3) The parent-participant's employment ends for any reason other than his or her gross misconduct;
(4) The parent-participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
(5) The parents become divorced; or
(6) The child stops being eligible for coverage under the Fund as a "Dependent Child."

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

9.4 Participant/Spouse Obligation to Give Notice to the Fund of Some Qualifying Events

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

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

9.5 How COBRA Coverage Is Provided

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

The COBRA notice will contain information regarding the premium that must be paid for COBRA coverage, which is 102% of the cost to the Fund for such coverage. If the period of COBRA coverage is extended due to disability, discussed below, the premium is 150% of the cost to the Fund.

Coverage under the Fund will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium.

9.6 Duration of COBRA Coverage

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

(a) When the qualifying event is the death of the participant, the participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce, or a dependent

child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

(b) When the qualifying event is the end of employment or reduction of the participant's hours of employment, and the participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement.

For example, if a participant becomes entitled to Medicare 8 months before the date on which his eligibility terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

(c) In all other events, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

(1) Disability Extension

- If the qualified beneficiary or anyone in his family covered under the Fund is determined by the Social Security Administration to be disabled and notifies the Plan Administrator in a timely fashion, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.
- The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.
- The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

(2) Second Qualifying Event Extension

If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Fund. This extension may be available to the spouse and any dependent children receiving continuation coverage if the participant or former participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the Fund as a

dependent child, but only if such event would have caused the spouse or dependent child to lose coverage under the Fund had the first qualifying event not occurred. The Plan Administrator must be notified of this second qualifying event within 60 days of such event.

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

9.8 Premium Payment for COBRA Coverage

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

Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. Coverage will be terminated the first day of the month of coverage for which payment has not yet been received, and rectroactively reinstated if such payment is received within the grace period. If payments are not made by the end of the grace period, coverage will terminate and the qualified beneficiary will not be given an opportunity to reinstate coverage.

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

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

9.9 Scope of Coverage

If a Qualifying Event occurs, the Plan Administrator will offer each Qualified Beneficiary an opportunity to elect to continue the Plan coverage provided below.

COBRA Continuation Coverage will be offered as follows:

- Combined Plan Coverage, which is all of the Plan medical coverage the Qualified Beneficiary received immediately prior to the Qualifying Event; or
- Core Coverage, which is Combined Plan Coverage other than coverage for Vision and Dental benefits.

Exclusions: The death, accidental death and dismemberment, loss-of-time and burial benefits are not included in Combined Plan or Core Coverage.

A COBRA participant will be permitted to change his or her election of Continuation Coverage (core or combined) one time during his period of coverage. Further, qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated active employees.

9.10 Enrollment of Dependents During Period of COBRA Coverage/Coverage Options

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

9.11 Qualified Medical Child Support Orders: If a Child is enrolled in the Fund pursuant to a qualified medical child support order while the Participant was an active employee under the Fund, he is entitled to the same rights under COBRA as any dependent Child.

9.12 Termination of COBRA Coverage

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

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

9.13 Keep the Plan Office Informed of Address Changes: A participant or his spouse must keep the Plan Administrator informed of any changes in the addresses of family members and is advised to keep a copy of any notices sent to the Plan Administrator.

ARTICLE 10 - QUALIFIED MEDICAL SUPPORT ORDER

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

ARTICLE 11 – FMLA

Certain Employers are required to continue to make contributions to the Fund on behalf of an employee while such employee is on a medical leave of absence pursuant to the federal Family and Medical Leave Act ("FMLA"). Requests for FMLA leave must be directed to such Employer; the Plan cannot determine whether or not a person qualifies for FMLA leave. If a dispute arises between a Participant and his Employer concerning eligibility for FMLA leave, the Participant may continue health coverage by making COBRA payments. If the dispute is resolved in the Participant's favor, the Plan will refund COBRA payments made by the Participant upon receipt of the FMLA-required contributions from the Employer.

If the Employer continues a Participant's coverage during an FMLA leave and the Participant fails to return to work, he may be required to repay the Employer for all contributions paid to the Plan for such coverage during the leave. The Fund will not return any contributions to the Employer. Failure to return to work at the end of a FMLA Leave may constitute a Qualifying Event under COBRA.

ARTICLE 12 - HIPAA PLAN SPONSOR PROVISIONS

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

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

ARTICLE 13 - INTERPRETATION OF PLAN DOCUMENTS

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

ARTICLE 14 - CHANGES TO OR TERMINATION OF COVERAGE

The Trustees reserve the right to amend, alter, or terminate any or all coverages hereunder, for any or all classes of Participants or Dependents, at any time.

ARTICLE 15 – RESCISSION OF COVERAGE

Rescission means the retroactive cancellation of coverage. Where coverage was provided as a result of fraud or an intentional misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan will rescind coverage. Failure to inform the Fund Office of a divorce or any other event which makes a Dependent ineligible for coverage is considered fraud or intentional misrepresentation of material fact. A thirty day notice of rescission will

be provided.

In the event coverage is rescinded, in addition to any legal and equitable means of recovery available, the Plan has the right to pursue the Participant or Dependent, jointly and severally, for the full amount paid for such coverage from the date of cancellation, including all costs and attorney's fees, expended in collecting the amount owed. At the Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered.

Nothing in this section limits the rights of the Plan to prospectively terminate coverage where such coverage was previously provided as a result of a mistake, intentional misrepresentation, or fraud. Further, nothing in this section limits the right of the Plan to cancel coverage retroactively for failure of a Participant or Dependent to make a self-payment, where there has been a reasonable delay in terminating coverage due to administrative recordkeeping.

ARTICLE 16 – REVERSION

In the event any payment issued by the Fund, for any reason, has not been cashed for a period of 24 months, or such lesser time set as forth on the check issued by the Fund, such payment is void and reverts to the Plan as a plan asset.

ARTICLE 17 – OTHER PROVISIONS

A. **Type of Administration/Plan Administrator/Plan Sponsor**
The Board of Trustees of the Iron Workers' Health Fund of Eastern Michigan is the Plan Administrator and Plan Sponsor. As such, the Trustees are responsible for overall Plan administration. There are three Trustees appointed by the Union and three Trustees appointed by the Association. The current Trustees are:

Jack O'Donnell, Secretary Iron Workers Local 25 P.O. Box 965 Novi, MI 48376-0965	John Rieckhoff, Chairman C.L. Rieckhoff Co., Inc. 26265 Northline Road Taylor, MI 48180
Steve Gulick Iron Workers Local 25 P.O. Box 965 Novi, MI 48376-0965	Patrick Dimet Vertex Steel Inc. 2175 Fyke Milford, MI 48381
Pat Buck Iron Workers' Local No. 25 P.O. Box 965 Novi, MI 48376-0965	Frank Nehr, Jr. Davis Iron Works, Inc. 1166 Bernstein Rd. Walled Lake, MI 48390

LEGAL COUNSEL FOR THE PLAN
Anthony A. Asher, Esq.
Sullivan, Ward, Asher & Patton, P.C.
25800 Northwestern Hwy, Suite 1000
Southfield, MI 48037-0222
(248) 747-0700

In the event of a conflict between this SPD and the plan document, which may contain additional limitations and exclusions, the plan document controls. The plan document is available without charge at the Fund Office (248) 347-3100 or (800) 572-8553.

The Trustees have delegated the day-to-day responsibilities for Plan administration to Dennis Kramer, Plan Manager, Iron Workers' Health Fund of Eastern Michigan, P. O. Box 8006, Novi, MI 48376-8006, 248-347-3100 or toll free 1-800-572-8553.

B. Effective Date of Plan/Fiscal Year: The effective date of the Plan is 11/30/50. The Plan's fiscal year ends April 30.

C. Agent for Service of Legal Process: Service of process should be made upon Dennis Kramer, Plan Manager, Iron Workers' Health Fund of Eastern Michigan, P. O. Box 8006, Novi, MI 48376-8006, 248-347-3100 or toll free 1-800-572-8553. Service of legal process may also be made upon any Plan Trustee.

D. Type of Plan/Employer Identification Number/Plan Number: The Plan is a welfare benefit plan hospitalization, medical, prescription drugs, dental, vision, disability and death benefits. The employer identification number assigned by the IRS is 38-6216995. The Plan Number is 501.

E. Collective Bargaining Agreements: The Plan is maintained pursuant to collective bargaining agreements. Copies of such agreements may be obtained upon written request to the Plan Administration Office, or are available for examination by participants and beneficiaries at the Plan Administration Office. Alternatively, within 10 days of a written request, such agreements will be made available at the Union hall or at any employer establishment where at least 50 or more participants are customarily working. The Plan may impose a reasonable charge for such copies.

F. Source of Plan Contributions: The primary source of financing for the benefits provided under the Plan and for the expenses of the Plan operations are employer contributions. The rate of contribution is set forth in the Collective Bargaining Agreement. Additionally, under certain circumstances pursuant to the terms of the Plan, a Participant may make self-payments to retain eligibility. A portion of Plan assets are invested and this also produces additional Plan income. A complete list of the employers contributing to the Plan may be obtained upon written request to the Plan Administration Office and may be examined at the Plan Administration Office.

G. Welfare Trust Assets and Reserves: The Board of Trustees holds all assets in trust for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses.

H. Compliance with Federal Laws. The extent applicable, the Plan will comply with the following laws:

- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) was enacted to provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- The Women's Health and Cancer Rights Act of 1998 (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans and health insurance issuers that provide coverage for medical and surgical benefits with respect to mastectomies must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema).

- The Patient Protection and Affordable Care Act of 2010, and the Health Care and Education Reconciliation Act (collectively known as Healthcare Reform) was enacted to provide various protections, including but not limited to the provision of minimum essential health benefits and certain preventative services without cost sharing.

I. Copies of Schedule of Benefits or Benefit Booklet/List of Network Providers. A copy of any benefits booklet or summary referred to in this SPD is available without cost to any participant or beneficiary under the Plan upon request to the Plan Office. Additionally, a list of network providers is also available without cost upon request to the Plan Office.

J. Statement of ERISA Rights: As a participant you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

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

Continue Group Health Plan Coverage: Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion

for 12 months (18 months for late enrollees) after your enrollment date in subsequent coverage. The procedure for requesting a certificate of creditable coverage is as follows:

a. A covered person may contact the Iron Workers' Health Fund of Eastern Michigan, P. O. Box 8006, Novi, MI 48376-8006, 248-347-3100 or toll free 1-800-572-8553, in writing to request a certificate of creditable coverage.
b. The requested certificate shall be provided by the earliest date that the Plan Administrator acting in a reasonable and prompt fashion, can provide the certificate. In that regard, the parties shall use best and reasonable efforts to process and mail (first class, postage paid) the requested certificate of creditable coverage to the requesting party within 5 business days of receipt of the request.
c. The above applies to requests for certificates made by a covered person before losing coverage or within 24 months after losing coverage.
d. This procedure is in addition to the automatic issuance of certificates of creditable coverage to covered persons upon termination of coverage.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights: If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

W1274357v1

In the event of a conflict between this SPD and the plan document, which may contain additional limitations and exclusions, the plan document controls. The plan document is available without charge at the Fund Office (248) 347-3100 or (800) 572-8553.

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

GROUP INSURANCE POLICY

Term Life Coverage

POLICYHOLDER: IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN

GROUP POLICY NUMBER	DELIVERED IN	POLICY DATE
G-00048485	Michigan	April 1, 2023

POLICY ANNIVERSARIES: April 1st of each year, beginning in 2024

GUARDIAN AGREES to pay benefits in accordance with and subject to the terms of this Policy. This promise is based on the Policyholder's application and payment of the required premiums.

This Policy is delivered in the jurisdiction shown above and is governed by its laws.

This Policy takes effect on the Policy Date shown above.

IN WITNESS OF WHICH, GUARDIAN has caused this Policy to be executed as of March 7, 2023 which is its date of issue.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

Non-Participating - No Dividends Payable

Please read this Policy carefully.

P030.0369

TABLE OF CONTENTS

GENERAL PROVISIONS

Option A

Incontestability

This Policy will be incontestable after two years from its Policy Date, except for non-payment of premiums.

This Policy may replace the group policy of another insurer. In that case, We may rescind this Policy based on misrepresentations made in Your or a Covered Person's signed application for up to two years from the Policy Date.

After a person's insurance has been in force under this Policy for two years during his or her lifetime, no statement in any application made by him or her will be used:

- to contest the validity of his or her insurance; or
- to deny a claim for a loss incurred by him or her.

In the event a Covered Person's insurance is rescinded due to a fraudulent statement made in his or her application We will refund premiums paid for the periods such insurance is void. The premium paid by the Covered Person will be sent to his or her last known address on file with You or Us. If You pay all or part of the cost of a Covered Person's insurance Your part of the premium will be paid to You.

P030.0374

Option A

Associated Companies

An associated company is a business entity affiliated with You through common ownership of stock or assets.

If You ask Us in writing to include such a company under this Policy, We will treat Members of that company like Your Members. We must give Our written approval. Our approval will show the starting date of the company's coverage under this Policy. Each eligible Member of that company must still meet all of the terms and conditions of this Policy before he or she will be insured.

You must notify Us in writing when a company ceases to be an associated company. On the date a company ceases to be such a company, this Policy will end for all of that company's Members, except those covered by You or another associated company as Members on such date.

P030.0375-R

Option A

Premiums

Premiums are payable by You as follows:

- The first premium is due on the Policy Date; and
- Later premiums are, during the time this Policy remains in force, due on the 1st of each month.

Premiums due under this Policy must be paid by You:

- At a Guardian office; or
- To a representative that We have authorized.

The premiums must be paid as shown above, unless by agreement between You and Us, the interval of payment is changed. In that event, adjustment will be made for payment annually, semi-annually, or quarterly.

The premium due under this Policy on each due date will be the sum of the premium charges for the insurance provided under this Policy. The premium charges are based on the rates set forth in the Schedule Of Premium Rates.

We may change such rates:

- On the first day of any policy month;
- On any date the extent or terms of coverage for You are changed by amendment of this Policy;
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or
- On any date that a change in federal or state laws, insurance programs or retirement benefits would impact our liability.

We must give You 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

P030.0376

Premiums for Member coverage must be paid solely from funds contributed by the Policyholder. No contributions toward the premium may be required of any Member.

P030.0378-R

Option A

Adjustment Of Premiums Payable Other Than Monthly Or Quarterly

A premium rate may be changed after an annual or semi-annual premium became payable with respect to insurance on and after the date of such change. In that case, the premium will be adjusted by a pro rata change for the rest of the period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to You by Us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This Policy's grace period will apply to any such premium due.

P030.0379

Option A

Grace In Payment Of Premiums - Termination Of Policy

A grace period of 31 days, without interest charge, will be allowed for each premium payment except the first. If any premium with respect to the Members is not paid before the end of the grace period, this Policy ends with respect to all Members at the end of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.

If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time this Policy was in force during the grace period.

This Policy ends on any date when a coverage under this Policy ends and, as a result, no benefits remain in effect under this Policy.

P030.2122-R

Option A

Term Of Policy - Renewal Privilege

This Policy is issued for a term of one year from the Policy Date shown on the face page. All policy years and policy months will be calculated from the Policy Date. All periods of insurance will begin and end at 12:01 A.M. Standard Time at Your place of business.

If this Policy provides insurance on a non-contributory basis, all of the Members eligible for such insurance must be enrolled.

You may renew this Policy for a further term of one year on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as shown in Premiums.

P030.0383-R

Option A

We have the right to decline to renew this Policy, or any coverage under it, on any Policy Anniversary or premium due date, if, on that date:

- Less than ten Members are insured; or
- With respect to non-contributory insurance, all of those Members eligible are not insured; or
- With respect to contributory insurance, less than 75% of those Members eligible are insured.

P030.1828-R

You may cancel this Policy at any time by giving Us 31 days advance written notice. This notice must be sent to Our Home Office. You will owe Us all unpaid premiums for the period this Policy is in force. We may cancel this Policy by giving You 31 days advance written notice.

P030.0398-R

Option A

The Contract

The entire contract between You and Us consists of:

- This Policy;
- The Schedule of Premium Rates;
- The Certificate(s) which describe(s) the insurance for which Covered Persons are insured;
- Any attached riders, schedule of benefits or amendments; and
- Your application.

In the event of a conflict, the Policy shall reign.

We can amend this Policy at any time, without the consent of the insured Members or any other person having a beneficial interest in it:

- Upon written request made by You and agreed to by Us; or
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements.

If We amend this Policy, except upon request made by You, We must give You written notice of such change.

Any amendments to this Policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

- Determine whether any contract, policy or certificate is to be issued;
- Waive or alter any provisions of any contract or policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

P030.0399-R

Option A

Clerical Error - Misstatements Of Age

Neither clerical error by You or Us in keeping any records on the insurance under this Policy, nor delays in making entries, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. On discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to You will be limited to the period of 90 days before the date of Our receipt of satisfactory evidence that such adjustments should be made.

The age of a Member, or any other relevant facts, may be found to have been misstated. If premiums are affected due to this, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by Us, or the amount of insurance, the true facts will be used to determine whether insurance is in force under the terms of this Policy, and in what amount.

P030.0400-R

Option A

Statements

No statement will void the insurance under this Policy, or be used in defense of a claim unless:

- in Your case, it is contained in the application signed by You;
- In the case of a Covered Person, it is contained in a written instrument signed by him or her.

All statements will be deemed representations and not warranties.

P030.0401

Option A

Assignment

A Member's right to assign any interest under this Policy is governed as shown in the Certificate that describes the insurance for which he or she is insured.

Assignment or transfer of Your interest under this Policy will not bind Us without Our written consent.

P030.0402-R

Option A

Certificate

We will issue to You, for delivery to each insured Member, a certificate of insurance. It will state the essential features of the insurance to which the Member is entitled and to whom the benefits are payable. In the event this Policy is amended, and such amendment affects the material contained in the certificate, a rider or revised certificate reflecting such amendment will be issued to You for delivery to affected Members .

P030.0403-R

Option A

Notice

From time to time We may provide You with notices that are needed due to state or federal requirements. You must deliver copies of these notices to each of Your Members.

P030.0404-R

Option A

Claims Of Creditors

Except when prohibited by the laws of the jurisdiction in which this Policy was issued, the insurance and other benefits under this Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Persons or their beneficiaries.

P030.0405

Option A

Records - Information To Be Furnished

You must keep a record of the insured Members containing, for each Member, the essential details of the insurance which apply to him or her. You must periodically forward to Us, on Our forms, such information concerning the Members in the classes eligible for insurance under this Policy as may reasonably be considered to have a bearing:

- On the administration of the insurance under this Policy; and
- On the determination of the premium rates.

For benefits which are based on a Member's salary, changes in his or her salary must promptly be reported to Us. Your payroll and other such records which have a bearing on the insurance must be furnished to Us at Our request at any reasonable time.

P030.0406-R

Option A

Examination And Autopsy

We have the right to have a doctor of Our choice examine the person for whom a claim is being made under this Policy as often as We feel necessary. We have the right to have an autopsy performed in the case of death, where allowed by law. We will pay for all such examinations and autopsies.

P030.0407

Option A

Conformity With Law

If the provisions of this Policy do not conform to the requirements of any state or federal law or regulation that applies, any such provision is changed to conform with the requirements of that law or regulation.

P030.0408

Option A

A Member's Right to Continue Life Insurance Coverage During A Family Leave of Absence

Important Notice: This section may not apply to Your Policy. The Member must contact You to find out if You must allow for a family leave of absence under federal law. If You must allow for such leave, this section applies.

If Coverage Would End: A Member's Life Insurance coverage would normally end because he or she ceases work due to an approved leave of absence. But, a Member may continue coverage if the leave has been granted to: (1) allow a Member to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to a Member's own serious health condition; or (4) because of a serious Injury or illness arising out of the fact that a Member's spouse, child, parent or next of kin who is a covered service member is on active duty, or has been notified of an impending call or order to active duty, in the Armed Forces in support of a contingency operation. To continue a Member's coverage, he or she will be required to pay the same share of the premium as paid before the leave of absence.

When Continuation Ends: Continued coverage will end on the earliest of the following:

- The date a Member returns to Active Work.
- In the case of a leave granted to a Member to care for a covered service member, the end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to a Member under this section for all reasons. If a Member takes an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case, the end of a total leave period of 12 weeks in any 12 month period.
- The date on which the Policyholder Plan is terminated or a Member is no longer eligible for coverage under this Policy.
- The end of the period for which premium has been paid.

Definitions: As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service member:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious Injury or illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in outpatient status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means a Member's nearest blood relative.
- **Outpatient Status:** This term means, in the case of a covered service member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered service member, an Injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

P030.0428-R

Option A

Definitions

The terms shown below have the meanings shown below.

Association: This term means the entity that purchased the Policy.

Covered Person: This term means a Member insured by this Policy.

Guardian, Our, Us and We: These terms mean The Guardian Life Insurance Company of America.

Life Insurance: This term means insurance on human lives.

Member: This term means a person who is an eligible member of an Eligible class.

Policy: This term means the Guardian group life insurance Policy purchased by You.

You and Your: As used in this Policy, these terms mean the Policyholder who purchased this group Policy. As used in the Certificate(s) attached to this Policy, these terms mean an insured Member.

P030.0433-R

Option A

COMPUTATION OF GROUP LIFE INSURANCE PREMIUMS

How Group Life Insurance Rates Are Computed

We will use the mortality rates and factors in Our rate manual, subject to Our rating methods, to compute the premium charges for group Life Insurance. We can change rates as stated in Premiums.

When this Policy starts, We will compute a preliminary monthly rate. We do this by: (1) multiplying the individual rates by the amounts of insurance in force at the respective ages, nearest birthday, of all Members; and (2) dividing the result by the total amount of insurance in force. We will use the characteristics of Your group and Our rating methods to modify such preliminary rate and compute Your final premium rate.

We may also compute Your final premium rate by any other method agreed to by You and Us which produces approximately the same total premium.

Monthly Premiums: If You pay monthly premiums, each monthly payment will be equal to the product of the total amount of Life Insurance in force on the premium's due date and the monthly rate in effect for each Member.

Annual, Semi-Annual, Or Quarterly Premiums: If You pay annual, semi-annual, or quarterly premiums, We will compute the applicable rate by multiplying the monthly premiums by: (1) 11.823 for annual premiums; (2) 5.956 for semi-annual premiums; or (3) 2.985 for quarterly premiums.

When Rates Can Be Changed: We or You may require rate changes: (1) on each Policy Anniversary after the effective date of this Policy; or (2) on any date on which the rate manual is changed.

P030.0435-R

SCHEDULE OF OPTION PACKAGES

This Policy's classes are shown below. The benefit option packages which are available to Covered Persons who are members of each class are shown below.

Class Description

Class 0001 ALL ACTIVE MEMBERS

P020.0087

Benefit Option Packages

Members may choose from the benefit packages available to members of their class. Coverage for a benefit will not become effective until the Covered Person satisfies the eligibility requirements. Coverage for a benefit that requires payment from the Member will not become effective until the Member: (1) elects it in a form acceptable by Us; and (2) agrees to make any required payments. The benefits are described in the applicable Certificate(s) attached to and made a part of this Policy.

P020.0089-R

Members of Class 0001 may choose from benefits in option package(s) A.

P020.0090-R

Option A

- Member Basic Term Life Insurance

P030.0524-R

ATTACHED CERTIFICATES

The Certificate(s) shown below are added to and made part of this policy.

P024.0662

Class 0001 Option(s) A

P024.0663-R

The Certificate(s) describe the Life Insurance benefits for which each class of Members is eligible.

Each Member's eligibility, effective date of insurance, plan of insurance, and termination date is determined by the option he or she has elected on his or her enrollment form, or other suitable document approved by Guardian, and the provisions of the Certificate that apply to that option.

Certificate(s) will include any changes made by rider or amendments to this Policy.

P020.0932-R

The Guardian Life Insurance Company of America

Schedule of Premium Rates

Life Insurance

The monthly premium rates, in U.S. dollars, for the benefits provided under the Policy are listed below. Guardian has the right to change any premium rate(s) set forth below at the times and in the manner set forth in the Premiums section of the Policy.

P030.0446

Option A — Premium Rates

Member Basic Term Life Insurance

P030.0447-R

Option A Class 0001

The following set of rates represents the rate per $1,000.00 of coverage.

Rate per Member
$ 0.16

P024.0722-R

Option A

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00048485-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

to

IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN

(herein called the Policyholder)

Effective the later of (i) the original effective date of the Policy, or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Plan by the addition of the following:

BENEFIT ADMINISTRATION PROGRAMS

Your Life coverage includes access to certain services, which will expedite and streamline the administration process.

Such services include, but are not limited to, quoting of Guardian products, implementation of group insurance plans, communications and education, enrollment, collection and transmission of enrollment/eligibility data, billing, premium collection, payroll services, and plan administration services. These additional services are not provided by Guardian. Guardian assumes no liability for the services provided under these programs, nor for the amounts charged by the companies providing such services.

Charges for the services will be 3% of the Policy's annual premium.

Payment of the services will be issued to the service provider.

Services are provided on a month to month basis while coverage remains in effect, subject to Guardian's terms and conditions. Guardian may terminate any such vendor at any time and will provide 30 days prior written notice of any vendor termination.

When this plan ends, access to the services ends.

Guardian reserves the right to terminate, modify or replace any service at any time.

Dated at _____ This _____ Day of _____ , ____

IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

P531.0506

Option A

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00048485-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN

(herein called the Policyholder)

This Rider amends this Policy by replacing the Grace In Payment Of Premiums - Termination Of Policy provision as shown below and is effective on its issue date.

Grace In Payment Of Premiums - Termination Of Policy

A grace period of 60 days, without interest charge, will be allowed for each premium payment except the first. If any premium with respect to the Members of any Policyholder is not paid before the end of the grace period, this Policy ends with respect to all Members of such Policyholder at the end of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.

If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time this Policy was in force during the grace period.

This Policy ends immediately on any date insurance coverage under this Policy ends, and as a result, no benefits remain under this Policy.

This rider is part of this Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

Harris Oliner, Senior Vice President,
Corporate Secretary

Michael Prestileo,
Senior Vice President

P055.0176-R

Option A

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00048485-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(herein called Guardian)

to

IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN

(herein called the Policyholder)

This Rider amends the Policy as follows and is effective on its issue date:

- The "Non-Participating - No Dividends Payable" notice on the Policy face page is replaced with "Dividends Apportioned Annually, if Payable".
- The Dividends provision is added or replaced in its entirety within the General Provisions as shown below.

Dividends

The portion, if any, of the divisible surplus of Guardian allocable to this Policy at each Policy Anniversary will be determined annually by the Board of Directors of Guardian and will be credited to this Policy as a dividend on such anniversary, provided this Policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this Policy will be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

In the event that the Members are contributing toward the cost of the coverage under any group policy issued to the Policyholder and the aggregate dividends under this Policy and any other group policy or policies issued to the Policyholder are in excess of the Policyholder's share of the aggregate cost, such excess will be applied by the Policyholder for the sole benefit of the Members.

Finally, please note that it is not expected that any dividends will be payable under this Policy.

This Rider is part of this Policy. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of this Policy.

Dated at Bethlehem, PA This 23rd Day of February , 2023

Harris Oliner, Senior Vice President,
Corporate Secretary

Michael Prestileo,
Senior Vice President

P070.0043-R

Option A

The Guardian Life Insurance Company of America

10 Hudson Yards, New York, NY 10001

GROUP POLICY AMENDATORY RIDER

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO.

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(herein called Guardian)

to

IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN

(herein called the Policyholder)

GROUP INSURANCE POLICY NO. G-00048485

This Rider amends the Policy as follows and is effective on 04/01/2023.

The **Claims Provisions** is added as follows:

The Policyholder shall hold and maintain records pertaining to insured Members and their listed beneficiaries and shall be the preliminary point of contact for the Members and beneficiaries regarding the Policy.

Upon notification of a potential claim under the Policy, the Policyholder will provide Guardian all information and documentation in the Policyholder's possession related to the claim, including the identity and contact information of the claimant(s), beneficiary(ies), Member(s), and any claim forms or other relevant documents. The Policyholder's responsibility related to any claim shall cease once the Policyholder provides such preliminary information and documentation to Guardian. The Policyholder's furnishing of such information is not a substitute for proof of loss, and Guardian retains all rights to require additional proofs of loss from the Member as set forth under the Policy.

The Policyholder delegates to Guardian the discretionary authority and responsibility to process claims, interpret the Policy and Certificate, and determine eligibility for coverage and benefits for all claims, including for competing claims or those that may be disputed. Guardian shall hold the Policyholder harmless for any disputes that arise after the Policyholder furnishes the preliminary claim information, unless the information provided by the Policyholder is erroneous or unreasonably delayed or unless such dispute is caused by the Policyholder's failure to meet its obligations under the Policy.

Subject to the foregoing, Guardian shall otherwise process claims as provided in the Policy and Certificate.

This Rider is part of the Policy. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of the Policy.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

P070.0043-R

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

GROUP INSURANCE POLICY

Accidental Death and Dismemberment Coverage

POLICYHOLDER: IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN

GROUP POLICY NUMBER	DELIVERED IN	POLICY DATE
G-00048485	Michigan	April 1, 2023

POLICY ANNIVERSARIES: April 1st of each year, beginning in 2024

GUARDIAN AGREES to pay benefits in accordance with and subject to the terms of this Policy. This promise is based on the Policyholder's application and payment of the required premiums.

This Policy is delivered in the jurisdiction shown above and is governed by its laws.

This Policy takes effect on the Policy Date shown above.

IN WITNESS OF WHICH, GUARDIAN has caused this Policy to be executed as of March 7, 2023 which is its date of issue.

Harris Oliner, Senior Vice President,
Corporate Secretary

Michael Prestileo,
Senior Vice President

Non-Participating - No Dividends Payable

Please read this Policy carefully.

P030.2445

TABLE OF CONTENTS

GENERAL PROVISIONS

Option A

Incontestability

This Policy will be incontestable after three years from its Policy Date, except for non-payment of premiums.

This Policy may replace the group policy of another insurer. In that case, We may rescind this Policy based on misrepresentations made in Your or a Covered Person's signed application for up to three years from the Policy Date.

After a person's insurance has been in force under this Policy for three years during his or her lifetime, no statement in any application made by him or her will be used:

- to contest the validity of his or her insurance; or
- to deny a claim for a loss incurred by him or her.

In the event a Covered Person's insurance is rescinded due to a fraudulent statement made in his or her application We will refund premiums paid for the periods such insurance is void. The premium paid by the Covered Person will be sent to his or her last known address on file with You or Us. If You pay all or part of the cost of a Covered Person's insurance Your part of the premium will be paid to You.

P030.2386

Option A

Associated Companies

An associated company is a business entity affiliated with You through common ownership of stock or assets.

If You ask Us in writing to include such a company under this Policy, We will treat Members of that company like Your Members. We must give Our written approval. Our approval will show the starting date of the company's coverage under this Policy. Each eligible Member of that company must still meet all of the terms and conditions of this Policy before he or she will be insured.

You must notify Us in writing when a company ceases to be an associated company. On the date a company ceases to be such a company, this Policy will end for all of that company's Members, except those covered by You or another associated company as Members on such date.

P030.0886-R

Option A

Premiums

Premiums are payable by You as follows:

- The first premium is due on the Policy Date; and
- Later premiums are, during the time this Policy remains in force, due on the 1st of each month.

Premiums due under this Policy must be paid by You:

- At a Guardian office; or
- To a representative that We have authorized.

The premiums must be paid as shown above, unless by agreement between You and Us, the interval of payment is changed. In that event, adjustment will be made for payment annually, semi-annually, or quarterly.

The premium due under this Policy on each due date will be the sum of the premium charges for the insurance provided under this Policy. The premium charges are based on the rates set forth in the Schedule Of Premium Rates.

We may change such rates:

- On the first day of any Policy month;
- On any date the extent or terms of coverage for You are changed by amendment of this Policy;
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or
- On any date that a change in federal or state laws, insurance programs or retirement benefits would impact our liability.

We must give You 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

P030.0887

Premiums for Member coverage must be paid solely from funds contributed by the Policyholder. No contributions toward the premium may be required of any Member.

P030.0889-R

Option A

Adjustment Of Premiums Payable Other Than Monthly Or Quarterly

A premium rate may be changed after an annual or semi-annual premium became payable with respect to insurance on and after the date of such change. In that case, the premium will be adjusted by a pro rata change for the rest of the period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to You by Us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This Policy's grace period will apply to any such premium due.

P030.0890

Option A

Grace In Payment Of Premiums - Termination Of Policy

A grace period of 31 days, without interest charge, will be allowed for each premium payment except the first. If any premium with respect to the Members is not paid before the end of the grace period, this Policy ends with respect to all Members at the end of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.

If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time this Policy was in force during the grace period.

This Policy ends immediately on any date when a coverage under this Policy ends and, as a result, no benefits remain under this Policy.

P030.2387-R

Option A

Term Of Policy - Renewal Privilege

This Policy is issued for a term of one year from the Policy Date shown on the face page. All policy years and policy months will be calculated from the Policy Date. All periods of insurance will begin and end at 12:01 A.M. Standard Time at Your place of business.

If this Policy provides insurance on a non-contributory basis, all of the Members eligible for such insurance must be enrolled.

You may renew this Policy for a further term of one year on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as shown in Premiums.

P030.0894-R

Option A

We have the right to decline to renew this Policy, or any coverage under it, on any Policy Anniversary or premium due date, if, on that date:

- Less than ten Members are insured; or
- With respect to non-contributory insurance, all of those Members eligible are not insured; or
- With respect to contributory insurance, less than 75% of those Members eligible are insured.

P030.1832-R

You may cancel this Policy at any time by giving Us 31 days advance written notice. This notice must be sent to Our Home Office. You will owe Us all unpaid premiums for the period this Policy is in force. We may cancel this Policy by giving You 31 days advance written notice.

P030.2388

Option A

Reinstatement

If Your Policy lapses You may reinstate it by sending in Your premium within 60 days of the Policy lapse. Our acceptance of a premium payment without requiring an application for reinstatement will reinstate this Policy

The reinstated Policy will cover only losses sustained on or after the date of reinstatement. No benefit will be payable for any loss between the date of lapse and the date of reinstatement.

P030.2389

Option A

The Contract

The entire contract between You and Us consists of:

- This Policy;
- The Schedule of Premium Rates;
- The Certificate(s) which describe(s) the insurance for which Covered Persons are insured;
- Any attached riders, schedule of benefits or amendments; and
- Your application.

In the event of a conflict, the Policy shall reign.

We can amend this Policy at any time, without the consent of the insured Members or any other person having a beneficial interest in it:

- Upon written request made by You and agreed to by Us; or
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements.

If We amend this Policy, except upon request made by You, We must give You written notice of such change.

Any amendments to this Policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

- Determine whether any contract, policy or certificate is to be issued;
- Waive or alter any provisions of any contract or policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

P030.0910-R

Option A

Clerical Error - Misstatements Of Age

Neither clerical error by You or Us in keeping any records on the insurance under this Policy, nor delays in making entries, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. On discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to You will be limited to the period of 90 days before the date of Our receipt of satisfactory evidence that such adjustments should be made.

The age of a Member, or any other relevant facts, may be found to have been misstated. If premiums are affected due to this, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by Us, or the amount of insurance, the true facts will be used to determine whether insurance is in force under the terms of this Policy, and in what amount.

P030.0911-R

Option A

Statements

No statement will void the insurance under this Policy, or be used in defense of a claim unless:

- in Your case, it is contained in the application signed by You;
- In the case of a Covered Person, it is contained in a written instrument signed by him or her.

All statements will be deemed representations and not warranties.

P030.0912

Option A

Certificate

We will issue a Certificate to You for delivery to each insured Member. It will state the essential features of the insurance to which the Member is entitled and to whom the benefits are payable. In the event this Policy is amended, and such amendment affects the material contained in the Certificate, a rider or revised Certificate reflecting such amendment will be issued to You for delivery to affected Members.

P030.0914-R

Option A

Notice

From time to time We may provide You with notices that are needed due to state or federal requirements. You must deliver copies of these notices to each of Your Members.

P030.0915-R

Option A

Claims Of Creditors

Except when prohibited by the laws of the jurisdiction in which this Policy was issued, the insurance and other benefits under this Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Persons or their beneficiaries.

P030.0916

Option A

Records - Information To Be Furnished

You must keep a record of the insured Members containing, for each Member, the essential details of the insurance which apply to him or her. You must periodically forward to Us, on Our forms, such information concerning the Members in the classes eligible for insurance under this Policy as may reasonably be considered to have a bearing on:

- The administration of the insurance under this Policy; and
- The determination of the premium rates.

For benefits which are based on a Member's salary, changes in his or her salary must promptly be reported to Us. Your payroll and other such records which have a bearing on the insurance must be furnished to Us at Our request at any reasonable time.

P030.0917-R

Option A

Examination And Autopsy

We have the right to have a doctor of Our choice examine the person at reasonable times and as frequently as reasonably required during the pendency of a claim under this Policy. We have the right to have an autopsy performed in the case of death, where allowed by law. We will pay for all such examinations and autopsies.

P030.2442

Option A

Conformity With Law

If the provisions of this Policy do not conform to the requirements of any state or federal law or regulation that applies, any such provision is changed to conform with the requirements of that law or regulation.

P030.0919

Option A

Definitions

The terms shown below have the meanings shown below.

Association: This term means the entity that purchased the Policy.

Covered Person: This term means a Member insured by this Policy.

Guardian, Our, Us and We: These terms mean The Guardian Life Insurance Company of America.

Member: This term mean a person who is an eligible member of an Eligible class.

Policy: This term means the Guardian group life insurance Policy purchased by You.

You and Your: As used in this Policy, these terms mean the Policyholder who purchased this group Policy. As used in the Certificate(s) attached to this Policy, these terms mean an insured Member.

P030.0927-R

SCHEDULE OF OPTION PACKAGES

This Policy's classes are shown below. The benefit option packages which are available to Covered Persons who are members of each class are shown below.

Class Description

Class 0001 ALL ACTIVE MEMBERS

P020.0087

Benefit Option Packages

Members may choose from the benefit packages available to members of their class. Coverage for a benefit will not become effective until the Covered Person satisfies the eligibility requirements. Coverage for a benefit that requires payment from the Member will not become effective until the Member: (1) elects it in a form acceptable by Us; and (2) agrees to make any required payments. The benefits are described in the applicable Certificate(s) attached to and made a part of this Policy.

P030.0933-R

Members of Class 0001 may choose from benefits in option package(s) A.

P030.0934-R

Option A

- Member Accidental Death and Dismemberment Insurance

P030.0935-R

ATTACHED CERTIFICATES

The Certificate(s) shown below are added to and made part of this policy.

P030.0946

Class 0001 Option(s) A

P030.0947

The Certificate(s) describe the Accidental Death and Dismemberment Insurance benefits for which each class of Members is eligible.

Each Member's eligibility, effective date of insurance, plan of insurance, and termination date is determined by the option he or she has elected on his or her enrollment form, or other suitable document approved by Guardian, and the provisions of the Certificate that apply to that option.

Certificate(s) will include any changes made by rider amendments to this Policy.

P030.0948-R

The Guardian Life Insurance Company of America

Schedule of Premium Rates

Accidental Death and Dismemberment Insurance

The monthly premium rates, in U.S. dollars, for the benefits provided under the Policy are listed below. Guardian has the right to change any premium rate(s) set forth below at the times and in the manner set forth in the Premiums section of the Policy.

P030.0950

Option A — Premium Rates

Member Basic Accidental Death and Dismemberment Insurance

P030.0951-R

Option A Class 0001

The following set of rates represents the rate per $1,000.00 of coverage.

Rate per Member
$ 0.020

P030.0952-R

Option A

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00048485-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

to

IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN

(herein called the Policyholder)

Effective the later of (i) the original effective date of the Policy, or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Plan by the addition of the following:

BENEFIT ADMINISTRATION PROGRAMS

Your Accidental Death and Dismemberment coverage includes access to certain services, which will expedite and streamline the administration process.

Such services include, but are not limited to, quoting of Guardian products, implementation of group insurance plans, communications and education, enrollment, collection and transmission of enrollment/eligibility data, billing, premium collection, payroll services, and plan administration services. These additional services are not provided by Guardian. Guardian assumes no liability for the services provided under these programs, nor for the amounts charged by the companies providing such services.

Charges for the services will be 3% of the Policy's annual premium.

Payment of the services will be issued to the service provider.

Services are provided on a month to month basis while coverage remains in effect, subject to Guardian's terms and conditions. Guardian may terminate any such vendor at any time and will provide 30 days prior written notice of any vendor termination.

When this plan ends, access to the services ends.

Guardian reserves the right to terminate, modify or replace any service at any time.

Dated at _____ This _____ Day of _____ , ____

IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN
Full or Corporate Name of Policyholder

_____ BY: _____

Witness Signature and Title

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

P531.0516

Option A

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00048485-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN

(herein called the Policyholder)

This Rider amends this Policy by replacing the Grace In Payment Of Premiums - Termination Of Policy provision as shown below and is effective on its issue date.

Grace In Payment Of Premiums - Termination Of Policy

A grace period of 60 days, without interest charge, will be allowed for each premium payment except the first. If any premium with respect to the Members of any Policyholder is not paid before the end of the grace period, this Policy ends with respect to all Members of such Policyholder at the end of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.

If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time this Policy was in force during the grace period.

This Policy ends immediately on any date insurance coverage under this Policy ends, and as a result, no benefits remain under this Policy.

This rider is part of this Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

Harris Oliner, Senior Vice President,
Corporate Secretary

Michael Prestileo,
Senior Vice President

P055.0176-R

Option A

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00048485-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(herein called Guardian)

to

IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN

(herein called the Policyholder)

This Rider amends the Policy as follows and is effective on its issue date:

- The "Non-Participating - No Dividends Payable" notice on the Policy face page is replaced with "Dividends Apportioned Annually, if Payable".
- The Dividends provision is added or replaced in its entirety within the General Provisions as shown below.

Dividends

The portion, if any, of the divisible surplus of Guardian allocable to this Policy at each Policy Anniversary will be determined annually by the Board of Directors of Guardian and will be credited to this Policy as a dividend on such anniversary, provided this Policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this Policy will be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

In the event that the Members are contributing toward the cost of the coverage under any group policy issued to the Policyholder and the aggregate dividends under this Policy and any other group policy or policies issued to the Policyholder are in excess of the Policyholder's share of the aggregate cost, such excess will be applied by the Policyholder for the sole benefit of the Members.

Finally, please note that it is not expected that any dividends will be payable under this Policy.

This Rider is part of this Policy. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of this Policy.

Dated at Bethlehem, PA This 23rd Day of February , 2023

Harris Oliner, Senior Vice President,
Corporate Secretary

Michael Prestileo,
Senior Vice President

P070.0043-R

Option A

The Guardian Life Insurance Company of America

10 Hudson Yards, New York, NY 10001

GROUP POLICY AMENDATORY RIDER

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO.

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(herein called Guardian)

to

IRONWORKERS HEALTH FUND OF EASTERN MICHIGAN

(herein called the Policyholder)

GROUP INSURANCE POLICY NO. G-00048485

This Rider amends the Policy as follows and is effective on 04/01/2023.

The **Claims Provisions** is added as follows:

The Policyholder shall hold and maintain records pertaining to insured Members and their listed beneficiaries and shall be the preliminary point of contact for the Members and beneficiaries regarding the Policy.

Upon notification of a potential claim under the Policy, the Policyholder will provide Guardian all information and documentation in the Policyholder's possession related to the claim, including the identity and contact information of the claimant(s), beneficiary(ies), Member(s), and any claim forms or other relevant documents. The Policyholder's responsibility related to any claim shall cease once the Policyholder provides such preliminary information and documentation to Guardian. The Policyholder's furnishing of such information is not a substitute for proof of loss, and Guardian retains all rights to require additional proofs of loss from the Member as set forth under the Policy.

The Policyholder delegates to Guardian the discretionary authority and responsibility to process claims, interpret the Policy and Certificate, and determine eligibility for coverage and benefits for all claims, including for competing claims or those that may be disputed. Guardian shall hold the Policyholder harmless for any disputes that arise after the Policyholder furnishes the preliminary claim information, unless the information provided by the Policyholder is erroneous or unreasonably delayed or unless such dispute is caused by the Policyholder's failure to meet its obligations under the Policy.

Subject to the foregoing, Guardian shall otherwise process claims as provided in the Policy and Certificate.

This Rider is part of the Policy. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of the Policy.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

P070.0043-R

END OF POLICY DOCUMENT

Guardian®

P.O. Box 14334
Lexington KY 40512

Beneficiary Designation/ Change Form

PLEASE TYPE or PRINT CLEARLY. *(The entire form, properly completed, signed and dated by the Insured, must be submitted or the changes cannot be processed.)*

EMPLOYER/PLANHOLDER NAME:	GROUP NUMBER
EMPLOYEE NAME (LAST, FIRST, M.)	SOCIAL SECURITY #
EMPLOYEE HOME ADDRESS (STREET, CITY, STATE, ZIP)	

Please indicate the coverage to which the beneficiary(ies) apply: ☐ Basic Life ☐ Voluntary Life ☐ Group Permanent Life ☐ AD&D ☐ Accident

I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan.
(PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.)

BENEFICIARY INFORMATION: *(Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter.* ***See FAQ attachment.***

Name	Primary ☐ Contingent ☐	Relationship	%	Social Security #	Date of Birth
Address		Phone#	Email		
Name	Primary ☐ Contingent ☐	Relationship	%	Social Security #	Date of Birth
Address		Phone#	Email		
Name	Primary ☐ Contingent ☐	Relationship	%	Social Security #	Date of Birth
Address		Phone#	Email		
Name	Primary ☐ Contingent ☐	Relationship	%	Social Security #	Date of Birth
Address		Phone#	Email		

SIGNATURE OF INSURED	SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY)	DATE

Community Property State Consent for Residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin. If you are married and live in a community property state your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit.

As the insured Employee's spouse, I am aware that my spouse, the Employee named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such life insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse _____

Minors named as beneficiaries

Attention: If any of the Beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the Beneficiaries identified above considered a minor in the state in which they reside?
Check one box only. ☐ Yes ☐ No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor Beneficiaries you have designated:

Custodian to Minor Beneficiaries:
Name:
Social Security Number (or FEIN/TIN # if a corporate entity): **-**
Date of Birth (mm-dd-yyyy) (if an individual): - - Address/City/State/Zip:
Phone: ( ) - -

ALL SIGNATURES MUST BE IN BLACK INK

CHANGE IN BENEFICIARY'S NAME *(Complete only if the name has been legally changed.)*			
FROM (WAS)	TO (NOW IS)	SOCIAL SECURITY #	DATE
CHANGE IN INSURED'S NAME *(Complete only if the name has been legally changed.)*			
FROM (WAS)	TO (NOW IS)	SOCIAL SECURITY #	DATE
SIGNATURE OF INSURED			DATE

ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM

THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY.

This is to certify that the following changes have been recorded in connection with the insurance for the above named insured.

☐ The BENEFICIARY has been changed ☐ The NAME of the BENEFICIARY has been changed ☐ New Employee

Recorded by _____ Date _____

FORWARD FORM TO THE PLANHOLDER OR GUARDIAN LIFE INSURANCE FOR RECORDING **(011/18)**

Frequently Asked Questions FAQ

1. **Primary Beneficiary**: Is the first choice to receive your insurance benefit. If you name more than one primary beneficiary and a beneficiary predeceases the insured, that portion of the benefit will be equally distributed among the surviving beneficiaries.
2. **Contingent Beneficiary**: Is the second choice to receive your insurance benefit if (all) the primary beneficiary(s) is (are) not living at the time of the employee's death. If you name more than one contingent beneficiary and a beneficiary predeceases the insured, that portion of the benefit will be equally distributed among the surviving beneficiaries.
3. **If more than one primary and/or contingent** beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the insured, unless otherwise provided herein. Primary beneficiary percentages must total 100% and contingent beneficiary percentages must total 100%.
4. **If you wish to have your insurance benefit disbursed in accordance with your will**, you should designate your estate as beneficiary. If you wish to name an estate as the beneficiary, you will need the following paper work: Letters of appointment naming the executor/administrator/personal representative and the estate tax ID number.
5. **If you wish to name a trust** as the beneficiary, you will need the following paper work: The name of the Trust, Date the trust was established (must be prior to the date this form is submitted), Name and Address of one of the trustee(s) (If Possible)
6. **If you wish to name an organization or charity** as the beneficiary, you will need the following information: Name, and Contact information (phone number, address, etc.).
7. **Minor Beneficiary(s)-** When you designate minors as beneficiaries, it is important to understand that insurance benefits will not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. Regulations governing minor beneficiaries vary by state.
8. **If you wish to designate your domestic partner** as your beneficiary, you must complete a beneficiary form. A domestic partner is not considered a legal spouse in most states and must be specifically named as a beneficiary.

- **This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.**

Iron Workers' Local No. 25 Fringe Benefit Funds
P.O. Box 99219
Troy, MI 48099-9219
Phone: (248) 347-3100 • Toll Free: (800) 572-8553 • Fax: (248) 813-9898
Website: www.iw25fringe.org

Iron Workers Local 25 Health Care Fund
Important Notice of Plan Changes Effective 1/1/25

Please read this notice carefully and keep it where you can find it. This notice has important information about your benefits under the Iron Workers Local 25 Health Care Fund (IW Health Fund). If you have any questions, please contact the Fund Office at the number above.

Due to an evaluation of rising health care costs, several changes will be made to the IW Health Fund Plan (Plan) effective January 1, 2025, as set forth below.

Medical Deductible

This is the amount paid by a covered person before the Fund pays medical benefits. Effective 1/1/25, these deductibles will adjust as follows:

	Current	Effective 1/1/25
In-network single	$250	$500
In-network family	$500	$1,000
Out of network single	$500	$1,000
Out of network family	$1,000	$2,000

Maximum Out of Pocket

This is the maximum amount a covered person or family will pay out of pocket under the Plan for in-network medical and prescription drug (Rx) benefits per year. Once this amount is reached, the Plan will pay in-network medical and Rx benefits at 100%. Effective 1/1/25, the maximum out of pocket maximums will adjust as follows, and annually thereafter to the limits allowed by the Affordable Care Act:

	Current	Effective 1/1/25
In-network single medical	$2,250	$4,300
In-network single Rx	$4,900	$4,900
In-network family medical	$4,500	$8,600
In-network family Rx	$9,800	$9,800

The out-of-network out of pocket maximums will remain the same for 2025 but will adjust effective 1/1/26, and annually thereafter, by the same percentage change in the Affordable Care Act out of pocket limits for in-network benefits. The current amounts, to remain in effect for 2025, are:

	Current
Out-of-network single medical	$12,700
Out-of-network single Rx	$4,900
Out-of-network family medical	$25,400
Out-of-network family Rx	$9,800

Prescription Drug Co-Payments

A co-payment is the fixed amount paid by a covered person for each prescription drug fill. Prescription drug co-payments will adjust as follows effective January 1, 2025:

	Current	Effective 1/1/25
Retail 30-Day supply - Generic	$10	$15
Retail 30-Day supply - Formulary Brand	$15	$25
Retail 30-Day supply - Non-Formulary Brand	$30	$50
Retail 30-Day supply - Specialty	$30	25% of cost, $250 maximum
Mail 90-Day supply - Generic	$20	$30
Mail 90-Day supply – Formulary Brand	$30	$50
Mail 90-Day supply – Non-Formulary Brand	$60	$100
Mail 90-Day supply - Specialty	$60	25% of cost, $500 maximum

Bank Rate

The Bank Rate for ongoing eligibility will be increased from $850 to $1,150 per month (but will remain at $850 per month to meet the initial eligibility requirements under the Plan).

Virtual Care by Teladoc Health (online visits)

	Current	Effective 1/1/25
Teladoc Health	$20 copay	$0 copay

The $20 copay per Teladoc Health visit will be eliminated as of January 1, 2025. Please note that online visits by a non-BCBSM selected vendor are not covered. A BCBSM flyer regarding Virtual Care 2024 – Online Visits is included to assist you with signing up for the Teladoc Health App.

Also enclosed is an informational BCBSM flyer regarding Choices for Care. This informational flyer details the various options available to you for when you need care that may not be considered an emergency, including a 24-hour nurse hotline, virtual care, and walk-in clinics.

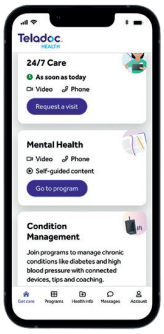
Health Reimbursement Account ("HRA")

Also enclosed is a general FAQ that covers questions and answers regarding reimbursements from your HRA. We hope this information will be helpful for you. As always, if you have any questions about your HRA or any of your Plan Benefits, please contact the Benefits Office at (248) 347-3100.

Virtual Care 2024

Previously Blue Cross Online Visits℠

Virtual care that's always there



GET CARE WHEN YOU NEED IT, WHEREVER YOU ARE.

With **Virtual Care** by Teladoc Health®, you and everyone on your health plan can get virtual medical and mental health care from a smartphone, tablet or computer.

Virtual Care is included with your Blue Cross Blue Shield of Michigan and Blue Care Network health care plan.

24/7 CARE

Have a virtual visit with a U.S. board-certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Visits are available for adults and children.

Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need an appointment and the average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

MENTAL HEALTH

Through the Mental Health option, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety and depression.

Mental health visits require an appointment, but many therapists and psychiatrists have evening and weekend availability.

SIGN UP TODAY

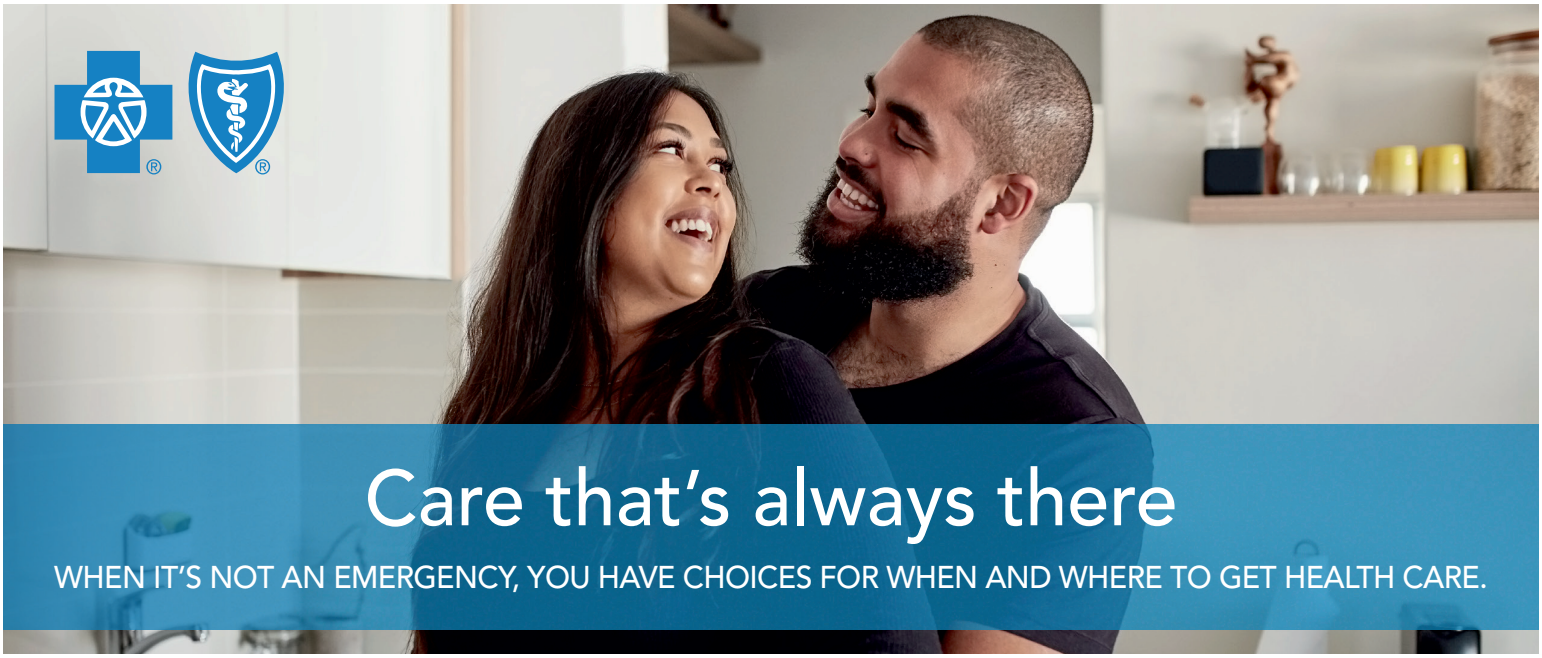
Visit bcbsm.com/virtualcare for a link to download the Teladoc Health app.

Family members ages 18 and older will need to create their own Virtual Care accounts. When updating or creating an account, choose your plan name and enter your member ID so your coverage is applied correctly. Call **1-800-835-2362** with any questions about your account or to arrange a telephone visit.

READY TO HELP

MICHIGAN

All Virtual Care services from Teladoc Health are separate from virtual care other providers may offer. Remember to follow up with your primary care provider. Your plan may have copayments, deductibles and out-of-pocket costs.



Care that's always there

WHEN IT'S NOT AN EMERGENCY, YOU HAVE CHOICES FOR WHEN AND WHERE TO GET HEALTH CARE.

ALWAYS START HERE

WHEN PRIMARY CARE ISN'T AVAILABLE

PRIMARY CARE PROVIDER

Comprehensive, personalized care from a trusted provider, virtually or in person — the first choice for care.

24-HOUR NURSE LINE

Free medical advice from a registered nurse from the comfort of home or on the go — anytime of day or night.

VIRTUAL CARE

(PREVIOUSLY BLUE CROSS ONLINE VISITS℠)

Virtual visits 24/7 with U.S. board-certified doctors anywhere in the U.S. Mental health is also available by appointment.

WALK-IN CLINICS

In-person care after hours or on weekends, without an appointment. Retail health clinics and urgent care centers are conveniently located near your home, school and work.

These convenient options for care can be used for:

- Back pain
- Colds and flu
- Earache
- Eye irritation or redness
- Low-grade fever
- Mild allergy symptoms
- Minor burns, cuts and scrapes
- Painful urination
- Skin rash
- Sore throat and cough
- Sprains and strains

Behavioral and mental health care are important. With your Blue Cross or Blue Care Network health care plan, you also have choices for behavioral and mental health care.

LEARN MORE AT **BCBSM.COM/FINDCARE**

Your choices for care

PRIMARY CARE PROVIDER	24-HOUR NURSE LINE	VIRTUAL CARE	WALK-IN CLINICS	
			RETAIL HEALTH CLINIC	URGENT CARE CENTERS
$	$0	$	$-$$	
AVERAGE WAIT TIME FOR CARE 30 minutes	**AVERAGE WAIT TIME FOR CARE** 1 minute	**AVERAGE WAIT TIME FOR CARE** 10 minutes	**AVERAGE WAIT TIME FOR CARE** 30 to 60 minutes	
APPOINTMENT REQUIRED? Yes	**APPOINTMENT REQUIRED?** No	**APPOINTMENT REQUIRED?** No	**APPOINTMENT REQUIRED?** No	
AVAILABLITY In person By phone Virtually	**AVAILABLITY** By phone	**AVAILABLITY** Virtually through the Teladoc Health® app	**AVAILABLITY** In person	
TREATMENT Start here when you want to talk with a doctor you know and trust	**TREATMENT** When you have questions about an illness or injury, anytime day or night	**TREATMENT** When you want to talk to a doctor or therapist virtually from your mobile device or telephone	**TREATMENT** For a quick, in-person evaluation to get minor health care and a prescription at one location	**TREATMENT** When your symptoms are a little more complicated and you need convenient, in-person care
• High-quality, comprehensive care • Knows you and your medical history and coordinates all your care • Many primary care offices offer virtual care, same-day appointments, extended hours and other services • You may have Virtual Primary Care through Teladoc Health® (for our Blue Cross PPO members*)	• No cost • Available by phone anytime, anywhere in the U.S. • Care provided by a registered nurse	• Video chat 24/7 with a provider or therapist anywhere in the U.S. • Send a visit summary to your primary doctor • Care provided by U.S. board-certified doctors and therapists • Prescriptions, if needed, can be sent to a pharmacy you prefer	• Evening and weekend hours • Convenient locations • Care provided by physician assistants and certified nurse practitioners, overseen by a U.S. board-certified doctor	• Evening and weekend hours • Convenient locations • May offer labs and X-rays • Care provided by U.S. board-certified doctors, nurses and nurse practitioners, depending on severity of symptoms

Remember to coordinate all your care with your primary care provider. Follow up with him or her after receiving care elsewhere.

LEARN ABOUT CARE THAT'S ALWAYS THERE AT **BCBSM.COM/FINDCARE**

This information isn't intended to be medical advice. In an emergency call 911 or go to an emergency room near you.
Not all services are covered by all plans. Log in to your member account to see what your plan covers.
*For language assistance, visit **bcbsm.com/language**. To view our nondiscrimination policy, visit **bcbsm.com/nondiscrimination**.
Teladoc Health® is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.
Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

Blue Cross Blue Shield Blue Care Network of Michigan

CF 16812 DEC 23

W011165

Commonly Asked Questions Regarding Your New Health Benefit Reimbursement Debit Card

Question	Answer
GENERAL INFORMATION	
What is the Benefit Reimbursement Card?	The Benefit Reimbursement Card is a prepaid debit card that contains the value of your Health Reimbursement Account (HRA). The card can be used at the point of sale to pay for eligible medical expenses with the payment taken directly from your HRA account. 
What is an eligible medical expense?	You can use your HRA account to reimburse you for amounts you pay for medical, dental, vision or prescription drug expenses, which are not covered by the Health Fund and which are considered a qualified medical expense as defined by the Internal Revenue Code. The HRA may be used for all "qualified medical expenses". Unfortunately, we cannot provide an exhaustive list of all possible "qualified medical expenses". A partial list is provided in IRS Pub 502 (available at www.irs.gov).
How many debit cards will I receive	Two debit cards, both of which will be issued in your name, will be sent to your home address at no cost to you. If you require additional cards, you can order them by contacting the Benefit Office at 800-572-8553 or via email at Local25BennyCard@benesys.com. There is a fee of $10 for additional or replacement cards if your card is lost or stolen. This fee will be deducted directly from your account. For a spouse or eligible dependent to use the card, they need only to sign the back of it.
ACTIVATING YOUR CARD	
How do I activate my cards?	To activate both of your cards, you must call 866-898-9795 as instructed on the front of the card or visit my.wexhealthcard.com. You only need to activate one card in order for both cards to work. Wait at least one (1) business day after activation for the cards to work. Anyone using the card should sign the card with their own name.
How much is on the Benefit Card?	The dollar value on the Benefit Card is the total amount in your HRA account. This amount will be sent to you monthly with your status slip.

Commonly Asked Questions Regarding Your New Health Benefit Reimbursement Debit Card

USING YOUR CARD	
How does the Card work?	The card works just like any other pre-paid credit card. When you purchase any eligible health care items or services at a business that accepts MasterCard®, you simply use your Benefit Card to purchase those items or services. The amount will then be deducted automatically from your HRA account. The Benefit Card eliminates most out-of-pocket cash outlays and paperwork, as well as the need to wait for reimbursement checks.
If my card can be used to pay for eligible medical expenses, where can I use it?	The Benefit Card can be used at most medical, dental and vision providers that accept MasterCard or VISA cards. This includes doctor's offices, hospitals, clinics and many other providers. The card may also be used on billing statements received from providers of the same types of service. Simply fill in the credit card area on the bill providing your WEX Health debit card number. If insurance coverage is available, make sure that the insurance company has processed the claim prior to the time you make your payment. This will ensure that any insurance discount and payment have been made so you are only paying your portion of the expense. Certain retail stores, like CVS or Rite Aid, may also be able to accept your debit card if they have installed an Inventory Information Approval System, referred to as IIAS. IIAS systems have the ability to separate eligible from ineligible expenses at the point of sale, which means the expense is auto-substantiated at the point of service. If the expense is auto-substantiated at the point of service, you will not have to provide additional documentation after the purchase. You can locate a list of IIAS Merchants via a link at www.iw25fringe.org. Pharmacies may be IIAS Merchants or 90% Rule Merchants. As IIAS Merchants, they auto-substantiate as explained above. If they are registered as a 90% Rule Merchant, the separation of eligible from ineligible expenses does not occur and you can generally expect to receive a request for additional documentation to substantiate the purchase. A list of 90% Rule Merchants can be found at www.iw25fringe.org.
If asked, should participants select "Debit" or "Credit" at checkout?	You should select "Credit." You do not need a PIN and cannot get cash with the Card.
How will the card work in participating stores and supermarkets?	**1.** Bring all of your eligible health care purchases to the register at checkout. **2.** Present the Benefit Card and swipe it for payment. **3.** If the transaction is approved, the amount of eligible purchases is deducted from your HRA account. Then use another form of payment for the purchases that cannot be reimbursed through your HRA. **4.** The receipt will identify the HRA-eligible items and may also show a subtotal of the HRA-

Commonly Asked Questions Regarding Your New Health Benefit Reimbursement Debit Card

	eligible purchases. **5.** In most cases, the Benefit Office will not request receipts for HRA-eligible purchases made in participating pharmacies or supermarkets.
Can I use my card if I receive a statement with a patient due balance for a medical service?	Yes, if all the following are true: (1) You and your covered dependents were eligible for insurance on the date you or your dependent received the services; (2) the dates of service were after February 1, 2023; (3) you have a sufficient balance in your HRA to cover the cost; and (4) the provider accepts MasterCard®. You can write the card number on your statement and send it back to the merchant and/or provider. The card will not work if you are trying to use it with a Collection Agency unless they are an IIAS certified provider; even if the card does work with the Collection Agency, you will be requested to submit an itemized billing to prove the charges are an eligible expense. **Before providing your Benefit Card number, be sure that the merchant or provider has submitted the charges to your medical carrier, and the carrier has processed and paid its portion of the claim. The amount remaining on the claim will be charged to the Benefit Card.**
How can I find out the balance on my card?	You may find the balance on your card by: 1. Logging on the Iron Workers Local 25 Participant Website at : www.iw25fringe.org 2. Creating an account on the WEX Health Participant Portal at: my.wexhealthcard.com 3. Calling the Benefit Office at 800-572-8553
What happens if I swipe the card for an amount greater than what is available in my account?	Your card works just like your personal debit card. If there is not enough money in the account, it will decline at the point of sale for insufficient funds.
What are some reasons that the Benefit Card might not work at point of sale?	The most common reasons why a card may be declined at the point of sale are: 1. The Benefit Card has not been activated. 2. You are not eligible for coverage from the Iron Workers Health Fund of Eastern MI. 3. The Benefit Card is being used less than 24 hours after activation. 4. You have insufficient funds in your HRA account to cover the expense. 5. Ineligible expenses were included at the point-of-sale. (Retry the transaction only with the eligible expense). 6. The merchant is encountering problems (e.g. coding or swipe box issues). 7. The merchant cannot identify HRA-eligible items at checkout.
What should I do if the store or provider doesn't accept VISA or Mastercard?	In the event that a provider or retailer does not accept VISA or MasterCards, you will need to arrange for a different payment method and submit the expense as a manual paper claim. Your claim must

Commonly Asked Questions Regarding Your New Health Benefit Reimbursement Debit Card

	be submitted with a completed claim form and an itemized bill from your provider or retailer. To obtain a claim form, please visit iw25fringe.org or call the Benefit Office at 800-572-8553.
What should I do if my card is lost or stolen?	To report your card lost or stolen, please contact the Benefit Office at 800-572-8553 or via email at Local25BennyCard@benesys.com.
When does the debit card expire?	Just like a debit or credit card, there will be an expiration date printed directly on the card. This date is typically 5 years from the date you receive it. A new card will automatically be issued to you 15 days before your card is set to expire.
SUBSTANTIATION	
Will I have to submit documentation?	IRS regulations have always required that expenses paid out of an HRA be substantiated to verify that they are eligible. This regulation has not changed with the addition of debit card technology. While BeneSys takes advantage of every method of auto-substantiation allowed by the IRS there are certain expenses that are difficult to auto-substantiate given the technology available. Therefore, when using your card, you should always retain an itemized receipt in case further substantiation is required. Failure to substantiate expenses may result in tax consequences (discussed below). ***Be assured, BeneSys is utilizing every method possible to reduce the number of requests you receive.***
What is considered valid documentation?	The regulations require that an itemized bill or statement showing the date of service/purchase, the services rendered/item purchased and the cost.
How will I know that my card transaction requires additional documentation for substantiation?	The IRS requires that the Fund substantiate all of the reimbursements from your HRA. Otherwise, the reimbursements from your HRA will be treated as income to you and you could end up receiving a 1099. Substantiation letters are sent in order to avoid this potential problem. Some reimbursements can be substantiated without needing anything from you. For example, a reimbursement that is equal to 1 to 5 times a copayment amount is considered by the IRS to be automatically substantiated. Other expenses that you use the Benefit Card for, however, may require more information from you. If you have a claim that requires additional substantiation, you will receive two (2) substantiation letters from the Benefits Office requesting a copy of a receipt for a Benefit Card purchase if the purchase does not match the date of service or charged amount for health care claim (medical, dental, vision, or pharmacy) that was made by you or a member of your family.
Where do I send valid documentation to substantiate my card transactions?	You may submit your substantiation documentation a few different ways: 1. **Email** - Local25HRAClaims@benesys.com **or** flexclaims@benesys.com 2. **Mail** - Substantiation Department, P.O. Box 99219, Troy, MI 48099 3. **Fax** - 248-731-5596 **or** 248-556-2596 4. **Participant Website** – iw25fringe.org. ***Note*** – you must be logged into the website using

Commonly Asked Questions Regarding Your New Health Benefit Reimbursement Debit Card

	your username and password in order to submit documentation 5. **Visit the Benefit Office** – 700 Tower Drive, Suite 300, Troy, MI 48098
What happens if I do not submit substantiation when it is requested?	Per the IRS guidelines, if substantiation is not submitted, the debit card transaction is considered an improper payment from the account. The debit card will be suspended from further use until the substantiation has been received (indicating the expense is an eligible one) or the amount of an ineligible expense has been paid back into your account (which then can be used for future eligible expenses). After the matter has been resolved, the debit card use will be reactivated. If not resolved, you will receive a 1099 tax form equal to the amount that requires substantiation.
How long should I keep my supporting documents?	Since the reimbursements you receive under the plan(s) are tax-free, you should keep all of your supporting documents with your tax return filed for that applicable tax year. You should keep all tax records until the period of limitations for that tax year ends. For more information on how long you should keep your records, please visit the IRS website at www.irs.gov.
What if I lose my receipts?	Usually, the merchant or provider can recreate an account history and provide a replacement receipt. In the event that a receipt cannot be located, recreated, or if the expense is ineligible, you will be required to send a check or money order to the Benefits Office for the amount so it can be credited back to your HRA account.
What If I fail to submit documentation to substantiate my reimbursement claim?	If you do not respond to either substantiation letter, and you do not submit receipts to verify the charge on your Benefit Card, then your card may be temporarily suspended. If not resolved, you will receive a 1099 tax form equal to the amount that requires substantiation. The Benefit Office will advise you if your card has been suspended or if a receipt is not received. Submitting a receipt or repaying the amount in question will activate the card again.
OTHER IMPORTANT INFORMATION	
How long do I have to submit a claim for reimbursement?	You have 12 months from the date the expense was incurred to submit reimbursement requests.
Is there a minimum amount for reimbursement requests?	Yes. If submitting a paper reimbursement request the minimum amount must total $25.00.

Commonly Asked Questions Regarding Your New Health Benefit Reimbursement Debit Card

Can my HRA account balance be forfeited?	Yes. If you are ineligible for coverage for at least 36 consecutive months, your HRA account will be forfeited. If you retire, you can use your HRA as long as you continue coverage with the Iron Workers Health Fund of Eastern MI. Upon the death of a Participant, any balance in his/her HRA will transfer to his/her Surviving Spouse, provided such individual otherwise qualifies for Surviving Spouse coverage. Upon the death of the Surviving Spouse, his/her HRA will terminate.
Can the HRA be terminated?	Yes. Like any other benefits provided by the Health Fund, the Fund may terminate the HRA at any time for any reason. Participants have no vested interest in the HRA. At all times, amounts in the HRA are the property of the Iron Workers Health Fund of Eastern MI.

IRON WORKERS' LOCAL NO. 25
FRINGE BENEFIT FUNDS
P.O. BOX 99219
TROY, MI 48099-9219

Important Fund Information

IRON WORKERS' LOCAL NO. 25 FRINGE BENEFIT FUNDS
DEFINED BENEFIT PENSION FUND

Beneficiary Election Form

Member's Name_____ **SS #** _____

Address _____**Phone**_____

Spouse's Name _____ **SS#** _____

Below please indicate the person(s) you wish to name as beneficiary(ies) of any death benefits through the above listed Pension Fund.

Note: If you are legally married at the time of your death Federal law and the Pension Plan require that benefits be paid to your surviving spouse, unless your spouse consents to the payment of the benefit to someone else. To make that type of change, the Pension Plan will require a notarized statement from your spouse – see bottom of form for notarized consent by your spouse.

Beneficiary Designation

Primary Beneficiary _____ Percentage of benefit** _____
SS# _____ Relationship _____
Address_____

Primary Beneficiary _____ Percentage of benefit** _____
SS# _____ Relationship _____
Address_____
**(PLEASE NOTE: THE TOTAL PERCENTAGE OF BENEFIT FOR PRIMARY BENEFICIAIES LISTED MUST EQUAL 100%)

In the event your Primary Beneficiary(ies) pre-deceases you, the below listed Contingent Beneficiary(ies) will be paid based on the percentages you indicate.

Contingent Beneficiary _____ Percentage of benefit* _____
SS# _____ Relationship _____
Address_____

Contingent Beneficiary _____ Percentage of benefit* _____
SS# _____ Relationship _____
Address_____
*(PLEASE NOTE: THE TOTAL PERCENTAGE OF BENEFIT FOR ALL CONTINGENT BENEFICIAIES MUST EQUAL 100%)

(Attach additional paper if necessary–please ensure that you indicate "primary" or "contingent" and percentage.)

I understand that this beneficiary designation cancels any previous designation I may have made and will be effective when received in the Fund office and only if **received** prior to my death. Further, I understand that this designation shall be cancelled if my current marriage ends and I remarry, which would make my legal spouse at the time of my death my new primary beneficiary.

Member's Signature _____ **Date** _____

Spousal consent of alternate beneficiary designation as noted above:

I hereby consent to my spouse's designation of the above beneficiary for death benefits payable through this Fringe Benefit Fund. I fully understand that by signing below, I will not be eligible for the receipt of the benefits payable on behalf of my spouse in the event of his or her death.

Spouse's Signature _____ **Date**_____

Subscribed to and sworn
to before me, this ____day of _____, 20_____.
Notary Public Signature_____
County of_____ State of _____
My Commission expires: _____