SUMMARY PLAN DESCRIPTION

IRON WORKERS' HEALTH FUND OF EASTERN MICHIGAN BENEFIT PLAN

2013

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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, alveoplasty 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.

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