SHEET METAL WORKERS' LOCAL UNION NO. 80
INSURANCE TRUST FUND

SUMMARY PLAN DESCRIPTION

OF THE PLAN FOR

CONSTRUCTION EMPLOYEES, PRODUCTION JOURNEYMEN,
RESIDENTIAL/LIGHT COMMERCIAL JOURNEYMEN,
ARCHITECTURAL METAL JOURNEYMEN (PPO COVERAGE),
OWNER-MEMBER EMPLOYEES,
NON-BARGAINING UNIT EMPLOYEES (PPO COVERAGE)

AND

NON-MEDICARE-ELIGIBLE RETIREES WITH PPO COVERAGE

As Of June 1, 2022

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

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IMPORTANT NOTICE

This Summary Plan Description describes the Plan for Employees classified as Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen, Architectural Metal Journeymen (PPO Coverage), Owner-Member Employees, Non-Bargaining Unit Employees (PPO Coverage) and Non-Medicare-Eligible Retirees with PPO Coverage as it is in effect on June 1, 2022.

The Plan of the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund also covers Employees classified as Production Employees, Residential and/or Light Commercial Employees, Service Employees, Duct Cleaning Employees, Apprentices, Special Resolution 78 Journeymen, Architectural Metal Journeymen (HMO coverage), Non-Bargaining Unit Employees (HMO coverage), Non-Medicare-Eligible Retirees with HMO coverage and Medicare-Eligible Retirees. If you have questions about the Plan as it applies to those individuals, contact the Fund Office for a separate summary plan description.

One word of caution: NO ONE HAS THE AUTHORITY TO SPEAK FOR THE BOARD OF TRUSTEES IN EXPLAINING THE ELIGIBILITY RULES OR BENEFITS OF THE FUND, EXCEPT THE FULL BOARD OF TRUSTEES.

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

SHEET METAL WORKERS' LOCAL UNION NO. 80 INSURANCE TRUST FUND

IMPORTANT ADDRESSES AND PHONE NUMBERS

BOARD OF TRUSTEES

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Sheet Metal Workers' Local Union No. 80
17100 W. 12 Mile Road
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The Board of Trustees is the legal Plan Administrator.

FUND OFFICE/ADMINISTRATIVE MANAGER

BeneSys, Inc.

Street Address:
700 Tower Drive, Suite 300
Troy, MI 48098-2808

Mailing Address:
P.O. Box 1408
Troy, Michigan 48099-1408

Phone (local): (248) 641-4980
Phone (toll-free): (800) 400-7710
Fax: (248) 813-9898

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

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

AGENT DESIGNATED FOR SERVICE OF LEGAL PROCESS

Joseph Pawlick, Esq.
Watkins, Pawlick, Calati & Prifti, PC
1423 East Twelve Mile Road
Madison Heights, MI 48017

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

FUND WEBSITE

www.sheet80fringe.org

Please contact the Fund Office for your user name and password.

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

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

INTRODUCTION

To All Participants and Dependents:

We are pleased to provide you with this summary description of the Plan for Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen, Architectural Metal Journeymen (PPO coverage), Owner-Member Employees, Non-Bargaining Unit Employees (PPO coverage) and Non-Medicare-Eligible Retirees with PPO coverage as it is in effect on June 1, 2022. If you have questions about the Plan or your rights under the Plan, contact the Fund Office.

The Plan of the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund also covers Production Employees, Residential and/or Light Commercial Employees, Service Employees, Duct Cleaning Employees, Apprentices, Special Resolution 78 Journeymen, Architectural Metal Journeymen (HMO coverage), Non-Bargaining Unit Employees (HMO coverage), and Non-Medicare-Eligible Retirees with HMO coverage. Those employees should refer to the Summary Plan Description for Production Employees, Residential and/or Light Commercial Employees, Service Employees, Duct Cleaning Employees, Apprentice and Probationary Employees, Special Resolution 78 Journeymen, Architectural Metal Journeymen (HMO coverage), Non-Bargaining Unit Employees (HMO coverage), and Non-Medicare-Eligible Retirees with HMO coverage. The Plan also covers Medicare-Eligible Retirees, who should refer to the Summary Plan Description tailored for them.

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

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

You should read this material carefully and keep it for reference. It will help you to understand how the Plan works, what rights and benefits it provides for you and your family, and how to obtain those benefits. This Summary reflects the provisions as they were in effect on June 1, 2022. Information on any changes made after that date are provided to you in the annual cumulative Summary of Material Modifications, and interim notices issued by the Fund Office. Keeping these materials together is the best way to have complete information on Plan provisions; however, if you have any question about any Plan provision, you should always contact the Fund Office before receiving any non-emergency services.

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

As Trustees, we pledge to maintain the best and most equitable program we can within the Fund's resources. We hope the benefits available through the Fund will serve the needs of you and your family.

Board of Trustees

David Karl	Tim Mulligan
Rick Mead	David Hartsuck
Dawn Norris-Senopole	Bryan McConnell
Ian Switalski	Eric McPherson

GENERAL INFORMATION

The Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund was created through collective bargaining. It is sponsored and administered by a Board of eight Trustees. Four of the Trustees are Union Trustees, where one is the Business Manager of the Sheet Metal Workers' Local Union No. 80 (the Union) and the other three are elected directly by the Union membership. The other four Trustees are appointed by SMACNA, Metropolitan Detroit Chapter, Inc. (the Association). The Board of Trustees is the legal Plan Administrator and it has hired the firm of BeneSys, Inc. as Administrative Manager to operate the program on a day-to-day basis.

The benefits under the Plan for Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen, Architectural Metal Journeymen (PPO Coverage), Owner-Member Employees, Non-Bargaining Unit Employees (PPO coverage) and Non-Medicare-Eligible Retirees with PPO coverage are provided on a **"self-funded"** (non-insured) basis, which means that all benefits from this Plan are paid for directly from the assets of the Fund, and are not paid by any insurance company. The Fund has hired BeneSys, Inc. for claims processing and other administrative functions only. The Fund has also hired BCBSM for provision of a medical network, prescription drug network and claims processing, vision network and claims processing (administered by VSP), Ulliance for Member's Assistance Program, and the Fund participates in the Delta Dental program.

You have the right to receive information on the BCBSM's PPO schedule of usual and customary amounts, and the usual and customary amounts that the Fund uses to determine, based on the nature of the illness, injury or other medical condition and the treatment provided, the amounts it will pay to health care providers.

The Fund has been assigned an Employer Identification Number by the Internal Revenue Service. It is 23-7165969. The Plan Number is 501.

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

The Plan established by the Board of Trustees is subject to the Employee Retirement Income Security Act of 1974, as amended, usually referred to as ERISA.

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

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

You (the employee or retiree) are entitled to participate in the Fund if you work or have worked under a collective bargaining agreement that requires your employer to make, and the employer does make, contributions to the Plan on your behalf. Other persons who may participate in the Fund are certain retirees, and officers and employees of the Union, the Association, the Apprenticeship School and other such organizations as may participate under the provisions of a participation agreement.

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

If you have any questions about the Fund's Plan, you should contact the Fund Office or the Board of Trustees.

Your rights under federal law as a participant in this program are set out in the ERISA RIGHTS section of this booklet, which you are urged to read and which begins on page 65.

IMPORTANT NOTICE – TIME LIMIT FOR FILING LAWSUITS

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

TRUSTEE AUTHORITY

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

Notices of any changes or deletions of the information in this booklet will be provided to each participant within the time required by any applicable regulations, but some changes may take effect before you are notified of a change. Before incurring any non-emergency expense, you should contact the Fund Office to confirm your current entitlement to coverage.

This booklet is intended to give you an accurate summary of the benefits and provisions of the Fund's Plan. It does not describe Plan changes that occurred after the booklet was printed. The Plan and the Agreement and Declaration of Trust, which you can read at the Fund Office or other specified locations, contain a detailed description of the rules, regulations, benefits and

provisions of the Fund. If any discrepancy exists between this booklet and the Plan documents, the provisions of the Plan documents will govern.

Only the full Board of Trustees is authorized to interpret the Plan and the benefits described in this booklet. The Board of Trustees' interpretation is final and binding on all persons dealing with the Fund or claiming a benefit from the Fund. If a decision of the Board of Trustees is challenged in court, that decision will be upheld, under current law, unless it is determined by the court to have been arbitrary and capricious. No agent, representative, officer or other person from the Union, the Association, or an employer has the authority to speak for the Board of Trustees or to act contrary to the written terms of the governing Plan documents.

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

DOING YOUR PART

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

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

Keep the Fund Office informed about you. One of your most important responsibilities is to make certain that the Fund Office always has current and accurate information about you and your dependents. This information is necessary in order for you to get notices, cards, verification of benefits, updates, for beneficiary designations, and numerous other reasons important to your coverage.

- You must complete a beneficiary card and other materials immediately and return them to the Fund Office if you are a new participant.

- Whenever any of the information on the beneficiary card or other materials changes, you must notify the Fund Office **immediately**. Some of the important changes include any change in your address, any change in your family, such as *marriage, birth, adoption, death, divorce, legal separation or a child losing dependent status, and any change in the beneficiary designation* for purposes of the Fund's Death Benefit. Failure to notify the Fund Office of these matters can result in loss of COBRA rights, missed notices from the Fund Office, personal responsibility for claims paid or medical expenses incurred, and distribution of a death benefit in a manner that was unintended.

- Other important things you should tell the Fund Office are:

    - If you are unable to work due to accident or illness;
    - If your disability has terminated;
    - If your employment with a contributing employer has terminated and you wish to continue your insurance by self-payment;
    - If you have applied for military, family or medical leave from your employer;
    - If a court has entered a qualified medical child support order directing that health care coverage be provided for your child(ren) through the Fund; and
    - If you or your dependent(s) are eligible for or have received benefits under another health care plan, insurance contract, program or statute.

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

Carry your cards. You should have a BCBSM PPO card. Be certain to carry this and show it whenever you receive medical care or get a prescription.

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

Keep notices you receive from the Fund. After the publication of this booklet, you will receive notices of benefit changes as they occur. You should keep those together with this booklet in order for you to have a complete record of the Fund's communications to you on your benefits.

Keep careful track of your hours worked and contributions submitted to the Fund on your behalf, and let the Fund know if your employer has not paid. The eligibility of working participants depends on hours worked plus contributions received. Many workers keep a log of their hours, by date, job and employer.

If your employer has failed to submit contributions on your behalf for hours you have worked, tell the Fund Office immediately. You may have to make a self-payment to continue your eligibility, but the Fund routinely pursue collection of any amounts owed and not paid by employers, and the sooner the Fund knows about this, the better. If the Fund recovers the amount due, any self-payments not needed are refunded.

Identify yourself. When you write to the Fund Office, please be sure to include your name, the alternative I.D. number and your trade in your letter. If you call, please be sure to have your alternative I.D. number handy.

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

Notify the Fund Office if you are working outside the Local 80 area. If you are traveling and your employer is making health care contributions on your behalf, check with the Local 80 Fund Office to find out whether there is a reciprocity agreement with the health care fund in the area where you are working and what you must do to have those contributions transferred to this Fund.

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

ADMINISTRATIVE RESPONSIBILITIES

The Plan Administrator, as a legal matter, is the Fund's Board of Trustees. However, the Board of Trustees has divided the day-to-day operations of the Fund into separate areas of responsibility, and has delegated them to the Fund Office, Blue Cross Blue Shield of Michigan, Delta Dental and Ulliance.

Fund Office: The Fund Office is responsible for the following:

- Day-to-day details of running the Fund, including all financial and record-keeping functions
- All matters pertaining to eligibility
- Self-payments, including actives, retirees, surviving spouse and COBRA
- Determination and processing of claims for the following benefits:
    - Medical, Surgical and Hospital Benefits
    - Weekly Disability Benefits
    - Accidental Death and Dismemberment Benefits
    - Death Benefits
- Reviewing and presenting appeals concerning eligibility and benefits which are administered at the Fund Office to the Board of Trustees

Blue Cross Blue Shield of Michigan (BCBSM) Preferred Provider Organization (PPO): The Fund has a contract with Blue Cross Blue Shield of Michigan (BCBSM) Preferred Provider Organization (PPO) to provide and maintain a network of providers that Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen, Architectural Metal Journeymen (PPO coverage), Owner-Member Employees. Non-Bargaining Unit Employees (PPO Coverage) and Non-Medicare Eligible Retiree participants and their dependents, can use as a preferred provider organization. BCBSM administers and pays all prescription drug claims. In addition, BCBSM, through VSP, provides vision services for Fund participants.

Delta Dental: The Fund has a contract with Delta Dental to determine and process all dental benefits.

Ulliance: The Fund has a contract with Ulliance to provide Member's Assistance Program (M.A.P.) services.

ELIGIBILITY AND COVERAGE

INITIAL ELIGIBILITY REQUIREMENTS

1. Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen, Architectural Metal Journeymen (PPO coverage)

You will be initially eligible for benefits on the first day of the month after you have been credited with 500 hours of work and employer contributions within the immediately preceding six consecutive months or less and you will remain eligible based on those hours of work and contributions for three months.

> **Example**: If you work a total of at least 500 hours (for which all employer contributions have been received by the Fund) in April, May, June, July, August and September, you become eligible for benefits on October 1 and you will remain eligible based on those hours of work and contributions for the months of October, November and December.

2. Owner-Members

You will be initially eligible for benefits on the first day of the month immediately following three consecutive months in each of which the Fund has received 160 hours of employer contributions on your behalf.

> **Example**: If the Fund receives employer contributions on your behalf for 160 hours in April, 160 hours in May and 160 hours in June, you will be eligible for benefits for the month of July.

3. Non-Bargaining Unit Employees (PPO coverage)

You will be initially eligible for benefits on the first day of the fourth month following the Fund's receipt of the required monthly employer contribution amount under the applicable Health Agreement in each of the three (3) preceding months.

> **Example**: If the Fund receives required employer contributions on your behalf under the applicable Health Agreement for April, May and June, you will be eligible for benefits for the month of July.

When you become eligible, you will be furnished with an application form to report all of your eligible dependents. This form should be completed and returned to the Fund Office as quickly as possible. Be certain to report all changes, additions, and deletions to your list of eligible dependents to the Fund Office immediately.

CONTINUING ELIGIBILITY REQUIREMENTS

1. Continuation by Working

Special Note - A bookkeeping period has been instituted for accounting, reporting and notification of eligibility to employees. Eligibility will be determined according to the following schedule:

Hours worked and employer contributions received for…	will provide eligibility for the Eligibility Month of . . .
June	September
July	October
August	November
September	December
October	January
November	February
December	March
January	April
February	May
March	June
April	July
May	August

(A) Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen

Once you have established initial eligibility for benefits, you will continue to be eligible for benefits in any month (eligibility month) in which you meet one of the following requirements:

(1) Your eligibility will continue if you were credited with 1,000 hours of work and employer contributions during the 12 consecutive months ending on the last day of the third calendar month prior to the eligibility month, **or**

(2) Your eligibility will continue if you have been credited with 125 hours of work and employer contributions for the third calendar month prior to the eligibility month.

Example: You will have coverage for the June eligibility month if you work (and employer contributions are received for) a total of at least 1,000 hours in the 12-month period from April through March. If you don't meet the above requirement, you would have coverage for the June eligibility month only if you work (and employer contributions were received for) at least 125 hours in March.

(B) Architectural Metal Journeymen (PPO Coverage)

Once you have established initial eligibility for benefits, you will continue to be eligible for benefits in any month (eligibility month) in which you meet one of the following requirements:

(1) Your eligibility will continue if you were credited with 750 hours of work and employer contributions during the 12 consecutive months ending on the last day of the third calendar month prior to the eligibility month, **or**

(2) Your eligibility will continue if you have been credited with 100 hours of work and employer contributions for the third calendar month prior to the eligibility month.

> **Example:** You will have coverage for the June eligibility month if you work (and employer contributions are received for) a total of at least 750 hours in the 12-month period from April through March. If you don't meet the above requirement, you would have coverage for the June eligibility month only if you work (and employer contributions were received for) at least 100 hours in March.

(C) Owner-Member Employees

Once you have established initial eligibility for benefits, you will continue to be eligible for benefits if 160 hours of employer contributions are made on your behalf each month. Once in any consecutive 12-month period, you will be permitted to continue to be eligible for benefits if employer contributions are made on your behalf for at least 80 hours.

> **Example**: If the Fund receives 160 hours of employer contributions on your behalf in April, your benefits will continue for July. If the Fund receives 80 hours of employer contributions on your behalf in May and it had received 160 hours of employer contributions on your behalf each of the 12 months preceding May, your benefits will continue for August.

(D) Non-Bargaining Unit Employees (PPO coverage)

Once you have established initial eligibility for benefits, you will continue to be eligible for benefits if the required hours of employer contributions under the applicable Health Agreement are made on your behalf each month.

> **Example**: If the Fund receives the required hours of employer contributions on your behalf in April, your benefits will continue for July.

2. Continuation by Self-Payments

Self-payments are due in the Fund Office on the 25th of the month before the month in which you want to maintain your eligibility.

(A) Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen

If you work at least 1 hour but fewer than 125 hours in a month, you may continue your eligibility by making self-payments to the Fund at either:

(1) the employer hourly contribution rate so that the total of hours paid by your employer and by you is 125, in which case you will be credited with 125 hours of work and contributions, **or**

(2) for a period not to exceed four consecutive months only, a subsidized self-payment rate established by the Board of Trustees (which is subject to change by the Board of Trustees), in which case you will be credited only with the actual hours of work and contributions.

> **Example:** If you work 50 hours in April, you may self-pay **either** 75 hours at your employer's contribution rate, in which case you will be credited with 125 hours of work and contributions, **or** you may pay the self-payment rate established by the Board of Trustees (which is subject to change by the Board of Trustees), in which case you will be credited with only 50 hours of work or contributions.

Note: If you become eligible for COBRA due to termination of employment or reduction of hours because you have worked zero hours in a month, you may elect to pay the full HMO COBRA rate and to receive the HMO COBRA coverage provided by the Plan to other classifications for your entire COBRA continuation period. If you return to work for fewer than 125 in a month during a period when you are making self-payments for HMO coverage, you will be permitted to self-pay for the PPO coverage in the usual manner.

(B) Architectural Journeymen (PPO coverage)

If you work at least 1 hour but fewer than 100 hours in a month, you may continue your eligibility by making self-payments to the Fund at either

(1) the employer hourly contribution rate so that the total of hours paid by your employer and by you is 100, in which case you will be credited with 100 hours of work and contributions, **or**

(2) for a period not to exceed four consecutive months only, a subsidized self-payment rate established by the Board of Trustees (which is subject to change by the Board of Trustees), in which case you will be credited only with the actual hours of work and contributions.

> **Example:** If you work 50 hours in April, you may self-pay **either** 50 hours at your employer's contribution rate, in which case you will be credited with 100 hours of work and contributions, **or** you may pay the self-payment rate established by the Board of Trustees (which is subject to change by the Board of Trustees), in which case you will be credited with only 50 hours of work and contributions.

Note: : If you become eligible for COBRA due to termination of employment or reduction of hours because you have worked zero hours in a month, you may elect to pay the full HMO COBRA rate and to receive the HMO COBRA coverage provided by the Plan to other classifications for your entire COBRA continuation period. If you return to work for fewer than 100 in a month during a period when you are making self-payments for HMO coverage, you will be permitted to self-pay for the PPO coverage in the usual manner.

(C) Owner-Member Employees and Non-Bargaining Unit Employees (PPO coverage)

Owner-Member Employees and Non-Bargaining Unit Employees (PPO coverage) are not permitted to continue coverage by self-payment except as provided under COBRA continuation coverage provisions.

3. Transfer of Class by Employee

If you transfer to employment covered by a different employee classification, the hours reported under each classification will be used to determine your eligibility for benefits. However, benefits for the month in which your claim occurs will be processed according to the schedule of benefits and provisions of the Plan applicable to the Class in which you were working in the month your eligibility was earned.

> **Example**: If you transfer employment from a Residential Employee to a Construction Employer as of April 1, any claims incurred before July 1 will be processed according to the schedule of benefits and provisions applicable to Residential participants and any claims incurred after July 1, according to the schedule of benefits and provisions of the Plan applicable to Construction participants.

DISABILITY ELIGIBILITY

1. **Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen, Architectural Metal Journeymen (PPO coverage)**

You will be eligible to receive a loss-of-time credit equivalent to 31.25 hours of work (25 hours of work for Architectural Metal Journeyman (PPO Coverage)) for each week you:

- are eligible to receive Weekly Disability Benefits under this Plan (see page 39 of this Summary for an explanation of those Benefits) or
- are not eligible to receive Weekly Disability Benefits under this Plan because:
  - your injury or illness was work related or
  - your injury was suffered in an auto/vehicular accident

provided you are eligible for benefits under this Plan at the time of the injury or illness.

Loss-of-time credits are applied to keep you eligible under the rules for Continuation by Working.

You must submit an application to the Fund Office for loss-of-time credits as soon as reasonably possible after the accident or sickness, but no later than 20 days after the accident or onset of sickness.

If you remain disabled after you have exhausted your eligibility for loss-of-time credits (based on the maximum of 26 weeks eligibility for Weekly Disability Benefits), then you may exhaust the extended eligibility you accrued while working.

Finally, if you remain disabled after you have exhausted the extended eligibility you accrued while working, you may continue coverage for up to an additional 18 or 29 consecutive months by making payments under COBRA (see page 28 of this Summary).

2. Owner-Member Employees

If you become disabled and unable to work you may continue coverage for up to 29 consecutive months by making payments under COBRA. (See page 28 of this Summary).

TERMINATION OF ELIGIBILITY

1. Construction Employees, Production Journeymen and Residential/Light Commercial Journeymen

If you have not worked and had employer contributions remitted on your behalf based on 1,000 hours in the consecutive 12-month period ending on the last day of the third calendar month immediately preceding the eligibility month, or you have not worked and had employer contributions remitted on your behalf based on at least 125 hours in the third calendar month prior to the eligibility month, your eligibility will end on the last day of the last month for which you were eligible based on your hours of work and employer contributions received. However, if you work at least one (1) hour in a month, you may continue eligibility by making self-payments as described above. If you do not work even one hour in a month, you may elect COBRA continuation coverage.

2. Architectural Journeymen (PPO coverage)

If you have not worked and had employer contributions remitted on your behalf based on 750 hours in the consecutive 12-month period ending on the last day of the third calendar month immediately preceding the eligibility month, or you have not worked and had employer contributions remitted on your behalf based on at least 100 hours in the third calendar month prior to the eligibility month, your eligibility will end on the last day of the last month for which you were eligible based on your hours of work and employer contributions received. However, if you work at least one (1) hour in a month, you may continue eligibility by making self-payments as described above. If you do not work at least one hour in a month, you may elect COBRA continuation coverage.

3. Owner-Member Employees

If employer contributions for 160 hours are not received on your behalf in a month (or 80 hours once in a 12 month period), your eligibility will terminate on the last day of the last month for which you were eligible based on required employer contributions received. If your coverage has stopped because you have suffered a qualifying event, you may elect COBRA continuation coverage.

4. Non-Bargaining Unit Employees (PPO coverage)

If employer contributions for the required number of hours under the applicable Health Agreement are not received on your behalf in a month, your eligibility will terminate on the last day of the last month for which you were eligible based on required employer contributions received. If your coverage has stopped because you have suffered a qualifying event, you may elect COBRA continuation coverage.

REINSTATEMENT OF ELIGIBILITY

1. Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen and Architectural Metal Journeymen (PPO coverage)

If your eligibility had terminated for less than 12 months, you will be eligible for benefits again on the first day of the second month following the month after you have been credited with **300** hours of work and employer contributions during a consecutive six (6) month period or less, and such eligibility shall continue until the last day of the fourth month following the month in which such requirements were met (that is, three months of coverage).

> **Example**: If your eligibility terminated on April 30 and you then work 300 hours in July, August and September for which all employer contributions are paid, you will again become eligible for benefits on November 1 and you will remain eligible based on those hours of work and employer contributions for the months of November December and January.

If your eligibility has terminated for less than 12 months, you will also be eligible for benefits again on the first day of the second month following the month after you have been credited with **at least 175 but less than 300** hours of work for which the Fund has received employer contributions during a consecutive six (6) month period or less, if you make a self-payment to the Fund at the current applicable contribution rate for your work classification so that the sum of the hours paid by your employer(s) and the hours for which you make self-payment equals 300.

Eligibility shall be reinstated on the first day of the second month following the month in which such requirements were met, and such eligibility shall continue until the last day of the fourth month following the month in which such requirements were met (that is, three months of coverage).

Example: If your eligibility terminated on April 30 and you then work 200 hours in July, August and September for which all employer contributions are paid, you will again become eligible for benefits on November 1 and you will remain eligible based on those hours of work and employer contributions for the months of November December and January if you remit a self-payment equal to100 hours multiplied by the current applicable contribution rate for your work classification, so that the sum of the hours paid by your employer(s) and the hours for which you make self-payment equals 300.

If eligibility was terminated more than twelve months earlier, you must satisfy the Fund's initial eligibility requirements in order to again be eligible for benefits.

2. Owner-Member Employees and Non-Bargaining Unit Employees (PPO coverage)

If your eligibility has terminated, you must satisfy the Fund's initial eligibility requirements in order to again be eligible for benefits.

RECIPROCITY

The Board of Trustees has entered into reciprocity agreements with other insurance and health care funds covering sheet metal workers throughout the country. Under these reciprocity agreements, employer contributions made on your behalf may be transferred from one fund to another upon your written request and authorization. Transferring contributions may enable you to meet the continuing eligibility requirements of this Fund or another fund. If you work in another jurisdiction and employer contributions are made to another fund on your behalf, you should request that such contributions be transferred to this Fund under the reciprocity agreement, if there is an agreement between that fund and this Fund.

Because employer contribution rates vary between funds, employer contributions received by this Fund from other funds pursuant to the terms of a reciprocity agreement shall be credited by this Fund toward hours for purposes of an Employee's eligibility on a pro-rata basis; that is, the hours credited based on the receipt of employer contributions shall be reduced as necessary to reflect a lower hourly contribution rate in the area in which the work was performed. As such, it is possible that even though the actual hours you work in another jurisdiction would have been sufficient for you to continue eligibility under this Fund, the pro-rated hours may not be enough to maintain eligibility under the Fund. Therefore, you may be required to make self-payments as described above in order to remain eligible. If the hourly contribution rate in the area in which the work was performed is higher, no additional hours will be credited.

You should contact the Fund Office to find out whether there is a reciprocity agreement between this Fund and another fund and, if there is, sign the necessary request form to have contributions transferred.

ELIGIBILITY OF DEPENDENTS

1. Dependent Children and Spouse

As a general rule, your dependents are eligible anytime you are eligible. Dependents are **never** eligible for M.A.P. Benefits, Death Benefits, Accidental Death and Dismemberment Benefits or Weekly Disability Benefits.

A. Who are your Dependents?

(1) **Your current lawful spouse**, if not legally separated or divorced.

A spouse's eligibility for coverage ends at the end of the month of divorce or legal separation from the participant. It is your obligation to notify the Fund immediately upon your divorce or legal separation. You must provide a copy of the Judgment of Divorce or Legal Separation to the Fund Office. If you delay in providing this notice and documentation of your divorce to the Fund, and the Fund pays benefits on behalf of a former spouse, you are liable to repay the Fund those amounts, and the Fund will pursue collection of those amounts from you. The Fund reserves the right to recover the amount of any benefits paid on behalf of your former or separated spouse from you, from your former or separated spouse, and from both of you, through offsetting the amount paid on behalf of your former or separated spouse from any future benefits payable to you, through litigation, through termination of your participation in the Fund and through any other lawful means. The Fund's attorneys pursue recoveries of such amounts aggressively. Any coverage for a former spouse after the date of entry by the court of a judgment of divorce or decree of legal separation is available only under the terms of COBRA continuation coverage. If the Fund Office is not notified of a divorce or legal separation within 60 days of the date of its entry, the Plan will not offer COBRA coverage.

(2) Each of your children, as limited immediately below, regardless of the child's marital status or the child's eligibility for other coverage.

Your "Child" is defined as your biological sons and daughters, adopted children (including children placed for adoption), stepchildren, and foster children prior to the last day of the calendar month in which such child reaches age twenty-six (26) years. A dependent child described in this subsection may not be older than you.

If you decide to disenroll a child who was previously covered as a dependent hereunder, you must do so in writing and on a form satisfactory to the Board of Trustees filed with the Fund office. Such election shall be effective as soon as administratively feasible, but not before the first day of the month following the month within which the election is received by the Fund. If you seeks to re-enroll a dependent child whom you previously elected to disenroll, then the dependent child shall be eligible for coverage as soon as administratively feasible, but not before the first day of the month following the month within which the election is received

by the Fund.

A stepchild's dependent coverage ends immediately upon that stepchild's natural parent's divorce from you. By seeking coverage of a stepchild, you agree to be personally liable to the Fund for any amounts the Fund pays in benefits for services rendered to or on behalf of the stepchild after the date of the entry of the judgment or decree of your divorce from the stepchild's natural parent but prior to notification to the Fund of the divorce.

No child shall be considered a dependent under this Plan after the end of the calendar month in which the child attains the age of twenty-six (26) years, except that any child who becomes totally and permanently disabled from either a physical or mental condition prior to the end of the calendar month in which he or she attains the age of twenty-six (26) shall continue as a dependent for as long as the permanent disability exists, at your election in accordance with the procedures set forth by the Board.

The Board of Trustees may, upon application, grant dependent status to a child otherwise related to you or your covered spouse if you or your covered spouse are the full legal guardian (other than a limited or temporary guardian), if the child otherwise meets the Internal Revenue requirements for dependent status and if the Board believes the relationship approximates that of child and parent. An individual who is not your or your dependent spouse's child shall not be a "dependent" as described above unless (1) the parents of such child do not claim the child as a dependent; and (2) your and your dependent spouse's adjusted gross income is higher than the highest adjusted gross income of any of that individual's parents. The Fund shall require proof that this requirement is satisfied prior to any individual being considered a dependent child. A dependent described in this subsection may not be older than you or your dependent spouse.

Status as a dependent hereunder shall require such documentation as the Fund may require from time to time, including, but not limited to, Federal income tax records, adoption records, physician's statements, birth certificates, marriage certificates, qualified medical child support orders and judgments of divorce or orders for separate maintenance. In the event that the required documentation is not filed and a claim is received, the Fund Office is required to request **and** obtain such proof **before** the claim can be processed.

B. Enrolling Your Dependents

You may enroll a newly eligible dependent for coverage under the Plan, retroactive to the date such person became your dependent, by giving the Fund written notice with all required documentation (birth certificates, adoption papers, marriage certificates, etc.) within thirty (30) days of the date such person becomes your dependent. If the Fund office does not receive such notice with all required documentation within thirty (30) days of such person becoming your dependent, the dependent may be enrolled for coverage under the Plan on a prospective basis only, with coverage to begin no earlier than the date on which the Fund receives the notice and can administratively implement such request for coverage.

If any dependent (a spouse or a child) is not enrolled in the Plan at the time you enroll because your dependent is covered by another health plan, your dependent may enroll in the Plan within 30 days of the loss of that other coverage (as long as the dependent continues to be eligible as a dependent under the Plan). This also applies to the spouse of a retiree who has other coverage and elects the dental/vision coverage only option – such spouse can enroll in the Plan within 30 days of the loss of that other coverage.

If you were never married to the mother of the dependent child you claim at the time of the dependent's birth, you must provide proof of paternity when you enroll the child for coverage. Proper proof includes a duly registered birth certificate naming you as the father, an order of filiation or an adoption order.

An Employee, or his dependent, who is eligible, but not enrolled, for coverage under the Plan may enroll for coverage under the Plan if either:

(1) the Employee or dependent is covered under a Medicaid plan or State CHIP; coverage of the Employee or dependent under such Medicaid plan or State CHIP is terminated as a result of loss of eligibility for the Medicaid plan or State CHIP; and the Employee requests coverage under this Plan no later than 60 days after the date the Employee's or dependent's coverage under such Medicaid plan or State CHIP terminates; or

(2) the Employee or dependent becomes eligible for assistance under a Medicaid plan or State CHIP (including under any waiver or demonstration project conducted under or in relation to those plans), and the Employee requests coverage under this Plan no later than 60 days after the date the Employee or dependent is determined to be eligible for such assistance.

C. Termination of Dependent Coverage by the Plan

A dependent's coverage shall terminate upon the occurrence of the first of the following events:

(a) termination of your eligibility under the Plan.

(b) termination of his/her status as a dependent as defined in the Plan.

(c) elimination of dependent coverage under the Plan.

If you die, the eligibility of your dependents shall terminate on the last day of the calendar month of your death, unless the dependent applies for COBRA continuation of coverage or the surviving spouse applies for surviving spouse coverage for themselves and their dependent children who have not reached the end of the calendar month of their 26th birthday, provided you, your spouse and/or dependent child(ren) were eligible for benefits at the time of the your death.

D. Qualified Medical Child Support Orders

Under federal law, the Fund must recognize qualified medical child support orders (QMCSO) mandating continuation of health care coverage for certain dependent children. A QMCSO is a court order that recognizes the right of an alternate recipient (child) to receive benefits under the Plan. A QMCSO may not require the Plan to provide a type or form of benefit not otherwise provided to children of eligible participants or retirees. A QMCSO is usually issued in a divorce or a paternity case in which you are ordered by the court to continue to provide medical support for your child or children, but it may also be in the form of a National Medical Support Notice (NMSN) issued by the Friend of the Court.

The Fund Office or legal counsel for the Fund will determine whether a document is a QMCSO. If the document is determined to be a QMCSO, the Fund will notify you and the possible alternate recipient (or custodial parent or issuing agency, as appropriate). If the document is determined not to be a QMCSO, the Fund will send a letter describing the reason for that determination. Payment of benefits made by the Plan pursuant to a QMCSO may be made to the alternate recipient's custodial parent or legal guardian, and notices and explanations of benefits relating to the alternate recipient will be sent to the custodian parent or legal guardian.

E. Eligibility Of Dependents After Your Death

If you die and you and your dependents were eligible at the time of your death, their coverage terminates *on the last day of the month of your death*. Your dependents may *not* use your 12-month look-back extended work eligibility, if any, to continue their coverage after your death.

However, your surviving spouse and dependent child or children may elect to continue coverage under the Plan under the special Surviving Spouse Coverage provisions.

The surviving spouse must elect Surviving Spouse Coverage on or before the 30th day of the month following your death, and the first payment, which must include the self-payment for the first and second months of coverage, must be made by that date. Surviving Spouses will pay a self-payment rate determined by the Board of Trustees from time to time, and the amount will vary depending on whether the surviving spouse is covered by Medicare and on whether there are any dependent children, and how many. The second monthly payment and each following payment are due no later than the 25th of the month before the coverage period. For example, payment for August coverage is due on July 25th.

Surviving Spouse Coverage will be the same as Fund's coverage for of the Non-Medicare Eligible Retirees until the surviving spouse becomes eligible for Medicare. At that time, the Surviving Spouse must elect to coverage under the Fund's coverage for Medicare Eligible Retirees.

If you have a dependent child or dependent children at the time of your death and you either do not have a surviving spouse at that time or your surviving spouse does not elect coverage, your dependent child or children may continue their coverage only under the provisions of COBRA continuation coverage.

If the surviving spouse makes all required self-payments when due, Surviving Spouse Coverage

will continue until:

(1) For the surviving spouse and dependent children, when the surviving spouse remarries;

(2) For the surviving spouse and dependent children, when Surviving Spouse Coverage is eliminated by the Board of Trustees, which is within its discretion to do at any time; or

(3) For each dependent child, when that child no longer meets the Plan's definition of a "dependent".

After coverage terminates upon the remarriage of the surviving spouse and/or the failure of a dependent child to meet the definition of dependent under the Plan, the surviving spouse and/or child may elect to continue coverage under the COBRA provisions of the Plan for a maximum of 36 months.

NON-MEDICARE ELIGIBLE RETIREE COVERAGE

1. Eligibility Rules

If you are eligible to receive retirement benefits as a Retiree, or disability benefits based on a disability from the Sheet Metal Workers' Local Union No. 80 Pension Trust Fund ("Pension Fund") (except Owner-Member Employees, who are not eligible for Retiree Coverage if they are receiving benefits from the Pension Fund due to disability), you will have a **one-time only** opportunity to elect Retiree Coverage under the Plan **if** you satisfy each and every one of the following requirements, A through E. There are additional exclusions and rules if you are eligible for disability benefits – see below.

A. You **must** be eligible for benefits under this Plan

(1) on the effective date of your retirement from the Pension Fund as a Retiree, or

(2) on the date of your retirement upon reaching age 55 or more if you are employed by SMACNA, or

(3) on the effective date of your disability benefit ("Effective Date") from the Pension Fund, and for the six calendar months preceding your Effective Date (eligibility based on hours and employer contributions, self-payment, disability-related extension of coverage or COBRA continuation coverage is considered for this purpose except for SMACNA retirees). **Note:** Owner-Member Employees are not eligible for Retiree Coverage if they are receiving benefits from the Pension Fund due to disability.

B. If you have accrued less than 25 Years of Credited Service with the Pension Fund, then you **must** have at least 2,500 hours of work and contributions in the five consecutive years immediately preceding the effective date of your starting benefits from the Pension Fund (hours credited due to self-payment of the balance of the

hours needed for eligibility related to a month in which you worked one or more hours may be applied toward meeting this requirement except for SMACNA retirees);

C. If you have accrued 25 or more Years of Credited Service with the Pension Fund, you **must** have at least 1,250 hour of work and contributions in the six consecutive years immediately preceding the effective date of your retirement or disability from the Pension Fund (hours credited due to self-payment of the balance of the hours needed for eligibility related to a month in which you worked one or more hours may be applied toward meeting this requirement except for SMACNA retirees);

D. You **must** have some hours of work and contributions in this Fund immediately prior to your Retiree coverage as follows:

(1) If you Retiree from the Penson Fund, you must have some hours of work and contributions in this Fund in *four of the five* consecutive years immediately prior to the effective date of your retirement (except if you have accrued 25 or more Years of Credited Service with the Pension Fund must have some hours of work and contributions in this Fund in three of the six consecutive years immediately prior to the effective date of your retirement). Hours credited due to self-payment of the balance of the hours needed for eligibility related to a month in which you worked one or more hours may be applied toward meeting this requirement. If you have no hours of work and contributions in your last year prior to your retirement, you must be registered on the Union's out of work list during that year.

(2) if you are receiving a disability benefits from the Pension Fund, you must have some hours of work and contributions in this Fund in *each* of the five consecutive years immediately prior to your effective date of your disability (hours credited due to self-payment of the balance of the hours needed for eligibility related to a month in which you worked one or more hours may be applied toward meeting this requirement), except that if you have no hours of work and contributions in the year prior to the effective date, you must have been registered on the Union's out of work list during that year. **Note:** Owner-Member Employees are not eligible for Retiree Coverage if they are receiving benefits from the Pension Fund due to disability.

(3) For a SMACNA retiree, you must have some hours of work and contributions in this Fund in each of the five (5) consecutive years immediately prior to the effective date of Retiree coverage.

E. You **must** make monthly self-payments according to the procedures determined by the Board of Trustees in an amount determined by the Board of Trustees, which may be adjusted by it from time to time. That rate may be reduced based on years of service under the Pension Plan (also applies to the surviving spouses of such

retirees). Such reduction may also be adjusted or eliminated by the Board of Trustees.

As a reminder, retiree benefits under the Plan currently include:

- Medical benefits
- Prescription drug benefits
- Dental benefits
- Vision benefits
- Death benefit
- Member's Assistance Program (M.A.P.)

All of the above benefits permanently terminate if your self-payment is not received by the Fund Office by its due date and, **once terminated, retiree/surviving spouse coverage may not be reinstated unless you return to Covered Employment and thereby re-establish the eligibility for Retiree Coverage!**

Notwithstanding the foregoing, the failure of an individual to meet the requirements of A, B and C, above solely due to his work for the Sheet Metal Workers International Association, the AFL-CIO or the State of Michigan Building Trades Council shall not prevent him from eligibility for Retiree coverage (as long as all other requirements are met) if (1) he has had continuous coverage under his employer's health plan from the time he ceased eligibility for benefits from this Fund until the effective date of his retirement with the Pension Fund, and (2) he has no comparable retiree medical coverage from the Sheet Metal Workers International Association, the AFL-CIO or the State of Michigan Building Trades Council. Proof of continuous coverage and proof of the unavailability of comparable retiree coverage from the Sheet Metal Workers International Association, the AFL-CIO or the State of Michigan Building Trades Council shall be required at the time of application for Retiree coverage.

Additional Rules, Exclusions and Limitations for Individuals Receiving Retiree Coverage Based on Receipt of Disability Benefits from the Pension Fund

1. If you are eligible based on your receipt of disability benefits from the Pension Fund, you will not be eligible for Retiree Coverage or, if covered, your coverage will end, if you become employed and eligible for other employer-provided health care coverage. If you will want to re-enroll in Retiree Coverage with the Fund later (assuming you would be eligible to do so), you must pay a monthly maintenance of records fee (currently $20.00 per covered person per month) to the Fund. Then, *assuming* you met all eligibility requirements for coverage when you first became disabled, when your disability benefit converts to an Early or Normal Retirement Benefit, or if you stop working and are no longer eligible for the employer-provided health care coverage, you may re-enroll in Retiree Coverage as long as you provide proof that you were continually covered during the period you were not covered by the Fund and paid your monthly maintenance of records fees when due.

   If you are eligible based on your receipt of disability benefits from the Pension Fund, you

may continue your Retiree Coverage but you will not be eligible for the waiver of self-payment for the first six months of Retiree Coverage (see below) if you become employed, but are not eligible for employer-provided health care coverage.

2. If you are receiving disability benefits from the Pension Fund you are not deemed permanently and totally disabled by the Pension Fund, and consequently ineligible for continued disability benefits from the Pension Fund, after twenty-four months from commencement of Pension Fund disability benefits unless you have been determined by the Social Security Administration to be entitled to receive Social Security Disability Benefits. If you would otherwise lose coverage for health benefits from this Fund because you are no longer eligible for continued disability benefits from the Pension Fund you will not lose eligibility in this Fund if, by the time your Pension Fund disability benefits cease, you have a pending application for Social Security Disability Benefits with the Social Security Administration.

   You must provide the Social Security Administration's determination letter to the Fund Office within 10 days of receipt. If the Social Security Administration awards you Social Security Disability Benefits, you may continue coverage in this Fund for as long as you receive Social Security Disability Benefits notwithstanding any determination or action of the Pension Fund, subject to the other rules and restrictions herein. If the Social Security Administration denies your application for Social Security Disability Benefits, your eligibility for coverage in this Fund shall cease at the end of the month in which you received the denial letter from the Social Security Administration. If you fail to timely notify the Fund Office of the Social Security Administration's denial, the Fund may pursue recovery of all amounts improperly paid on your behalf.

2. When To Enroll

You must enroll in Retiree Coverage, or notify the Fund Office that you wish to delay your decision because you are covered under your spouse's employer's health care plan and pay the maintenance of records fee (see details below), **within 30 days after the date on which your eligibility for retiree benefits starts.**

If you do not elect to enroll in Retiree Coverage, or notify the Fund Office that you wish to delay your coverage under your spouse's employer's health care plan and pay the maintenance of records fee, within 30 days after the date on which your eligibility for retiree benefits starts, you will **not** have the opportunity to elect Retiree Coverage under this Plan unless you return to Covered Employment and thereby re-establish the eligibility for Retiree Coverage.

Special Delayed Enrollment Rule for Retirees with Coverage through their Spouse's Employment - You must notify the Fund to make this election when your eligibility for retiree benefits starts!

If, on the effective date of your starting benefits from the Pension Fund, you have health care coverage available to you through your spouse's employer and you want to delay your Retiree Coverage under this Plan while you have that other coverage, you may elect to begin Retiree

Coverage under the Plan at some later date as long as you can provide written proof that you had continuous health insurance coverage under your spouse's employer-provided health care coverage from the effective date of your starting benefits from the Pension Fund until the date on which you wish to begin your Retiree Coverage under this Plan. **You must notify the Fund Office about this when you retire, and you will be required to pay a monthly maintenance of records fee (currently $20.00 per person per month) throughout the period of your other coverage.** If you fail to pay the maintenance of records fee by the 25th day of each month before the month for which it is due, you will not be permitted to return to coverage under the Plan unless you return to work and meet all of the above requirements for Retiree Coverage. The monthly maintenance of records fee may be adjusted by the Board of Trustees from time to time.

If you enroll in Retiree Coverage upon your effective date of retirement, you will **not** be able to later suspend your enrollment and elect this special delayed enrollment. ***This option to delay enrollment is available only upon retirement!***

You can elect to delay your spouse's enrollment separately – see below.

3. Special Enrollment Rules for Spouses of Retirees

There are several options for coverage of spouses of retirees, adopted to meet your needs and/or save you money as you move into retirement:

Post-Retirement Marriage: If you get married after you retire and you are enrolled in Retiree Coverage, your new spouse will be eligible for coverage under the Plan provided that an application is filed with the Fund Office within *30 days of your marriage*. You may enroll your new spouse in Retiree Coverage, or in the Dental and Vision Only Option, effective the first day of the month following the marriage, or you may elect to delay enrollment as explained below. In either situation, you still must file an application with the Fund Office within *30 days of the marriage*. Failure to file this application in the time permitted results in the permanent loss of your right to add your spouse to any coverage under the Plan.

Spousal Delayed Enrollment Option: If your spouse has his/her own health benefits from his/her own employer, he/she may decline enrollment at the time of your retirement and may enroll in this Plan when that other coverage ends, provided that the enrollment is made within *30 days of the loss of the other coverage.* **You must notify the Fund Office about this when you retire, and you will be required to pay a monthly maintenance of records fee (currently $20 per covered person per month) throughout the period of your other coverage.** If you fail to pay the maintenance of records fee by the 25th day of each month before the month for which it is due, your spouse will not be permitted to return to coverage under the Plan unless you return to work and meet all of the above requirements for Retiree Coverage. The monthly maintenance of records fee may be adjusted by the Board of Trustees from time to time. Also, your spouse must produce written proof that s/he had continuous coverage under his/her employer's health plan from the effective date of your starting benefits from the Pension Fund until the date on which your spouse wishes to enroll under your Retiree Coverage under this Plan.

Dental and Vision Only Option: If your spouse has his/her own health benefits from his/her own

employer, he/she could elect Dental and Vision Only coverage under this Plan. Your spouse can make this choice only at the time of your retirement. The Board of Trustees determines the self-payment amount for such limited coverage, which also must be paid by the 25th day of the month before the month of the coverage. As is the case with all self-payments, if payment is not received when due, coverage will be terminated.

As above, in the event of the termination of your spouse's other coverage, he/she may enroll for full Retiree Coverage under this Plan from the Dental and Vision Only Option when the other coverage ends, provided that the enrollment for full coverage is made within *30 days of the loss of your spouse's other health benefits coverage*. Again, your spouse must produce written proof that s/he had continuous coverage under his/her employer's health plan from the effective date of your starting benefits from the Pension Fund until the date on which your spouse wishes to enroll under your Retiree Coverage under this Plan.

4. Termination of Retiree Coverage

Your Retiree Coverage eligibility will end on earliest of the following:

(a) on the date the Fund does not receive any required self-payment or maintenance of record amount; or

(b) on the date you return to covered employment or are suspended from receipt of retirement benefits from the Penson Fund; or

(c) if you are covered under this Fund due to receipt of a disability benefit from the Pension Fund, when you become employed and eligible for health care coverage from your employer; or

(d) if you are covered under this Fund due to receipt of a disability benefit from the Pension Fund, when you are no longer eligible for disability benefits from the Pension Fund, (except when you have an application pending with the Social Security Disability Administration); or

(e) upon elimination of Retiree coverage by the Board of Trustees, which is in its sole and exclusive discretion to do at any time for any and all current and future retirees.

5. Return to Covered Employment by Retiree

If you re-enter covered employment for more than 39 hours in any month, you must re-establish eligibility under the initial eligibility provisions of the Plan. If you are a **Construction Employee, Production Journeyman, Residential/Light Commercial Journeyman, or an Architectural Metal Journeyman (PPO coverage),** you will be allowed to make self-payments until you have satisfied the initial eligibility provisions of the Plan. Your monthly self-payment rate will be the hourly contribution rate in effect at the time you return to active employment multiplied by 125 hours (100 hours for Architectural Journeymen (PPO coverage)). Owner-Member Employees and

Non-Bargaining Unit Employees (PPO coverage) must establish initial eligibility in the usual manner.

You may not use a 12-month (or the 125 hour/month) look back period for the purpose of determining continuing eligibility as an Active Employee.

COBRA CONTINUATION COVERAGE

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This is only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office and/or get a copy of the Plan Document.

The Board of Trustees has delegated the day-to-day responsibilities for the administration of COBRA continuation coverage to the Administrative Manager. Both the Board of Trustees and the Administrative Manager can be contacted at the Fund Office, 700 Tower Drive, Suite 300, Troy, Michigan 48098, (248) 641-4980, (800) 400-7710. Please use the following mailing address for the Board of Trustees and the Administrative Manager: P.O. Box 1408, Troy, Michigan 48099-1408.

COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension 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. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

COBRA continuation coverage provides medical, surgical, hospital, prescription, dental (if any), death and vision benefits *only*. ***The Fund's non-group health plan benefits (weekly disability benefits, accidental death and dismemberment benefits and M.A.P benefits) are not available under COBRA.***

There may be other coverage options for you and your family. You could buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

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

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

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

- **Your spouse (the Employee or Retiree) dies;**
- **Your spouse's (the Employee's) hours of employment are reduced;**
- **Your spouse's (the Employee's) employment ends for any reason other than his or her gross misconduct; or**
- **You become legally separated or divorced from your spouse (the Employee or Retiree).**

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

- **The parent-Employee (or parent-Retiree) dies;**
- **The parent-Employee's hours of employment are reduced;**
- **The parent-Employee's employment ends for any reason other than his or her gross misconduct;**
- **The child's parents become legally separated or divorced (but see Qualified Medical Child Support Orders, page 21); or**
- **The child stops being eligible for coverage under the Plan as a "dependent child."**

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is the death of the Employee or the reduction or termination of the employment of the Employee, the employer must notify the Fund Office of these qualifying events *within 30 days.*

You Must Give Notice of Some Qualifying Events

For other qualifying events (legal separation or divorce of the Employee and spouse or a dependent child's loss of eligibility for coverage as a dependent child), you must notify the Fund Office. The Plan requires you to notify the Fund Office within 60 days after one of these qualifying events occurs. The Fund Office may require that you provide evidence that a qualifying event has taken place, such as a copy of the Judgment of Separation or Divorce, death certificate or birth certificate. You must send notification to the Fund Office, P.O. Box 1408, Troy, Michigan 48099-1408. ***Failure to comply with these rules will result in the permanent loss of COBRA rights.***

Note that some qualifying events result in an immediate loss of coverage (such as legal separation, divorce and loss of dependent status), and some are determined on a monthly basis (such as termination of employment and loss of hours). Therefore, you should **never delay** in notifying the Fund Office of any qualifying event, or you risk losing your rights under COBRA.

How is COBRA Coverage Provided?

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

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

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

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the

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

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

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

  If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must send this notice to the Fund Office, P.O. Box 1408, Troy, Michigan 48099-1408.

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

  If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the Employee or former Employee dies, or gets legally separated or divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event's occurrence. You must send this notice to the Fund Office, P.O. Box 1408, Troy, Michigan 48099-1408.**

If you have a newborn child or have a child placed with you for adoption while your COBRA continuation coverage is in effect, you have the right to elect coverage for such child if the Plan Administrator receives notice of that birth, adoption or placement for adoption *within 30 days* of its occurrence. A child born or placed with you for adoption while you are receiving COBRA

continuation coverage will have the same COBRA rights as your spouse or dependents who were covered by the Plan before the event that triggered COBRA coverage. Like all qualified beneficiaries with COBRA coverage, the child's continued coverage depends on the timely and uninterrupted payment of your COBRA payments.

Cost of COBRA Continuation Coverage

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you have to pay the Fund's full cost of coverage, plus a 2% administrative surcharge, for your continuation coverage. If the Social Security Administration determines that you were disabled at the time of termination or reduction of hours and you elect to continue coverage beyond the 18-month period, you may be charged an additional 50% surcharge beginning on the 19th month of coverage.

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

Special Note: If you become eligible for COBRA due to termination of employment or reduction of hours because you have worked zero hours in a month, you may elect, as an alternative to COBRA, to change your coverage to the (less costly) HMO COBRA coverage provided by the Plan. If you decide to elect the HMO COBRA coverage, you cannot return to PPO coverage unless you reinstate your eligibility through working.

Termination of COBRA Continuation Coverage

The law also provides that you or your dependents' COBRA continuation coverage may be terminated by the Fund for any of the following reasons:

- The Fund no longer provides coverage for similarly situated employees;
- Your payment for continuation coverage is not received by the Fund in a timely fashion;
- You or your dependent becomes covered under another group health plan that does not include a preexisting conditions clause that applies to you or to a covered dependent (note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act):
- If you are or become covered under another group health plan, you must notify the Fund Office immediately;
- You are receiving COBRA continuation coverage because of a disability defined under the Social Security Act and Social Security determines that you are no longer disabled. You must notify the Fund Office within 30 days of the date of any final determination by the Social Security Administration that you are no longer disabled; or
- You provide written notice to the Fund Office that you wish to end your COBRA continuation coverage.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office, P.O. Box 1408, Troy, Michigan 48099-1408. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep the Fund Office Informed of Address Changes and Life Changes

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

FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act of 1993 provides for up to 12 weeks of unpaid, job protected leave for certain family and medical reasons and up to 26 weeks if the leave is to care for a family member who is recovering from a serious illness or injury sustained in the line of duty during military service that has rendered the person unfit to perform military service. You are eligible if you have worked for your employer for at least 12 months and for at least 1,250 hours in the 12 months before the leave starts and if your employer is covered by the Act and has at least 50 employees within 75 miles of where you work.

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

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

ELIGIBILITY WHEN ENTERING MILITARY OR UNIFORMED SERVICE

If you leave covered employment to serve in the military or other uniformed services (service), the Uniformed Services Employment and Reemployment Rights Act (USERRA) requires that the Fund permit you to elect to continue your and your dependents' eligibility with the Fund (except for M.A.P. Benefits, Death Benefits, Accidental Death and Dismemberment Benefits and Weekly Disability Benefits (not available for Retirees or Surviving Spouses)).

You should notify the Fund Office as soon as possible that you will be departing for service. If you do not notify the Fund Office before you depart for service and your departure causes you to lose coverage, the Fund Office will generate a notice of COBRA continuation coverage. You (or your family member) must notify the Fund Office that you have departed for service **no later** than 60 days after receiving that notice of COBRA continuation coverage to be eligible for coverage during the period of your service and for special initial eligibility provisions upon your return to work.

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

Notice should be provided to Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund, P.O. Box 1408, Troy, MI 48099-1408, (248) 641-4980, (800) 400-7710.

If you serve fewer than 31 days, no self-payment is required and no reduction of your extended eligibility will occur - the Fund is legally required to continue your eligibility without charge if you are in the service for fewer than 31 days without charge or penalty to you.

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

(1) Making monthly self-payments from the beginning date of your service without drawing on your "extended eligibility" (which is determined by the number of hours of work and contributions credited to you in a 12-month look-back period), if any, in which case that extended eligibility will be available to you upon your return to work, as explained below, or

(2) Drawing on your extended eligibility, if any, in which case your extended eligibility will either be reduced or eliminated over the duration of your service, and as a result may not be available to you upon your discharge to the extent that you have used it to delay the need to make monthly self-payments.

Eligibility Upon Return to Work: If you serve between 31 days and five years, and you (or your family member on your behalf) have provided the Fund Office with notice of your departure for the services as described above, you will not have to meet the normal rules for reinstatement of eligibility if you return to work for a contributing employer (or register on the out of work list) within 90 days of your discharge under honorable conditions, but you may have to make self-payments if you have elected to draw on your extended eligibility.

If you did <u>not</u> elect to draw on your extended eligibility during your service, your extended

eligibility will be available to you in full upon your return and will be applied to provide you with eligibility upon your return.

These rules can be complicated. Therefore, please notify the Fund **immediately** when you enter military service and **immediately** upon your discharge to take advantage of your rights under the law. The Fund Office will review with you how many hours of extended eligibility are available to you, if any, and if you make the decision to have the Fund utilize it during your service, how many months of coverage those hours of extended coverage will provide before you need to begin making monthly self-payments.

BENEFITS

MEDICAL, SURGICAL, HOSPITAL AND PRESCRIPTION DRUG BENEFITS

GENERAL COVERAGE RULES

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

a. Medically necessary (but see post-mastectomy services, page 65), and

b. Not excluded from coverage.

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

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

BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM) PREFERRED PROVIDER ORGANIZATION (PPO)

If you are a Construction Employee, Production Journeymen, Residential/Light Commercial Journeymen, Architectural Metal Journeymen (PPO coverage), Owner-Member Employee, Non-Bargaining Unit Employees (PPO coverage) Non-Medicare Eligible Retiree with PPO Coverage, you and your dependents will receive medical, hospital and surgical benefits as set forth in the schedules of benefits in the Fund's agreements with the Blue Cross Blue Shield of Michigan (BCBSM) Preferred Provider Organization (PPO) Network. Detailed information regarding these benefits can be found in the Benefits at a Glance document, which are attached at the end of this SPD.

Note: Apprentice Employees who in a work classification for which non-Apprentice Employees receive PPO coverage, the Employee's coverage will change from HMO coverage to PPO coverage effective as of the date the Apprentice turns out of the apprenticeship program, as determined by the Sheet Metal Workers Local 80 Training Center.

Under a PPO program, some providers are "in-network" and some providers are "out-of-network" or "non-network". You may contact the Fund Office, the BCBSM or your health care provider directly to see if they are in-network/participating providers.

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

A. In-Network Benefits

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

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

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

B. Out-of-Network Benefits

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

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

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

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

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

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

C. Coverage Outside of BCBSM PPO, Coverage Area

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

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

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

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits under the Plan are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. You will receive coverage under the Plan through the self-funded arrangement with BCBSM. Please referrer to the Benefit at a Glance document attached at the end of the SPD for a detailed description of deductibles and copays.

You can have your prescriptions filled at a network or non-network pharmacy. The choice is always yours. Remember that when your prescriptions are filled through a non-network pharmacy, you have higher out-of-pocket costs. Also, remember that the Fund does not cover any prescriptions obtained at Wal-Mart or Sam's Club. If you or your dependents purchase a prescription at Wal-Mart or Sam's Club, you will not receive any benefit or reimbursement from the Fund, and you will be required to pay one hundred percent (100%) of the cost, even if Wal-Mart and Sam's Club are part of the Blue Cross Blue Shield of Michigan pharmacy network.

You will receive prescription drug benefits as described in this summary only if you are a Construction Employee, Production Journeymen, Residential/Light Commercial Journeymen,

Architectural Metal Journeymen (PPO coverage), Owner-Member Employee, Non-Bargaining Unit Employees (PPO coverage) Non-Medicare Eligible Retiree with PPO Coverage. Also, unless stated otherwise, your dependent(s) will receive the same coverage, services, etc. that you receive.

HIGH-COST DRUG DISCOUNT OPTIMIZATION PROGRAM

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

DENTAL AND ORTHODONTIC BENEFITS

Dental and Orthodontic benefits vary based on your benefit/coverage classification. Dental benefits under the Plan are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. The Fund has engaged Delta Dental PPO (Point-of-Service) to provide your dental benefits.

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

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

VISION EXPENSE BENEFITS

Vision benefits under the Fund are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. The Fund's vision benefits are administered by BCBSM; however, as a practical matter, BCBSM uses VSP as its vision network provider. For a complete list of services covered by VSP copayments, annul maximus and exclusions, see the "**Your VSP Vision Benefits Summary**" attached at the end of this SPD.

The Fund also provides coverage for prescription safety glasses as described in the "Your VSP

Vision Benefit Summary, for Active Participants only. Retirees, COBRA Participants and Dependents are not eligible for this benefit.

Vision Correction Benefit

The plan provides LASIK vision correction up to a lifetime maximum of $900 per eye per person for Construction Employees, Owner-Member Employees and Non-Medicare Eligible Retirees.

CPAP CLEANING MACHINE

The Fund will reimburse you for up to $260 once every 5 years for out of pocket expenses for the purchase of a CPAP Cleaning Machine. You or your covered dependent must currently be using a CPAP device and must provide a copy of the prescription for the CPAP device and a copy of the receipt for the purchase of the cleaning machine to be reimbursed.

MASSAGE THERAPY BENEFIT

The Fund will cover the reasonable and customary cost of medically necessary massage therapy, given pursuant to a physician's order and administered by a physical therapist, chiropractor or certified massage therapist only, for up to 24 visits per calendar year, subject to a $25 per visit copayment. **This Benefit is available for Active Participants only**.

WEEKLY DISABILITY BENEFITS

Weekly Disability Benefits are available only for Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen, and Architectural Metal Journeymen (PPO coverage).

If you are eligible for benefits and are unable to work because of an accident occurring **off** the job or any illness **not** connected with employment, you will be entitled to Weekly Disability Benefits in the amount of $400 for a maximum of 26 weeks or the period of your disability, whichever is shorter. If you have an occupational-related disability, you are not entitled to Weekly Disability Benefits. Weekly Disability Benefits will not be paid unless you file a claim form with the Fund Office within **20 days** after the first day of disability and submit written proof that you are disabled (you will have an additional 30 days to submit any additional documentation the Fund Office may require).

Benefits are payable from the first day of a disability caused by an accident; the eighth day of a disability caused by an illness; first day when hospital confined; first day following surgery in an outpatient department of a hospital; and first day if a disabling surgical procedure is performed on an outpatient basis. You must be under the direct care of a physician during the entire period of disability for which you receive benefits.

Weekly Disability Benefits due to your pregnancy are available for 6 weeks prior to the due date through 12 weeks after delivery. You must provide medical documentation of continued disability as defined herein to receive more than 18 weeks of Weekly Disability Benefits described in this paragraph for a pregnancy, but in no case shall Weekly Disability Benefits exceed 26 weeks.

If you return to work following a disability period of less than 26 weeks, you will not be eligible for benefits for the same or related disability until you have been reemployed in full-time covered employment for at least 2 weeks. You may receive no more than 26 weeks of Weekly Disability Benefits for disability due to the same or related cause whether received during one or more Weekly Disability Benefit periods.

If you become disabled due to a cause different from the cause of any prior disability, you are eligible for a new Weekly Disability Benefit period provided you work one day of full-time covered employment prior to the new Weekly Disability Benefit period.

Benefits are not payable during a strike unless the disability commenced prior to the strike and while you were still actively employed, except for emergency hospital confinements.

Benefits are not payable after you retire with the Pension Fund because Retirees are not eligible to this benefit.

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

Owner-member employees and Non-Bargaining Member Employees are not eligible for Weekly Disability Benefits.

Limitations

No Benefits shall be paid under this Weekly Disability Benefits provision:

- for any period of disability during which you are not under the direct care of a physician (it is understood that no disability will be considered as beginning more than three (3) days prior to your first doctor visit);

- for disability due to accidental bodily injuries arising out of and in the course of you employment;

- for disability due to occupational disease (for the purpose of the Plan, the term "occupational disease" shall mean a disease for which you are entitled to benefits under the applicable Workers' Compensation Law, Occupational Disease Law, or similar legislation) **unless** you signs an agreement stating that the Fund shall be subrogated to all rights of your (or your representative(s)) recovery arising out of any claim or cause of action which may accrue against a third party and to reimburse the Fund for any benefits so paid hereunder out of monies recovered;

- where you are eligible for Weekly Disability Benefits through another Plan and for which benefits are being provided in an amount equal to or greater than the benefits provided under this Plan;

- for dependents, retirees and participants maintaining eligibility by self-payment because they have not worked at least one (1) hour in a month;

- for disability caused by war or any act of war (declared or undeclared) or caused by service in the armed forces of any country.

DEATH BENEFITS

The amount of the Death Benefit payable from the Fund varies based on whether you are an Active Participant or Retiree when you die **(including Participants receiving benefits pursuant to COBRA continuation provisions of the Plan)**, and whether your surviving spouse is covered when s/he dies. The amounts are set out below, by benefit class.

You/your covered surviving spouse may designate as a beneficiary any person or persons you each choose. You and your covered surviving spouse may change that beneficiary at any time by completing forms, which are available at the Fund Office.

However, the designation of a spouse as beneficiary shall terminate immediately upon the entry of a judgment or decree of divorce between you and your spouse. The former spouse shall be recognized as a beneficiary following the entry of such judgment or decree only if designated by you as beneficiary after the entry of the judgment or decree on a form prescribed and furnished by the Board of Trustees.

If you/your covered surviving spouse have not named a beneficiary (or if that beneficiary dies before you do and no replacement is named), the Death Benefit will be paid as follows: to the deceased's widow or widower; but if none, to the deceased's surviving children (excluding step-children) in equal shares; but if none, to the deceased's surviving parents in equal shares; but if none, to the deceased's surviving brothers and sisters in equal shares; but if none, to the deceased's estate.

Written notice of a death must be received by the Fund Office within **two years** of such death for a Death Benefit to be payable.

1. All Active Participants

For these benefit classes, a Death Benefit of $20,000 is payable to your beneficiary in the event of your death from any cause.

An amount not to exceed $2,500 may be paid from the $20,000 Death Benefit to any person incurring the expense of your burial, provided a receipt is submitted to and determined satisfactory by the Board of Trustees.

2. Retirees and Surviving Spouses

A Death Benefit of $10,000 is payable to the beneficiary in the event of your death (Retiree) or your covered surviving spouse's death (Surviving Spouses) from any cause.

An amount not to exceed $2,500 may be paid from the $10,000 Death Benefit to any person incurring the expense of your or your covered surviving spouse's burial, provided a receipt is submitted to and determined satisfactory by the Board of Trustees.

3. Death of an Eligible Dependent Child

A Death Benefit of $10,000 is payable to you upon the death of your eligible dependent child.

4. Death of an Eligible Dependent Spouse

A Death Benefit of $10,000 is payable to you upon the death of your eligible dependent spouse.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Active Employees only)

The principal sum, $20,000, is payable to your beneficiary if you lose your life, or to you, if you lose both hands, both feet, sight of both eyes, one hand and one foot, one hand or one foot and sight of one eye by accidental means.

One-half the principal sum, $10,000, is payable to you if you lose one hand, one foot or sight of one eye. The maximum amount payable for all losses resulting from one accident is the largest amount payable for any one loss.

You or your survivors must provide proof of your loss to the Fund Office within **90 days** after the accident. The availability of this benefit is not affected by any other benefits you may receive.

You may designate any person or persons you choose as your beneficiary. You may change your beneficiary at any time by completing forms, which are available at the Fund Office. If you have not named a beneficiary (or if your beneficiary dies before you do and you do not designate a replacement), your Accidental Death Benefit will be paid as follows: to your widow or widower; but if none, to your surviving children in equal shares; but if none, your surviving parents in equal shares; but if none, your surviving brothers and sisters in equal shares; but if none, to your estate.

Benefits are **not** payable for losses resulting from:

- bodily or mental infirmity, hernia, ptomaine, bacterial infections (except infections cause by pyrogenic organisms which shall occur with and through an accidental cut or wound), or disease or illness of any kind, or
- intentional self-destruction or intentional self-inflicted injury, while sane or insane, or
- participation in the commission of a felony, or

- war or any act of war, or service in any military, naval or air force of any country while such country is engaged in war, or police duty as a member of any military, naval or air organization.

MEMBER'S ASSISTANCE PROGRAM (M.A.P.)

The Fund has engaged Ulliance to be the Fund's Employee Assistance Program (EAP) provider to provide employee assistance services to you and your family members experiencing difficulty with alcohol and/or drugs, have a concern about another's alcohol and/or drug use, are in need of information about other social or emotional problems, or are in need of legal or financial planning consultation.

The Ulliance Life Advisor Employee Assistance Program is designed to help you and your family deal with the many personal and family issues that we all encounter at some point in our lives. Ulliance provides many services to meet your needs, including counseling, coaching, crisis intervention, and community resources.

The Life Advisor Employee Assistance Program provides completely confidential, free assistance in many areas, including:

- Relationship and family concerns
- Death of a loved one
- Stress, anxiety and depression
- Substance Abuse
- Eldercare or childcare referrals
- Financial or legal referrals

There is no cost to you or your dependents for the Ulliance services which are available 24 hours a day, 7 days a week.

You can reach Ulliance at its toll free number 800-448-8326 for free, confidential assistance. You can also visit their website, www.LifeAdvisorEAP.com for more information and a wide variety of resources. To login, simply enter 'Local 80' as your employer and 'Southfield' as your city of employment. We hope you and your dependents take advantage of the many services Life Advisor EAP has to offer.

OTHER ADMINISTRATIVE MATTERS

NOTICE OF HOURS WORKED

Each month the Fund Office will mail you a "Monthly Status Report". This Report provides you with a summary of hours worked during the most recent three-month period so that you may compare the Fund's records to your pay stubs.

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

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

SPECIAL PROVISIONS FOR PARTICIPANTS REGARDING MEDICARE

A. Medicare

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

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

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

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

You must enroll in both Medicare Part A and Part B and pay all premiums immediately as soon as you become eligible (unless you are currently covered under another plan as an active participant); but you are not required to enroll for Medicare Part D coverage. In those cases where Parts A or B of Medicare and the Fund cover the same items or services, the Fund will pay first and then Medicare will supplement the Fund's coverage up to the Medicare limits. In most cases, the Fund's benefits are more generous than those provided under Medicare. Where they are not, you retain the right to file your claim with Medicare for whatever supplemental coverage is available. Your combined benefits from Medicare and the Fund will remain unchanged even though the Fund, rather than Medicare, is the primary payer.

You should not forget to continue to pay the Part "B" Medicare premium for medical services for your own protection. Failure to pay the Part "B" premium on time will result

in the loss of Medicare protection for medical services. However, if you are working at age 65, you may be able to delay enrollment in Medicare Part B, without a penalty, until you stop working.

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

If you enroll in Medicare Part D (prescription drug coverage), you will lose your prescription drug coverage with the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund. The Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund will not provide prescription drug coverage for participants who enroll in Medicare prescription drug coverage. If you enroll in Medicare Part D (prescription drug program), the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund will continue to provide you with your other non-prescription health benefits.

Medicare generally will be the ***secondary payer*** of medical benefits (and the Plan will be ***primary*****)** for individuals in the following categories:

- Certain individuals with end stage renal disease prior to 30 months of coverage;
- Certain disabled individuals who are covered *because* of the individual's (or a family member's) *current* employment status; and
- Certain individuals (age 65 or older) who are Medicare-eligible and are working as employees, or certain dependents of such employees.

Medicare generally will be the ***primary payer*** of medical benefits (and the Plan will be ***secondary*****)** for individuals in the following categories:

- Certain individuals with end stage renal disease after 30 months of coverage;
- Certain disabled individuals who are covered, but *not because* of the individual's (or a family member's) *current* employment status; and
- Certain former employees or certain dependents of such individuals.

For information on COBRA continuation coverage and Medicare, see COBRA provision on page 28 of this SPD.

B. Employed Persons Aged 65 or Older

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

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

Important: If you continue to be covered through the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund for your primary health care benefits, **you should still apply for Medicare Part A and Part B.**

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

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

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

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

Reminder: If you are working and you chose the Fund's coverage as primary, the Fund must provide your spouse, if s/he is over age 65, with the same coverage as you have.

C. Retired Persons Aged 65 or Older

The Fund currently provides benefits for Medicare-eligible retirees via Blue Cross Blue Shield of Michigan (BCBSM) Medicare Advantage PPO Plan. At the time of this Summary, when you become eligible for Medicare, your available coverage will change to Blue Cross Blue Shield of Michigan (BCBSM) Medicare Advantage PPO Plan, the details for which are outlined in another booklet - the Summary Plan Description of the Plan for Medicare-Eligible Retirees. If you are in this category, and have not received this booklet, please contact the Fund Office. Non- Medicare Eligible Retiree participants and their dependents receive medical benefits through the Blue Cross Blue Shield of Michigan as the Fund's network provider.

COORDINATION WITH MEDICAID

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

COORDINATION OF BENEFITS/NON-DUPLICATION OF BENEFITS

Coordination of benefits provisions come into play whenever an eligible person has other coverage under any health care plan, fund, group insurance program, Medicare, or any statute (law).

Under these provisions, the Fund will pay the benefits in accordance with its applicable Schedule of Benefits if it is considered to be primary. Otherwise, the other plan, fund, program, etc., will be required to pay the benefits up to the maximum amount payable in accordance with its Schedule of Benefits and the Plan will then pay any remaining amounts not otherwise covered up to and in accordance with its Schedule of Benefits so that, in the aggregate, no more than 100% of the incurred covered expenses will be paid.

The Fund will not duplicate benefits paid to you or your dependents under another health care plan, fund, policy, contract, program or statute. Benefits from the Fund are subject to, and limited to, benefits payable in accordance with this Coordination of Benefits/Non-Duplication of Benefits provisions. Coordination of benefits provisions are rules which determine the order in which two or more plans which may be covering you or your dependents pay benefits first, so that benefits will be paid up to but not to exceed 100% of the Plan's allowable expenses on the claim. These rules apply to every eligible person covered by the Plan and to all benefits payable under the Plan, **except** Death Benefits, Accidental Death and Dismemberment Benefits and M.A.P. Benefits.

The Plan's Coordination of Benefits provisions will apply notwithstanding any non-compliance with the terms of any other plans under which you may have coverage.

This Plan **excludes** coverage and will pay **no** benefits for treatment of injuries resulting from an automobile or motor vehicle accident (however, the Plan will provide for treatment of injuries sustained in a motorcycle accident, so long as the accident does not involve an automobile or other non-motorcycle motor vehicle.). Therefore, coordination of benefits is unnecessary with respect to no-fault automobile insurance coverage because there are no benefits for motor vehicle related injuries provided from this Fund. You should carefully review this with your automobile or other motor vehicle insurance carrier to make certain that your own insurance is adequate in this regard.

Generally speaking, the following rules are applied to determine whether the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund or the other health care plan, fund, policy, contract, program, or statutory payer pays first in accordance with its Schedule of Benefits.

A. If the other plan, fund, policy, contract, program, or statutory payer has not adopted a coordination of benefits provision, it shall be required to pay first.

B. If both have coordination of benefits provisions, then

   (i) the plan in which the eligible person is covered as an employee shall pay in accordance with its Schedule of Benefits as primary. The plan in which the eligible person is covered as a dependent shall pay secondary up to its maximum Schedule of Benefits.

   (ii) where the claim is for an eligible dependent child, the following order of priority shall be followed in determining which plan shall pay first:

(a) for children of parents not separated or children of legally separated, divorced or never married parents with joint physical custody:

(1) the one covering the parent who has the earlier birth date anniversary in the calendar year,

(2) if both parents have the same birth date, the one which covered the child for the longer period of time;

(b) for children of legally separated, divorced or never married parents without joint physical custody:

(1) the one covering the parent with physical custody of the child,

(2) then the one of the spouse of the parent with physical custody of the child,

(3) then the one of the parent or spouse of the parent without physical custody of the child.

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

(iii) where the claim is for a person who is covered as a dependent child under this Plan and a dependent spouse under the plan of his or her spouse, the following order of priority shall be followed in determining which health and welfare plan, fund, policy, contract or program shall pay as primary:

(a) the plan covering the covered part or the covered spouse who has the earlier birth date anniversary in the calendar year shall be primary,

(b) if both the covered parent and the covered spouse have the same birth date, the plan which covered the child/spouse for the longer period of time shall be primary.

SUBROGATION AND REIMBURSEMENT

In the event of any payments for services to or on behalf of any person under this Plan, the Fund shall, to the extent of such payments, be subrogated to all rights of recovery of that person (or his

representative(s) or successor(s) in interest) arising out of any claim or cause of action which may accrue against a third party, including any occupationally related claim or cause of action covered by the Michigan Workers' Disability Compensation Act or Occupational Disease Act or similar federal or state statutes. That person (or his representative(s) or successor(s) in interest), by acceptance of benefits provided by this Fund, hereby agrees to reimburse the Fund for any benefits so paid hereunder out of monies recovered, fully or partially, from such third party as the result of judgment, settlement or otherwise, irrespective of how differentiated, without any offset for expenses, including legal fees, that person (or his representative(s) or successor(s) in interest) may owe, and before that person (or his representative(s) or successor(s) in interest) pays any other individual, organization or entity out of that full or partial recovery. That person (or his representative(s) or successor(s) in interest) may take no action which would prejudice the rights of this Fund (and/or its service provider(s) and/or its designee(s)), and that person (or his representative(s) or successor(s) in interest) hereby agrees to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Trustees may require to facilitate the enforcement of the Fund's rights, including periodic updates of the status of the underlying case as well as notice of any settlement. Neither the Fund (nor its service provider(s) nor its designee(s)) will be responsible for any attorney's fees or costs incurred and/or paid by or on behalf of that person (or his representative(s) or successor(s) in interest) unless the Fund (and/or its service provider(s) and/or its designee(s)) has agreed in writing in advance to pay such fees or costs or some portion thereof.

If the Fund and/or its service providers pays benefits on behalf of any person (or his representative(s) or successor(s) in interest) and that person (or his representative(s) or successor(s) in interest) receives a settlement, that person (or his representative(s) or successor(s) in interest) must obtain the Fund's consent to both the underlying settlement and the amount owed to the Fund. The covered person (or his representatives) may seek and obtain settlement authority and final claims information either directly through the Fund or through the Fund's legal counsel. Additionally, upon final settlement, after such settlement has been approved by the Fund, the individual receiving settlement payments arising out of such claim (or his representative(s)) is obligated to notify the Fund no more than three (3) business days after such resolution or settlement has been reached.

These rules apply to any type of payment or partial payment received from any source, irrespective of how such payment or partial payment is differentiated or characterized, which reimburses or compensates that person (or his representative(s) or successor(s) in interest), wholly or partially, for any injury or illness for which the Fund (and/or its service provider(s) and/or its designee(s)) paid benefits related to that person's injury or illness, including voluntary settlements with a Workers' Compensation carrier in situations where it is reasonable to conclude that the injury or sickness was work-related.

Upon receipt of the monies recovered, as specified above, the covered person (or his representative(s)) must hold all settlement funds in a trust account so that the recovery proceeds are segregated from the covered person's general assets until the Fund or any of the Fund's designees has been reimbursed up to the amount of benefits it/they have paid. The participant and/or beneficiary may not comingle the settlement proceeds with his or her general assets or

spend such proceeds until any disputes regarding the amount due or the Fund's right of recovery have been resolved and final payment is disbursed to the Fund.

If that person (or his representative(s) or successor(s) in interest) fails to do so, the Fund (and/or its service provider(s) and/or its designee(s)) may, in its/their sole and exclusive discretion, treat the amount of benefits paid on behalf of such person and not repaid to the Fund (and/or its service provider(s) and/or its designee(s)) as a debt of that person (or his representative(s) or successor(s) in interest) to the Fund (and/or its service provider(s) and/or its designee(s)), and may pursue recovery of said amount from that person (or his representative(s) or successor(s) in interest) by any legal means and/or reduce any future benefits payable on behalf of that person (or his representative(s) or successor(s) in interest) in this amount until this amount has been restored.

CLAIMS APPLICATIONS, LIMITS AND APPEALS

1. Applying for Benefits and Time Limit for Claims

Eligibility Determinations

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

Claims for Medical, Hospital, Surgical, Prescription Drug Benefits, Death Benefits, Accidental Death and Dismemberment Benefits, Weekly Disability Benefits, Dental Expense Benefits, Vision Expense Benefits and M.A.P. Benefits.

BeneSys is responsible for the processing and determination of all claims for Medical, Hospital and Surgical Benefits, Death Benefits, Accidental Death and Dismemberment Benefits, and Weekly Disability Benefits.

Blue Cross Blue Shield of Michigan is responsible for the processing and determination of all Prescription Drug Benefits.

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

Blue Cross Blue Shield of Michigan (through VSP) is responsible for the processing and determination of all Vision Expense Benefits covered by group coverage agreements and other contracts issued by it.

Ulliance is responsible for the processing and determination of all M.A.P. Benefits covered by group coverage agreements and other contracts issued by it.

Claim forms for benefits administered by BeneSys are available from the Fund's administrative

office. All such forms and supporting documentation must be submitted within the following time periods:

(1) Claims for Medical, Hospital and Surgical Benefits administered by BeneSys must be submitted within 12 months from the date you or your dependent received the services for which payment is sought.

(2) Claims for a Death Benefit must be submitted within two years from the eligible individual's death.

(3) Claims for an Accidental Death and Dismemberment Benefit must be submitted within 90 days from your loss or death.

(4) Claims for Weekly Disability Benefits must be submitted within twenty (20) days from the onset of your disability. After submission of the initial application, you then have an additional 30 days to submit the documentation required to perfect the claim for benefits (including, but not limited to, the physician's report).

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

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

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

Claim forms for prescription drug benefits are available from Blue Cross Blue Shield of Michigan, and all such forms and supporting documentation must be submitted **within 6 months from the fill date.** If you disagree with a determination made by Blue Cross Blue Shield of Michigan, you must appeal directly to Blue Cross Blue Shield of Michigan and comply with Blue Cross Blue Shield of Michigan's claims appeal process.

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

Claim forms for vision benefits are available from VSP, and all such forms and supporting documentation must be submitted **within 12 months from the date the service was provided.** If you disagrees with a determination made by VSP, you must appeal directly to VSP and comply with VSP's claims appeal process.

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

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

2. Denial of Claims

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

3. Appealing a Denial of Your Benefit Claim

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

A. Appeals Regarding Medical, Hospital or Surgical Benefits Administered by BeneSys

Most questions or concerns about decisions BeneSys makes on claims or requests for benefits can be resolved through a phone call to one of BeneSys' Customer Service Representatives. You can locate the phone number in the top right hand corner of the first page of your Explanation of Benefits statement or in the letter BeneSys sends to notify you that BeneSys has not approved a request for benefits.

(1) General.

If a claim for benefits under the BCBSM PPO Network is denied for any reason other than eligibility, the Plan provides for a two-step review process. The first step is an internal appeal to the Board of Trustees. The second step is an external review to an Independent Review

Organization, as defined in 29 C.F.R. § 2590.715-2719(a)(2)(vii). The initial adverse benefit determination and both steps of the review process will be determined in accordance with all applicable and effective laws and regulations.

If a claim for benefits under the BCBSM PPO Network is denied based on ineligibility for benefits under the Plan at the relevant time, the claimant may appeal the ineligibility determination to the Board of Trustees, which appeal will be determined in accordance with all applicable and effective laws and regulations.

(2) Internal Appeal.

You may appeal a denial of a claim for Medical, Hospital or Surgical, Benefits by writing out the reasons for your disagreement and the facts on which you rely for your claim to benefits and mailing your appeal within 180 days of the notice of denial to the Board of Trustees, Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund, P.O. Box 1408, Troy, Michigan 48099-1408. An appeal of the denial of a pre-service claim for urgent care may be requested by telephone. No special form is required. Just be sure that what you have written explains your position as clearly as you can state it. You have the right to appoint someone else (such as a lawyer) to prepare and submit your appeal to the Fund. Make sure your name, the last four digits of your social security number, trade and name of the claimant (such as your spouse) are included to avoid delays in processing your appeal.

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

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

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

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

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

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

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

(3) External Review.

You may request external review for a denial of any appeal for Medical, Hospital or Surgical, Benefits. The request must be filed in writing within four (4) months after your receipt of the appeal denial. Within five business days following the date of receipt of the request, the Board of Trustees will complete a preliminary review of the request to determine whether it is eligible for external review based on whether:

(a) the claimant was covered under the Plan at the time the claim was made,

(b) the denial relates to the claimant's failure to meet the Plan's eligibility requirements,

(c) the claimant has exhausted the Plan's internal Claims and Appeals procedures, as outlined above, unless not required to do so, as noted below, and

(d) the claimant has provided all the information required to process an external review.

Within one business day after completion of this preliminary review, the Board of Trustees will provide written notification to the claimant of whether the request is eligible for external review.

If the request is complete but not eligible for external review, the Board of Trustees will notify the claimant of the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (866-444-3272). If the request is not complete, the notice will describe the information needed to complete it and the claimant will have 48 hours or until the last day of the four month filing period, whichever is later, to submit the additional information.

If the request is eligible for external review, the Fund will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request has been accepted. The IRO's notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when

conducting the review. The IRO will share this information with the Fund and, based upon this information, the Fund may decide to reverse its denial of the appeal. If the denial is reversed, the external review will end.

If the Fund does not reverse the denial, the IRO will review the request de novo and not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. The IRO will make its decision on the basis of its independent review of all the information in the record, as well as the following information where appropriate and available:

(a) the claimant's medical records,

(b) the attending health care professional's recommendation,

(c) reports from appropriate health care professionals and other documents submitted by the Fund, claimant, or the claimant's treating provider,

(d) the terms of the Plan,

(e) appropriate practice guidelines,

(f) any applicable clinical review criteria developed and used by the Fund, and

(g) the opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Fund and the claimant of its final decision within 45 days after the IRO receives the request. The IRO's decision notice will contain:

(a) a general description of the reason for the external review, including information sufficient to identify the request,

(b) the date the IRO received the assignment to conduct the review and the date of the IRO's decision,

(c) references to the evidence or documentation the IRO considered in reaching its decision,

(d) a discussion of the principal reason(s) for the IRO's decision,

(e) a statement that the determination is binding and that judicial review may be available to the claimant, and

(f) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Generally, a claimant must exhaust the claims and appeals procedures in order to be eligible for external review. However, in some cases the Plan provides for an expedited external review if:

(a) the claim that is denied involves a medical condition for which the time for completion of the Plan's internal claims and appeal procedure would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review, or

(b) the appeal that is denied involves a medical condition where the time for completion of a standard external review, above, would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function.

Immediately upon receipt of a request for expedited external review, the Fund must determine and notify the claimant whether the request satisfies the requirements for expedited review, including eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition and circumstances require, but in no event more than 72 hours after the IRO receives the request for expedited external review. If the original notice of its decision is not in writing, then the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Fund.

Upon receipt of a notice of external review decision from the IRO reversing the Fund's decision, the Fund must immediately provide coverage or payment for the claim, but the Fund reserves the right to pursue judicial review or other remedies available or that may become available to it under applicable law and regulations.

B. Appeals Regarding Eligibility Determinations, Death Benefits, Accidental Death and Dismemberment Benefits, Weekly Disability Benefits and Member's Assistance Program Benefits

You may appeal a denial of a claim related to an eligibility determination or a claim for Death Benefits, Accidental Death and Dismemberment Benefits, Weekly Disability Benefits, and/or Member's Assistance Program Benefits by writing out the reasons for your disagreement and the facts on which you rely for your claim to benefits and mailing your appeal within 180 days of the notice of denial to the Board of Trustees, Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund, P.O. Box 1408, Troy, Michigan 48099-1408. No special form is required. Just be sure that what you have written explains your position as clearly as you can state it. You have the right to appoint someone else (such as a lawyer) to prepare and submit your appeal to the Fund. Make sure your name, the last four digits of your social security number, trade and name of the claimant (such as your spouse) are included to avoid delays in processing your appeal.

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

When a claimant's appeal is received, it will be reviewed "de novo" (meaning "anew" and without

deferring to the initial denial of your claim) and additional materials and information you submit with the appeal, if any, will also be reviewed.

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

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

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

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

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

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

C. Appeals Regarding Claims for Prescription Drug Benefits, Dental Expense Benefits or Vision Expense Benefits

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

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

CIRCUMSTANCES THAT CAN RESULT IN DENIAL OF OR LOSS OF BENEFITS

The Board of Trustees or its representatives have the authority to deny payment for claims, and the reasons for denial may include one or more of the following:

- The person receiving the benefit was not eligible for any benefits, or for the particular benefit, on the day the expense was incurred. This includes a former spouse or any person no longer eligible as a dependent when an expense was incurred.

- The claim was not received by the Fund within the applicable claims period from the date the expense was incurred.

- The expense was for services not medically necessary, not covered by the Fund or the expense was not actually incurred.

- The person for whom the claim was filed already received the maximum benefit for the type of benefit; for example, a lifetime maximum, a calendar year maximum, etc.

- The person for whom the claim was filed had not yet satisfied any required deductible imposed by the Fund.

- The person for whom the claim was filed (or another person on their behalf) failed to sign the Fund's subrogation agreement, failed to cooperate with the Fund's right of reimbursement or failed to remit the Fund's reimbursable amount from a recovery, including a partial recovery (in which case, future claims will be denied up to the amount of the Fund's reimbursable amount).

- Another entity was primarily responsible for paying benefits (see the Fund's rules on coordination of benefits).

- The benefit or the Fund was terminated.

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

EXCLUSIONS AND GENERAL LIMITATIONS

In addition to the exclusions and limitations listed earlier in the Summary and except as may be provided for under the terms of the Plan, the Plan shall not provide benefits for the following, except Death Benefits and Accidental Death and Dismemberment Benefits (not available to Retirees or Surviving Spouses):

1. **The Plan will NOT provide benefits (including, Weekly Disability, etc.) for treatment of injuries sustained in a motor vehicle accident or other motor vehicle licensed to be on the road or complications resulting for such injuries or accident.** (However, the Plan will provide for treatment of injuries sustained in a motorcycle accident, so long as the accident does not involve an automobile or other non-motorcycle motor vehicle.)

2. The Plan will **NOT** provide for loss or expense from sickness, or disease which entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law, or as a result of any accidental bodily injury which arises out of or in the course of employment for pay or profit, **unless** the person who is seeking benefits payable for such sickness, disease or accidental bodily injury signs an agreement stating that the Fund shall be subrogated to all rights of recovery of that person (or his representative(s)) arising out of any claim or cause of action which may accrue against a third party and to reimburse the Fund for any benefits so paid by the Fund out of monies recovered. If the claimant or his representatives fail to cooperate with the Fund's rights or comply with any of the obligations set out in the Plan or in the Agreement, coverage will immediately terminate even if an agreement has been signed.

3. The Plan will **NOT** provide for services that would not be charged if there was no coverage under this Plan.

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

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

6. The Plan will **NOT** provide for installation of air conditioning units, humidifier or dehumidifiers for environmental controls, whirlpools, air filters, bathroom rails, special toilet seats, commodes, chair lifts, or other home-installed devices even if prescribed by a physician, including ergometers and exercycles, bicycles, etc.

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

8. The Plan will **NOT** provide for care and services payable by government-sponsored health care programs such as Medicare.

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

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

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

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

13. The Plan will **NOT** provide for hospital confinements and/or treatment required by order of any court of law, even when prescribed by a physician.

14. The Plan will **NOT** provide for coverage, including Weekly Disability Benefits, for expenses resulting from causes other than sickness, accidental injury or disease, except those incurred as a result of domestic violence. In case of any questionable claims of this type, the Fund will require a copy of any police report and full details regarding the incident.

15. The Plan will **NOT** provide for coverage including Weekly Disability Benefits, for expenses resulting from injuries sustained while the person is engaged in any unlawful act, except those incurred as a result of domestic violence.

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

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

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

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

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

21. The Plan will **NOT** provide for drugs dispensed for cosmetic purposes. However, the Plan will provide coverage for Retin-A for participants over age 26 upon proof of medical necessity.

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

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

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

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

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

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

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

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

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

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

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

ADDITIONAL ADMINISTRATIVE MATTERS

1. Payment of Benefits

Benefits are payable individually for you and each of your dependents up to but not to exceed the maximum benefits shown in this Summary according to the following provisions:

- All bills from hospitals and doctors who participate with BCBSM's PPO will automatically be sent to BeneSys, which pays the Fund's share of the expenses to the hospital or doctor directly to them. You will receive an "Explanation of Benefits" (EOB) from BeneSys telling you what has been paid. You are responsible for paying any amount remaining due.
- Generally, bills from hospitals and doctors who do not participate with BCBSM's PPO and some other service providers will be sent directly to you. You may then file a claim at the Fund Office.
- When you receive an EOB from BeneSys, please review it carefully. Contact the Fund Office with questions in this regard.
- If a person is not mentally, physically or otherwise able to handle his/her business affairs, the Fund may pay benefits to the legally appointed guardian or conservator, or if none, to the individual who has assumed responsibility for the person's primary care and maintenance. If the person dies and the Fund owes benefits, the Fund may make payments to the estate, surviving spouse, parents, child or children or to any individual that the Board of Trustees determines, in its sole discretion, is entitled to the benefits.
- In determining whether a deductible amount has been satisfied, a charge for any service will be considered to have been incurred on the date that the service was provided to the patient.
- Any payment made by the Fund in accordance with these provisions will fully discharge the Fund's liability to the extent of the payment

2. Examinations

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

3. Free Choice of Provider

You have the free choice of any provider. However, the amount of benefits paid by the Fund may vary and be limited based on the provider you choose and the provider's participation in a preferred provider organization utilized by the Fund.

4. Board of Trustees Interpretation and Authority; Decisions Regarding Claims

Under the terms of the Plan and the Trust establishing the Fund, the Board of Trustees has the sole authority to interpret and apply the rules of the Plan, the Trust and any other rules and regulations,

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

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

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

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

5. Workers' Compensation Not Affected

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

6. Plan Discontinuation or Termination

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

7. Right of Offset

If any payment is made by the Fund to or on behalf of a person who is not entitled to the payment or to the full amount of such payment, the Fund has the right to reduce future payments to that

person or to the person responsible for the erroneous payment by the amount of the erroneous payment. This right of offset will not limit the right of the Fund to recover such erroneous payments in any other manner.

8. Legal Actions – IMPORTANT NOTICE

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

LEGAL NOTICES

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

To request special enrollment or obtain more information, contact the Fund Office at 700 Tower Drive, Suite 300, Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund, P.O. Box 1408, Troy, MI 48099-1408, (248) 641-4980, (800) 400-7710.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending provider and the patient.

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

If you would like more information on WHCRA benefits, contact the Fund Office at 700 Tower Drive, Suite 300, P.O. Box 1408, Troy, MI 48099-1408, (248) 641-4980, (800) 400-7710.

ERISA RIGHTS

As a participant in the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund, 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 administrator's 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 your coverage. Note: there are limitations on plans' imposing a preexisting condition exclusion, and such exclusions are prohibited as of 2014 under the Affordable Care Act.

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

You can read the materials listed above by making an appointment at the Fund Office during normal business hours. Also, copies of the materials will be mailed to you if you send a written request to the Fund Office. There will a per-page charge for copying some of the materials. Before requesting materials, call the Fund Office and find out the cost. If a charge is made, your check must be attached to your request for the material.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND CONTACT THE FUND'S PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS.

The Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund ("Plan") is required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) to make sure that health information that identifies you is kept private to the extent required by law.

The Plan is also required to give you this Notice regarding

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

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

This Notice and its contents are intended to conform to the requirements of HIPAA. Please be advised that other entities that provide services to you related to your participation in the Plan have

issued or may issue separate notices regarding disclosure of PHI that is maintained on the Plan's behalf by those entities.

How the Plan May Use and Disclose PHI About You

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

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

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

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

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

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

identifying information has been deleted in accordance with federal regulations.

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

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

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

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

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

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

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

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your PHI to a law enforcement official for certain law enforcement purposes, including the reporting of certain types of wounds, upon the request of a law enforcement official for locating a

suspect, fugitive, material witness, missing person, or crime victim, to report a death, to report a crime on the premises and to report a crime in a medical emergency. A disclosure of information about an individual who is or is suspected to be a crime victim may be made only if a) the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances, b) the law enforcement official represents that the information is not intended to be used against the individual and the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and c) the Plan determines disclosure is in the best interest of the individual as determined by the exercise of its best judgment.

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

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

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

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

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

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

Other Uses and Disclosures

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

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

The Plan asks you to complete an authorization form if you would like someone, such as a spouse, to be able to have access to your PHI.

If you provide the Plan with written authorization to use or disclose your PHI, you may revoke

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

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

You have the following rights:

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

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

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

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

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

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

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

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

To request an accounting of disclosures, you must submit your request in writing to the Plan's Privacy Officer. Your request must specify a time period, which may not be longer than six (6) years. You may request and receive an accounting of disclosures once during any twelve (12) month period for no charge. If you request more than one accounting within the same twelve (12)

month period, a reasonable, cost-based fee may be charged. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

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

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

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

- a power of attorney for health care purposes;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- a birth certificate identifying the parent of a minor child.

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

LEGAL DUTIES OF THE SHEET METAL WORKERS' LOCAL UNION NO. 80 INSURANCE TRUST FUND REGARDING YOUR HEALTH INFORMATION

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

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

Minimum Necessary Standard

When using, disclosing or requesting PHI, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose

of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose. However, the minimum necessary standard will not apply in the following situations:

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

YOUR RIGHT TO FILE A COMPLAINT

You have the right to express complaints to the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund should be made in writing to the Fund's Privacy Officer. The Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

FOR MORE INFORMATION CONTACT THE PRIVACY OFFICER

For questions about this Notice, to exercise your privacy rights, or to file a complaint, contact the Plan's Privacy Officer, Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund, P.O. Box 1408, Troy, MI 48099-1408, (248) 641-4980.

SOCIAL SECURITY NUMBER PRIVACY POLICY

The Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund is required by Michigan law to make sure that your Social Security number and the Social Security numbers of your family members are kept private as set forth in that law.

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

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

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

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

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

What is balance billing?

Balance billing – sometimes called surprise billing – is when you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that doesn't participate with your health plan.

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

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

You are protected from balance billing for:

Emergency services

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

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

Certain services at a participating hospital or ambulatory surgical center

When you get services from a participating hospital or ambulatory surgical center, certain providers there may be nonparticipating. In these cases, the most those providers may bill you is your plan's in-network out-of-pocket amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services.

These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

- You're only responsible for paying your share of the cost (such as copayments, coinsurance and deductibles that you would pay if the provider or facility was in network). Your health plan will pay nonparticipating providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization)
    - Cover emergency services by nonparticipating providers
    - Base what you owe the provider or facility (out-of-pocket costs) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits
    - Count any amount you pay for emergency services or services rendered by nonparticipating providers in the circumstances outlined above toward your deductible and out-of-pocket limit

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

SUBROGATION AGREEMENT

ASSIGNMENT AND ACKNOWLEDGMENT OF LIEN FOR THE BENEFIT OF THE SHEET METAL WORKERS' LOCAL UNION NO. 80 INSURANCE FUND

I, _____ (Name of Participant), hereby make this Acknowledgment of Lien for the Benefit of the Sheet Metal Workers' Local Union No. 80 Insurance Fund (hereafter the "Assignment"), as stated below.

WHEREAS, I and/or my dependent(s) have made application to Sheet Metal Workers' Local Union No. 80 Insurance Fund (hereinafter referred to as the "Fund") for benefits, which may include payment of hospital and other medical expenses and weekly disability benefits (hereinafter collectively referred to as the "benefits") arising from a medical condition commencing on _____; and

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

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

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

representative, guardian, next friend or heir and any other successor in interest to my or my dependent's(s') rights.

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

I further understand and agree that the intent of this assignment is to assure the Sheet Metal Workers' Local Union No. 80 Insurance Fund that I will reimburse to the Fund 100% of the amount paid to me or on my behalf arising from the medical condition giving rise to my claim against a third party, whether or not I or my dependent(s) recover in full or only partially. I understand and agree that the Fund does not have any financial responsibility with respect to the cost of legal services or other costs in connection with my or my dependent's(s') claims(s). I agree that the Fund shall maintain a lien on my or my dependent's(s') recovery from any third party, whether I/my dependent(s) recover money through civil lawsuit, arbitration, or other proceeding, pursuant to the Subrogation and Reimbursement section of the description of benefits provided by the Fund which has been distributed to me.

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

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

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

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

Sheet Metal Workers' Local Union No. 80 Insurance Fund

P.O. Box 1408
Troy, MI 48099-1408
(248) 641-4980

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

Signature:_____
Date:
Social Security Number: _____
Address: _____
Telephone Number:__(_____)_____ _____

Signature: _____ _____

Subscribed and sworn to before me
this _____ day of _____, 20_____.
_____
Notary Public, _____
County, State of _____

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

Attorney's Name:_____
Address:_____
Telephone Number:(_____)_____

ACKNOWLEDGMENT OF LIEN BY ATTORNEY

Dated:
Regarding Client: _____
(Please Print)

The undersigned attorney hereby acknowledges and recognizes a lien on behalf of the Sheet Metal Workers' Local Union No. 80 Insurance Fund ("Fund") for all payments made by the Fund to or on behalf of the attorney's above-named Client(s) in connection with the Client's(s') injuries, including payments made for medical claims and wage loss.

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

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

ATTORNEY'S SIGNATURE

DATE:_____

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Sheet Metal Workers Local 80 Insurance Trust Fund
Group Number: 71725 Package Code(s): 002
Section Code(s): 1000, 2000
Sheet Metal Workers PPO Plan, Rx, Hearing, Vision
Effective Date: 04/01/2022
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$400 per member $800 per family	$1,500 per member $3,000 per family
Copays • Fixed Dollar Copays	$25 copay for: • Facility Urgent care services • Professional Urgent care services • Office visits • Chiropractic spinal manipulations $100 copay for : • Facility medical emergency	$100 copay for: • Facility medical emergency
Coinsurance • Percent Coinsurance	20% up to a maximum of: $1,000 per member $2,000 per family	50% up to a maximum of: $4,500 per member $9,000 per family **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$8,550 per member $17,100 per family Includes Deductible, Coinsurance and Copays	None Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered

Annual Gynecological Exam - one per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 50% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams: Colonoscopy – one per calendar year Sigmoidoscopy & Proctosigmoidoscopy – one per calendar year	 Covered - 100% Covered – 100%	 Covered - 50% after deductible Not Covered
Well Child Care • 6 visits,birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $25 copay	Covered - 50% after deductible
Telemedicine Visits	Covered - 100% after $25 copay	Covered - 50% after deductible
Office Consultations	Covered - 100% after $25 copay	Covered - 50% after deductible
Pre-Surgical Consultations	Covered - 100% after $25 copay	Covered - 50% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $100 copay	Covered - 100% after $100 copay
Non-Emergency use of the Emergency Room	Covered - 100% after $100 copay	Not Covered
Facility Urgent Care Services	Covered - 100% after $25 copay	Covered - 50% after deductible
Physician Urgent Care Services	Covered - 100% after $25 copay	Covered - 50% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 50% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 50% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 50% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 50% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 50% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 50% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 50% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100%	Covered - 100%
Home Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 80% after deductible	Covered - 80% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 50% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 50% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 50% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 50% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 50% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Inpatient Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 50% after deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Outpatient Mental Health Care • Telemedicine Mental Health Care	Covered - 80% after deductible Covered - 80% after deductible	Covered - 80% after deductible Covered - 80% after deductible
Outpatient Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 50% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 80% after deductible	Covered - 50% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 50% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 50% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 50% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per calendar year	Covered - 100% after $25 copay	Not Covered
Durable Medical Equipment	Covered - 80% after deductible	Covered - 80% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 80% after deductible
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 50% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 50% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 50% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 50% after deductible

Sheet Metal Workers Local 80 Insurance Trust Fund
Group Number: 71725 Package Code(s): 002
Section Code(s): 1000, 2000
Hearing Care Coverage
Effective Date: 07/01/2021
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Limited to a maximum of $5,000 Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Sheet Metal Workers Local 80 Insurance Trust Fund
Group Number: 71725 Package Code(s): 002
Section Code(s): 1000, 2000
Prescription Drugs
Effective Date: 06/01/2022
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30-day supply	$10 copay - Generic drugs $30 copay - Preferred brand drugs $60 copay - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	$20 copay - Generic drugs $60 copay - Preferred brand drugs $120 copay - Non-Preferred brand drugs
Specialty Drugs – 30-day supply Retail and Mail Order	$60 copay Members are restricted to a 30-day supply at both retail and mail order and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	

Smoking Cessation Drugs	Covered
Weight Loss Drugs	Not Covered
Impotency Drugs	Covered
Infertility Drugs	Not Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Sheet Metal Workers Local 80 Insurance Trust Fund
Group Number: 71725 Package Code(s): 002
Section Code(s): 1000, 2000
Vision Coverage - Blue Choice Vision
Effective Date: 08/01/2018
Benefits-at-a-glance

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

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. There are more than 3,000 VSP provider locations in Michigan and 53,000 locations nationwide. To find a VSP provider, call **1-800-877-7195** or visit VSP's Web site at **www.vsp.com**.

Member's responsibility (copayments)

Benefits	VSP Provider	Out-of-Network Provider
Eye Exam	$10 copay	Reimbursement up to $45
Lenses and/or frames	$25 copay combined with frames	Member responsible for difference between approved amount and provider's charge
Medically necessary contact lenses	Not Covered	Not Covered

Eye exams

Benefits	VSP Provider	Out-of-Network Provider
Covers a complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered - $10 copay	Covered - reimbursement up to $45
	One per calendar year	

Lenses and frames

Benefits	VSP Provider	Out-of-Network Provider
Single vision, bifocal, trifocal or lenticular lenses in glass or plastic. **Note:** Additional pairs of prescription glasses and non-covered lens options are discounted when purchased from a VSP provider.	Covered - $25 copay combined with frames	Covered - reimbursement up to $30 for single vision lens; $50 for bifocal lens; $65 for trifocal lens; for lenticular lens
	One per calendar year	
Covers standard eyeglass frames. A wide selection of quality frames is fully covered by VSP up to the frame allowance. Members should ask their	Covered - $25 copay combined with lenses	Covered - reimbursement up to $70

doctor which frames are covered in full. Members may select a more expensive frame and pay a cost-controlled price difference.	Once every 2 calendar years	
Covers Frames for Safety glasses in addition to regular frames (Employees only)	Covered – reimbursement up to $65	Not Covered
	Once every 2 calendar years	

Contact Lenses: Members may obtain either eyeglasses or contact lenses, but not both

Benefits	VSP Provider	Out-of-Network Provider
Elective contact lenses (prescribed, but not medically necessary) may be chosen instead of spectacle lenses and a frame.	Covered - $130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	Covered - $210 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	One per calendar year	
Therapeutic contact lenses (medically necessary)	Not Covered	Not Covered

A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM SHEET METAL WORKERS LOCAL UNION NO. 80 INSURANCE FUND AND VSP.

VSP® Vision Care

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

PREMIER PROGRAM

Like shopping online? Go to **eyeconic.com**® and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®. This comprehensive eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditio[illegible]e.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA $50 + TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

Enroll today.

Contact us: **800.877.7195** or **vsp.com**

YOUR VSP VISION BENEFITS SUMMARY
SHEET METAL WORKERS LOCAL UNION NO. 80 INSURANCE FUND and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
01/01/2022

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		$25	
FRAME	• $175 frame allowance • $225 featured frame brands allowance • 20% savings on the amount over your allowance • $95 Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$55 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
PROTEC SAFETY® (EMPLOYEE-ONLY COVERAGE)			
FRAME	• Fully covered when you choose a safety frame from your VSP doctor's ProTec Eyewear® collection • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0	Every other calendar year
LENSES	• Prescription single vision, lined bifocal, and lined trifocal • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $50 to spend on featured frame brands. Go to **vsp.com/framebrands** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization 's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor 's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Classification: Restricted

DELTA DENTAL

Active Participants

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 2580-1000
Sheet Metal Workers' Local Union No. 80 Insurance Fund

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

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
Basic Services			
Emergency Palliative Treatment – to temporarily relieve pain	50%	50%	50%
Sealants – to prevent decay of permanent teeth	50%	50%	50%
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	50%	50%	50%
TMD Treatment – treatment of the disorder of the temporomandibular joint, including related films	50%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Dependent children up to age 19	Dependent children up to age 19	Dependent children up to age 19

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

- Oral exams (including evaluations by a specialist) are payable once in any period of six consecutive months.

- Prophylaxes (cleanings) are payable once in any period of six consecutive months. A periodontal maintenance procedure is also payable once in any four-month period. Benefits for full mouth debridement are unlimited.
- Fluoride treatments are payable once in any period of six consecutive months with no age limit.
- Space maintainers are Covered Services with no limitations.
- Bitewing X-rays are payable once in any period of six consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period. Benefits for panorex are unlimited.
- Sealants are payable for the occlusal surface of any tooth. The surface must be free from decay and restorations.
- Veneers are payable on any tooth once per tooth per five-year period.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain facings on crowns are Covered Services on posterior teeth.
- Frenulectomy and frenuloplasty are Covered Services.
- Benefits for Temporomandibular Disorders (TMD) are limited to those services normally provided by a dentist to relieve oral symptoms associated with malfunctioning of the temporomandibular joint. This does not include services that would normally be provided under medical care.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- Nitrous oxide and occlusal guards are Covered Services.
- Harmful habit appliances are not Covered Services.

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

Maximum Payment – $1,500 per person total per Benefit Year on all services except orthodontics. $1,750 per person total per lifetime on orthodontic services. Routine oral examinations for dependent children under the age of 16 will not apply to the annual maximum.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered as determined by the rules and regulations of the Fund.

Eligible People – All eligible employees as determined by the rules and regulation of the Fund. The Contractor pays the full cost of this plan.

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

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

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

DELTA DENTAL

COBRA DEPENDENT SPOUSE AND CHILDREN
Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 2580-3000
Sheet Metal Workers' Local Union No. 80 Insurance Fund

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

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
Basic Services			
Emergency Palliative Treatment – to temporarily relieve pain	50%	50%	50%
Sealants – to prevent decay of permanent teeth	50%	50%	50%
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	50%	50%	50%
TMD Treatment – treatment of the disorder of the temporomandibular joint, including related films	50%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%

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

- Oral exams (including evaluations by a specialist) are payable once in any period of six consecutive months.
- Prophylaxes (cleanings) are payable once in any period of six consecutive months. A periodontal maintenance procedure is also payable once in any four-month period. Benefits for full mouth debridement are unlimited.
- Fluoride treatments are payable once in any period of six consecutive months with no age limit.
- Space maintainers are Covered Services with no limitations.

- Bitewing X-rays are payable once in any period of six consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period. Benefits for panorex are unlimited.
- Sealants are payable for the occlusal surface of any tooth. The surface must be free from decay and restorations.
- Veneers are payable on any tooth once per tooth per five-year period.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain facings on crowns are Covered Services on posterior teeth.
- Frenulectomy and frenuloplasty are Covered Services.
- Benefits for Temporomandibular Disorders (TMD) are limited to those services normally provided by a dentist to relieve oral symptoms associated with malfunctioning of the temporomandibular joint. This does not include services that would normally be provided under medical care.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- Nitrous oxide and occlusal guards are Covered Services.
- Harmful habit appliances are not Covered Services.

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

Maximum Payment – $1,500 per person total per Benefit Year on all services. Routine oral examinations for dependent children under the age of 16 will not apply to the annual maximum.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered as determined by the rules and regulations of the Fund.

Eligible People – All eligible employees as determined by the rules and regulation of the Fund. The Contractor pays the full cost of this plan.

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

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

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

DELTA DENTAL

Delta Dental of Michigan Ohio Indiana QUALITY ISO 9001 CERTIFICATION

Non-Medicare Eligible Retirees

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 2580-5000
Sheet Metal Workers' Local Union No. 80 Insurance Fund

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

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
Basic Services			
Emergency Palliative Treatment – to temporarily relieve pain	50%	50%	50%
Sealants – to prevent decay of permanent teeth	50%	50%	50%
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	50%	50%	50%
TMD Treatment – treatment of the disorder of the temporomandibular joint, including related films	50%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%

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

- Oral exams (including evaluations by a specialist) are payable once in any period of six consecutive months.
- Prophylaxes (cleanings) are payable once in any period of six consecutive months. A periodontal maintenance procedure is also payable once in any four-month period. Benefits for full mouth debridement are unlimited.
- Fluoride treatments are payable once in any period of six consecutive months with no age limit.
- Space maintainers are Covered Services with no limitations.
- Bitewing X-rays are payable once in any period of six consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period. Benefits for panorex are unlimited.

- Sealants are payable for the occlusal surface of any tooth. The surface must be free from decay and restorations.
- Veneers are payable on any tooth once per tooth per five-year period.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain facings on crowns are Covered Services on posterior teeth.
- Frenulectomy and frenuloplasty are Covered Services.
- Benefits for Temporomandibular Disorders (TMD) are limited to those services normally provided by a dentist to relieve oral symptoms associated with malfunctioning of the temporomandibular joint. This does not include services that would normally be provided under medical care.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- Nitrous oxide and occlusal guards are Covered Services.
- Harmful habit appliances are not Covered Services.

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Maximum Payment – $1,500 per person total per Benefit Year on all services. Routine oral examinations for dependent children under the age of 16 will not apply to the annual maximum.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered as determined by the rules and regulations of the Fund.

Eligible People – All eligible employees as determined by the rules and regulation of the Fund. The Contractor pays the full cost of this plan.

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

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

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