**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**

## 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 January 1, 2014.

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, Apprentice and Probationary Employees, 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 OR THE FUND'S ADMINISTRATIVE MANAGER TO WHOM SUCH AUTHORITY HAS BEEN DELEGATED.

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

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

IMPORTANT ADDRESSES AND PHONE NUMBERS

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Keith Trelfa
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:
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Troy, MI 48098-2808

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

Phone (local): (248) 641-4980
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**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**

Patricia J. Tarini, Esq.
Sachs Waldman, Professional Corporation
1423 E. Twelve Mile Road
Madison Heights, Michigan 48071

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.

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## 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 January 1, 2014. 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, 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. 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 as it is in effect on January 1, 2014. The Plan also covers Medicare-Eligible Retirees, who should refer to the Summary Plan Description tailored for them as it is in effect on January 1, 2014.

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 January 1, 2014. 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.

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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**

Anthony A. Asher
Rick Mead
David Karl
Nick Seraphinoff
Mark Saba
Eric McPherson
Stacy Huffman
Keith Trelfa

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## 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 elected by the membership of Sheet Metal Workers' Local Union No. 80 (the Union) and four 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.

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, 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 HAP for provision of a medical network, Envision for prescription drug claims processing, and the Fund participates in one dental preferred provider organization (DenteMax).

You have the right to receive information on the HAP's Alliance Health and Life 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.

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 77.

## 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.

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

## 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.

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**Carry your cards.** You should have a HAP Alliance Health and Life PPO card, with an Envision prescription logo. 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, as 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 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 three areas of responsibility, and has delegated them to the Fund Office, Health Alliance Plan PPO and Envision.

**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
    - Dental Benefits
    - Vision Benefits
    - Member's Assistance Program (M.A.P.)
    - 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

**HAP Alliance Health and Life PPO:** The Fund has a contract with HAP's Alliance Health and Life PPO to provide and maintain a network of providers that Fund participants can use as a preferred provider organization.

**Envision:** The Fund has a contract with Envision to determine and process all outpatient prescription drug benefits**.**

## 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 full requirement monthly employer contribution amount under the applicable Health Agreement in each of the three (3) preceding months.

**Example**: If the Fund receives employer contributions on your behalf for full requirement monthly employer contribution amount 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 three-month 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) If you have not been credited with 1,000 or more hours and employer contributions during the immediately preceding 12 consecutive months ending on the last day of the third calendar month prior to the eligibility month, 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 April through March. However, if you work (and employer contributions were received for) less than 1,000 hours in the 12-month period April through March, you will have coverage for the June eligibility month 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) If you have not been credited with 750 or more hours during the immediately preceding 12 consecutive months ending on the last day of the third calendar month prior to the eligibility month, 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 April through March. However, if you work (and employer contributions were received for) less than 750 hours in the 12-month period April through March, you will have coverage for the June eligibility month 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, employer contributions may be made on your behalf for only 80 hours for a month.

**Example**: If the Fund receives 160 hours of employer contributions on your behalf in April, your benefits will continue for July.

**(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) a subsidized self-payment rate (which is subject to change by the Board of Trustees), in which case you will be credited only with the hours of work and contributions based on those hours actually received.

**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 only with the hours of work and contributions based on those hours actually received.

**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 at the time you would normally elect COBRA coverage, *as an alternative to COBRA*, to pay the full HMO COBRA rate and to receive the HMO coverage provided by the Plan to other classifications for six months. After that six-month period of HMO coverage, you will be eligible to continue that HMO coverage (still at the full HMO COBRA rate) for the remaining balance of what would have been your 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) a subsidized self-payment rate (which is subject to change by the Board of Trustees), in which case you will be credited only with the hours of work and contributions based on those hours actually received.

**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 only with the hours of work and contributions based on those hours actually received.

**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 at the time you would normally elect COBRA coverage, *as an alternative to COBRA*, to pay the full HMO COBRA rate and to receive the HMO coverage provided by the Plan to other classifications for six months. After that six-month period of HMO coverage, you will be eligible to continue that HMO coverage (still at the full HMO COBRA rate) for the remaining balance of what would have been your 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**

Owner-Member Employees are not permitted to continue coverage by self-payment except as provided by COBRA continuation coverage.

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

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

**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) and Non-Bargaining Unit Employees (PPO coverage)

If you become disabled and unable to work while you are eligible for benefits, you will be permitted to exhaust the extended eligibility you accrued while working. If you remain disabled and less than six consecutive months have passed since you incurred your disability, you may continue coverage without cost to you for a period that ends at the end of the sixth consecutive month following the month in which you incurred the disability. For this purpose, you are disabled if you are unemployable because of injury or illness either on or off the job.

You will not be entitled to this continuation of eligibility based on disability unless you submit satisfactory evidence of disability to the Fund Office. Upon approval of your application for disability eligibility, your disability eligibility will be retroactive to the date your disability commenced.

If you remain disabled and six consecutive months have passed since the month your disability commenced, or if you remain disabled after exhausting your extended eligibility accrued while working, whichever is later, you may continue coverage for up to an additional 18 or 29 consecutive months by making payments under COBRA. (See pages 28 - 33 of this Summary.)

### 2. Owner-Member Employees

You are eligible to continue coverage **only** through COBRA continuation coverage if you stop working for any reason.

## 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 even 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, 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 and Residential/Light Commercial Journeymen**

If your eligibility has terminated, 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 third month following the month in which such requirements were met (that is, two 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 and December.

If your eligibility has terminated, you will be eligible for benefits again on the first day of the second month following the month after you have been credited **at least 175 but less than 300** hours of work for which the Fund has received employer contributions at the current applicable

contribution rate for his work classification during a consecutive six (6) month period or less, if both of the following requirements are met:

a. 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; and

b. The number of hours for which you make such self-payment does not exceed 125.

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 third month following the month in which such requirements were met (that is, two 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 and December 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.

**2. Architectural Metal Journeymen (PPO coverage)**

If your eligibility has terminated, 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 third month following the month in which such requirements were met (that is, two 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 and December.

If your eligibility has terminated, you will be eligible for benefits again on the first day of the second month following the month after you have been credited **at least 175 but less than 300** hours of work for which the Fund has received employer contributions at the current applicable contribution rate for his work classification during a consecutive six (6) month period or less, if both of the following requirements are met:

a. 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; and

b. The number of hours for which you make such self-payment does not exceed 100.

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 third month following the month in which such requirements were met (that is, two 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 and December 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.

**3. Owner-Member Employees**

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

**4. 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, it is possible that even though the hours you work in another jurisdiction would be sufficient for you to continue eligibility under this Fund, you may be required to pay the monetary difference between the employer contributions paid to the other fund at its lower employer contribution rate and this Fund's employer contribution rate in order to remain eligible.

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.** 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**. 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 administrative 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.

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. A Dependent child (such as a stepchild) may not be older than you.

The Board of Trustees may, upon application, grant Dependent status to a child otherwise related to you or your covered spouse for you or your covered spouse is the full legal guardian (other than a limited or temporary guardian), if the child otherwise meets the Internal Revenue requirements for dependent status and the

Board believes the relationship approximates that of child and parent. An individual who is not be covered as a Dependent child unless (1) the parents of such child do not claim the child as a dependent; and (2) your adjusted gross income is higher than the highest adjusted gross income of any of the individual's parents. The Fund shall require proof that this requirement is satisfied prior to any individual being considered a dependent hereunder. A dependent described in this subsection may not be older than you or your covered 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 by giving written notice to the Fund Office, together with all required documentation (birth certificates, adoption papers, marriage certificates, etc.). Eligibility for new eligible dependents (such as a new spouse or new children) begins no sooner than the notice and the documentation are received, so it is to your benefit to provide the notice and the documentation to the Fund Office as quickly as possible. An eligible retiree will be allowed to add a new spouse, whose coverage will begin the first day of the month following their marriage if an application for coverage is filed with the Fund Office within 30 days of the date of the marriage accompanied by a copy of the marriage certificate.

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. Ineligibility of Working Spouse with Other Available Coverage

**If your spouse works thirty or more hours per week for an employer is eligible for health care coverage from that employer, but rejects such coverage, your spouse will not be eligible for coverage under this Plan.** However, if your dependent spouse is enrolled in health care coverage from his/her employment and loses that coverage, your dependent spouse can enroll within 30 days of the loss of such other coverage (as long as s/he is still eligible as a dependent as defined by this Plan). In addition, if such spouse is eligible for benefits under a health maintenance organization, preferred provider organization, or similar type of plan, which requires that health care services be obtained only from certain designated health care providers and/or organizations, and if such individual fails to comply with the requirements of such policy or plan, then he/she shall not be eligible for benefits hereunder. Only if a participant and/or a beneficiary is/are denied benefits under another health care plan, after complying with all of its requirements for eligibility and/or coverage, will he/they become eligible for coverage under this Plan.

### 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 employees or retirees. A QMCSO is usually issued in a divorce or a paternity case in which the eligible employee or retiree is ordered by the court to continue to provide medical support for their 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 the eligible employee or retiree and the possible alternate recipient (or custodial parent or issuing agency, as appropriate). If the document is determined not to be a QMCSO, the Fund will send a letter describing the reason for that determination. 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.

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, as applicable:

(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 or 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.

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.

## RETIREE COVERAGE

### 1. Eligibility Rules

If you are eligible to receive retirement benefits from the Sheet Metal Workers' Local Union No. 80 Pension Trust Fund as a Normal or Early Retiree, or disability benefits based on a disability

(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 D. 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 Sheet Metal Workers' Local Union No. 80 Pension Trust Fund as a Normal Retiree or Early 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 Sheet Metal Workers' Local Union No. 80 Pension Trust 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. 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. You **must** have some hours of work and contributions in the five consecutive years immediately prior to your Retiree coverage

(1) For a Normal Retiree or an Early Retiree, you must have some hours of work and contributions in *four of the five* 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), except that if you have no hours of work and contributions in his year prior to your retirement, you must be registered on the Union's out of work list during that year.

(2) For an individual receiving a disability benefits from the Sheet Metal Workers' Local No. 80 Pension Trust Fund, you must have some hours of work and contributions in *each* of the five consecutive years immediately

prior to his Effective Date (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 be 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 each of the five (5) consecutive years immediately prior to the effective date of Retiree coverage.

D. 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 will be reduced by 25% for retirees who accrued at least 25 years of service under the Sheet Metal Workers' Local Union No. 80 Pension Plan, and for the surviving spouses of such retirees (which 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 payable to your beneficiary

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!**

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 Non-Medicare Eligible Retiree and Medicare Eligible 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 under the Sheet Metal Workers' Local Union No. 80 Pension Trust 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**

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 Insurance 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. Rules on Delay of Self-Payment**

You may be eligible to continue coverage during the first three months of your retirement only, **without** making self-payments (unless you are an Owner-Member or a Non-Bargaining Unit Employee (PPO coverage)) if you had either 1,000 hours of work and contributions during the 12-month period prior to each of those first three months of retirement (750 hours of work and contributions for Architectural Metal Journeymen (PPO coverage)), or if you were credited with 125 hours and contributions in each of the last three months before you retired (100 hours of work and contributions for Architectural Metal Journeymen (PPO coverage)). Owner-Member Employees and Non-Bargaining Unit Employees (PPO Coverage) must remit self-payments for Retiree Coverage immediately upon retirement.

If you are eligible for Retiree Coverage based on receiving disability benefits from the Pension Fund, and you are not working, you may continue coverage without cost to you for a period that ends at the end of the sixth consecutive month following the month in which your disability commenced. This period of no-cost coverage may be changed or terminated by the Board of Trustees at any time.

**3. 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 you retire.**

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 (see details below), within 30 days after the date on which you retire, 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 <u>when you retire</u>!***

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. **<u>You must notify the Fund Office about this when you retire</u>, 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. ***<u>This option to delay enrollment is available only upon retirement!</u>***

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

**4. 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 or 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:** Some spouses of retirees have their own health benefits from their own employers, and may wish to delay their enrollment in this Plan. Your spouse may decline enrollment at the time of your retirement if s/he has coverage under another health

plan, and your spouse 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:** Some spouses of retirees who have their own health benefits from their own employers may wish to 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, 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.

## 5. 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 Pension benefits; or

(c) if you are covered under this Fund due to receipt of a disability benefit from the Pension Fund, when you becomes 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 Sheet Metal Workers' Local Union No. 80 Pension Trust Fund; or

(e) upon elimination of Non-Medicare Eligible Retiree or Medicare Eligible 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.

**6. Reinstatement in Active Employee Plan – 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.

Retirees may not use a 12-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) and vision benefits *only*. ***The Fund's non-group health plan benefits (weekly disability benefits, death 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. When key parts of the health care law take effect, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of 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 will lose your coverage under the Plan because either one of the following qualifying events happens:**

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

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

- **Your spouse (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 will 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 60$^{th}$ 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 coverage provided by the Plan at the Fund's annual open enrollment period for the balance of your COBRA period. If you decide to elect the HMO coverage, once your COBRA election period runs out, 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 (not available for Retirees or Surviving Spouses), 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 not 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.

**CREDITABLE COVERAGE FOR PRE-EXISTING CONDITIONS (expires December 31, 2014)**

The Health Insurance Portability and Accountability Act (HIPAA), a federal law, limits the amount of time that group health plans can exclude coverage for a new enrollee's pre-existing health conditions to 12 months (or 18 months for late enrollees). But that waiting period (exclusion period) can be reduced by the number of months the individual was covered previously under another health plan, including COBRA coverage, so long as there has not been a gap of more than 63 days in the individual's coverage.

If your coverage under this Plan ends for any reason, you will receive from the Fund a "Certificate of Group Health Plan Coverage" which you should present to your new group health plan. That new group health plan will then "credit" your months of coverage under this Plan against any exclusion period for pre-existing conditions imposed by the new plan, provided you did not have a gap of more than 63 days in your coverage.

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.

## BENEFITS

## MEDICAL, SURGICAL AND HOSPITAL BENEFITS

### 1. 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 77), and

b. Not excluded from coverage.

A list of exclusions can be found on page 71 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.

### 2. Operation of HAP'S Alliance Health and Life PPO

Although all benefits are paid directly from the Fund, the Fund participates in and adopts the medical, hospital and surgical benefits of the HAP'S Alliance Health and Life PPO. 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 or www.hap.org and click on Alliance Health and Life PPO providers by county, or you may simply contact health care providers 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:** When you receive services in-network you **must** pay an in-network deductible of **$750** per person or **$1,500** per family **before** payment will be made for benefits by the Plan, except where a fixed dollar copayment is required (see below). This deductible is required to be met each calendar year.

> ***Note:*** Out-of-network deductible amounts also apply toward the annual in-network deductible.

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.

The in-network deductible does **not** apply to:

- Preventive care services in an in-network (PPO) physician's office
- Covered services received in an in-network (PPO) physician's office
- Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Services subject to a fixed dollar co-pay
- Chiropractic spinal manipulation
- Outpatient diabetic management program – training *only*
- Pre-surgical consultations (in-network *only*)
- Specific human organ transplants in designated facilities only, when coordinated by Hines/HCC Life, the Fund's precertification provider
- Prescription contraceptive devices and contraceptive injections
- Pre-natal and post-natal care (office visits *only* - includes such services provided by a certified nurse midwife)
- Allergy testing and therapy
- Hospice care (see details in Section 4 below)
- Hearing care coverage (up to 100% of the HAP'S Alliance Health and Life PPO usual and customary amount, includes audiometric exam, hearing aid evaluation, ordering and fitting the hearing aid, hearing aid conformity test)

**When is a Benefit considered "In-Network":** To receive benefits at the in-network level, a HAP'S Alliance Health and Life PPO provider must provide your health care services.

**When is There No Difference Between In-Network and Out-of-Network Providers**: The following services have no difference in the out-of-pocket cost, once the deductible is met, whether they are provided in-network or out-of-network providers:

- Hospital emergency room services
- Ambulance Services (air or ground)
- Hospice care (see details in Section 4 below)
- Home health care

- Home infusion therapy
- Skilled nursing services
- Specific human organ transplants in designated facilities only, when coordinated by the Hines/HCC Life, the Fund's precertification provider
- Mental health services provided inpatient or outpatient
- Durable medical equipment
- Prosthetic and orthotic appliances
- Private duty nursing providers

**Fixed Dollar Co-Pays:** You are responsible for the fixed dollar co-pays listed below. These co-pays do not apply to your out-of-network deductible or co-pay maximum.

- $25 for office visits and all services during office visits (co-pay applicable in-network only)
- $25 for mental health care provided at a physician's office (co-pay applicable in-network only)
- $25 for substance abuse treatment in a physician's office (co-pay applicable in-network only)
- $25 for a chiropractic spinal manipulation (benefit covered in-network *only*). When an office visit and a manipulation are billed on the same day by the same in-network provider, only one co-payment for the office visit will be required.
- $25 for an office consultation (co-pay applicable in-network only)
- $25 for medical services in an *urgent* care center (co-pay applicable in-network only)
- $100 per visit for all hospital emergency room treatment (whether received in-network or out-of-network), which is waived if the patient is admitted to the hospital or for an accidental injury.

**Percent Co-Pays:** <u>After</u> you have met your annual in-network deductible, you will be responsible for the following percent co-pays:

- **You must pay 20%** percent of the HAP'S Alliance Health and Life PPO usual and customary amount for the following services:
    - Injections
    - Ambulance Services (air or ground)
    - Laboratory and pathology tests
    - Diagnostic tests and X-rays
    - Diabetic supplies

- Cardiac Rehabilitation
- Hemodialysis
- Radiation therapy
- Pre-natal and post-natal diagnostic tests
- Delivery and nursery care
- Colonoscopy based on medical necessary (covered 100% in-network once per year for preventative/screening purposes)
- Semi-private hospital room and board, in-patient physician and ancillary care, intensive care unit and cardiac care unit services, general nursing care, hospital services and supplies (non-emergency services must be rendered by an in-network participating hospital to be covered)(unlimited days)
- In-patient consultations
- Chemotherapy
- Surgical intervention for obesity – pre-authorization for medical appropriateness is required
- Skilled nursing care (up to 120 days per calendar year)
- Home health care
- Home infusion therapy
- Surgery, whether emergency or non-emergency, in-patient, outpatient or at an ambulatory surgical center, including related surgical services, anesthesia (whether physician or CRNA provided), assistants, etc. For in-patient surgery, pre-certification is required. If multiple surgeries are performed in the same surgical session, the second surgery is covered at 50% of the HAP'S Alliance Health and Life PPO usual and customary amount, and subsequent surgeries at 25% of the HAP'S Alliance Health and Life PPO usual and customary amount.
- Voluntary sterilization
- Bone marrow transplants when coordinated through the Hines/HCC Life, the Fund's precertification provider
- Kidney, cornea and skin transplantations
- Mental health care, whether inpatient or outpatient (for physician office visits, see fixed dollar copayments, above)
- Substance abuse care, whether inpatient or outpatient
- Outpatient physical, speech and occupational therapy (limited to a combined 60 visits per calendar year)
- Durable medical equipment
- Prosthetic and orthotic appliances

- **You must pay 50%** of the HAP'S Alliance Health and Life PPO usual and customary amount for private duty nursing

***Note:*** The usual and customary amount is HAP'S Alliance Health and Life 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.

**In-Network Co-Pay Maximum and Rules**

After you have paid **$3,000** per person or **$6,000** per family in **in-network percentage co-payments** for general services, you do not need to pay any further in-network percentage co-pays for the rest of that year, except this does not include or apply to private duty nursing. However, you are still required to pay fixed dollar co-payments.

The following **cannot** be used to meet your in-network co-pay maximum:

- Deductibles, in-network or out-of-network
- Fixed dollar co-pays
- Private duty nursing co-payments
- Charges for non-covered services
- Charges in excess of HAP'S Alliance Health and Life PPO's usual and customary amount

**Dollar Maximums:** There is no lifetime dollar maximum.

### B. Out-of-Network Benefits

**When Out-of-Network Benefits Apply:** Benefits will be covered at the out-of-network level when a HAP'S Alliance Health and Life 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 send you its usual and customary amount after your deductible and out-of-network co-pays have been deducted. You also may be responsible for paying the difference between the provider's actual charge and the usual and customary amount.

**Annual Out-of-Network Deductible:** Your coverage requires you to pay a yearly deductible of **$1,500** per person or **$3,000** per family before payment will be made for out-of-network benefits. This deductible is required each calendar year.

***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:*** Out-of-network deductible amounts also apply toward the in-network deductible.

The out-of-network deductible **does not** apply to:

- Hospital emergency room services
- Hospice care
- Home health care
- Home infusion therapy
- Specific human organ transplants in designated facilities only, when coordinated by the Hines/HCC Life, the Fund's precertification provider

**Out-of-Network Percent Co-Pays:** After you have met your out-of-network deductible, you will be responsible for the following percent co-pays:

- **You must pay 20%** percent of the HAP'S Alliance Health and Life PPO usual and customary amount for the following services:
    - Ambulance Services (air or ground - if out-of-network, **in-network** deductible must be met first)
    - Home health care and home infusion therapy
    - Mental health care, whether inpatient, outpatient or in physician's office
    - Durable medical equipment
    - Prosthetic and orthotic appliances
    - Skilled nursing care (up to 120 days per calendar year)
- **You must pay 50%** of the HAP'S Alliance Health and Life PPO usual and customary amount for the following services:
    - Mammograms (out-of-network reading and interpretation is covered only if the mammogram itself is performed in-network)
    - Office visits and all services during the office visit
    - Office consultations
    - Injections
    - Services from an urgent care center
    - Laboratory and pathology tests
    - Diagnostic tests and x-rays
    - Outpatient diabetic management program – training and supplies

- Radiation therapy
- Cardiac Rehabilitation
- Hemodialysis
- Colonoscopy based on medical necessary (for preventative/screening purposes, covered 100% in-network *only*)
- Surgical intervention for obesity – preauthorization for medical appropriateness is required
- Pre-natal and post-natal care (includes certified nurse midwife services)
- Delivery and nursery care
- Semi-private hospital room and board, in-patient physician and ancillary care, intensive care unit and cardiac care unit services, general nursing care, hospital services and supplies (non-emergency services must be rendered by a participating in-network hospital If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition has been stabilized, you must move to a hospital in network in order to pay the in-network cost sharing amount for the part of your stay after stabilization. If you stay at the out-of-network hospital, your stay will not be covered for the part of your stay after your condition has been stabilized.)
- In-patient consultations
- Chemotherapy
- Pre-surgical consultation
- Surgery, whether in-patient (emergency only), outpatient or at an ambulatory surgical center, including related surgical services, anesthesia (whether physician or CRNA provided), assistants, etc. For in-patient surgery (emergency only), pre-certification is required. If multiple surgeries are performed in the same surgical session, the second surgery is covered at 50% of the HAP'S Alliance Health and Life PPO usual and customary amount, and subsequent surgeries at 25% of the HAP'S Alliance Health and Life PPO usual and customary amount.
- Outpatient physical, speech and occupational therapy (limited to a combined 60 visits per calendar year)
- Voluntary sterilization
- Bone marrow transplants when coordinated through the Hines/HCC Life, the Fund's precertification provider
- Kidney, cornea and skin transplantations
- Substance abuse care, whether inpatient, outpatient or in physician's office
- Allergy testing and therapy
- Private duty nursing

- Prescribed contraceptive devices and injections

- **You must pay 100%** for the following out-of–network services - the following services that are covered in-network **are not covered out-of-network at all**:

  - Preventative services

  - Chiropractic spinal manipulation

  - Hearing care coverage (includes audiometric exam, hearing aid evaluation, ordering and fitting the hearing aid, hearing aid conformity test)

  - Non-emergency hospital services. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition has been stabilized, you must move to a hospital in-network in order to pay the in-network cost sharing amount for the part of your stay after stabilization. If you stay at the out-of-network hospital, your stay will not be covered for the part of your stay after your condition has been stabilized.

  - Non-emergency surgery (inpatient only)

***Note:*** The usual and customary amount is HAP'S Alliance Health and Life 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.

**Out-of-Network Co-Pay Maximum:** After you have paid **$4,500** per person or **$9,000** per family in out-of-network co-pays, you do not need to pay any further out-of-network co-pays for the rest of that year. However, you are still required to pay fixed dollar co-pays.

***Note:*** Out-of-network co-pay amounts also apply toward the in-network maximum.

The following **cannot** be used to meet your out-of-network co-pay maximum:

- Deductibles, in-network or out-of-network
- Fixed dollar co-payments
- In-network percent co-payments
- Private duty nursing percent co-payments
- Charges for non-covered services
- Charges in excess of HAP'S Alliance Health and Life PPO's usual and customary amount

**Lifetime dollar maximum:** There is no lifetime dollar maximum.

### C. Coverage Outside of HAP'S Alliance Health and Life PPO Coverage Area

When you need medical care outside of the service area for HAP'S Alliance Health and Life PPO, but in the country, contact the CIGNA PPO Network using 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 CIGNA PPO Network for in-network coverage, and outside of the CIGNA 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.

### 3. Preventative Services Detail

The following preventive services are covered 100% only when received in-network, with no deductible or copayment required. **With the two exceptions noted below, these services are not covered out-of-network at all, with or without a referral.**

- Health maintenance exam – one per individual per calendar year
- Gynecological exam – one per individual per calendar year
- Pap smear screening (laboratory and pathology services) – one per individual per calendar year.
- Well-baby and child care visits – routine visits to a physician to monitor the development and well-being of children. These visits are covered as follows:
  - Six visits per year from birth through age 35 months
  - Two visits per year from age 36 months through age 47 months
  - One visit per calendar year through age 15
- Immunizations (adult and child)
- Fecal occult blood screening – one per individual per calendar year
- Flexible sigmoidoscopy exam – one per individual per calendar year
- Prostate specific antigen (PSA) screening – one per individual per calendar year
- Blood Chemical Profile – one per individual per calendar year
- Cholesterol screening – one per individual per calendar year
- Complete Blood Count – one per individual per calendar year

- EKG – one per individual per calendar year
- Urinalysis – one per individual per calendar year
- Chest X-Ray – one per individual per calendar year
- Mammogram – one per individual per calendar year (out-of-network reading and interpretations are covered are covered at 50% after the out-of-network deductible is met only when the screening mammogram itself is performed by an in-network provider)
- Colonoscopy – for preventative purposes, one per individual per calendar year (covered out-of-network at 50% of the HAP'S Alliance Health and Life PPO usual and customary amount based on medical necessity only)

**4. Hospice Benefit Details**

The Fund's hospice benefit covers up to 28 pre-hospice counseling visits prior to electing hospice services. Hines/HCC Life, the Fund's precertification provider, will be engaged whenever there is a referral to hospice care.

**PRESCRIPTION DRUG BENEFITS**

The Fund has engaged Envision as the administrator of its prescription drug benefit program, and provider of its prescription drug PPO network.

You will see the Envision prescription logo on your HAP Alliance Health and Life PPO card, which you and your eligible dependents must present whenever you fill a prescription. You should keep this card as safely as you would a credit card. Loss of this card should be reported to the Fund Office immediately. You should use the HAP Alliance Health and Life PPO card with the Envision prescription logo only for benefits for you, your spouse or your dependent children. Any attempted unauthorized use of this card could result in the permanent cancellation of your right to prescription drug benefits and, as is the case with other attempts at defrauding the Fund, could lead to other sanctions, including criminal liability under Michigan's Health Care False Claims Act and expulsion from the Fund.

If you have a question about whether a pharmacy participates with Envision or if a particular prescription is either a "preferred" brand name drug or a "maintenance" drug, call Envision at 1-800-361-4542 or go to Envision's website at www.envisionrx.com, where you will be asked to register for privacy purposes.

**The Fund does not cover any prescriptions filled at Wal-Mart or Sam's Club.**

Envision has a free glucometer program: call 1-866-224-8892 for an Abbott Diabetes Care Glucometer (Free Style or the Precision X-tra® Blood Glucose and Ketone Monitoring Systems) or call 1-877-229-8777 for a Bayer Health Care, Diabetes Care Glucometer (Ascensia® Contour® or Ascensia® Breeze®). If you call, identify yourself as an Envision customer, and Abbott or Bayer will take care of the rest. There is a limit of one free glucometer per participant.

This is merely provided as a benefit – the Fund is **not** recommending or requiring use of these products or providers. You should discuss your glucometer needs with your health care provider.

**Mail Order**

As well as providing full prescription benefit services through its network of retail pharmacies, Envision also provides mail order prescription services through its affiliated company, Orchard Pharmaceutical Services, in North Canton, Ohio. Mail order can be a good way to receive your "maintenance" medications (that is, medications taken for a long period of time) without visiting or worrying about the availability of supply at your local pharmacy, but it is not mandatory that you use it.

In order to start receiving maintenance drugs via mail order, you must first register your information with Orchard Mail Order Pharmacy, using one of the following three methods:

1. **Online (recommended)**: Visit www.orchardrx.com and select "Not registered? Click here to register." Your account will activate within 24 hours. By registering online, you are also able to track the progress of your orders.

2. **Phone:** Call Orchard Pharmaceutical Services Customer Service at 1-866-909-5170 to speak with a representative.

3. **Mail:** Complete and return the Registration and Prescription Order Form you received from Envision.

After you are registered, you will need to obtain NEW 90-day supply prescriptions from your physician. **Mail** the original prescription(s) for a 90-day supply (plus refills, if applicable) with the form you receive from Envision, along with your first payment or payment information. Once you are registered, your physician can also **FAX** your prescriptions directly to Orchard at 1-866-909-5171. Be sure that your prescriber includes your date of birth and contact information on the FAX. Only faxes sent from a physician's office will be valid and accepted – Orchard will not fill prescriptions faxed by or from anywhere else.

1. **In-Network Benefits**

Each time you fill or refill a prescription at an Envision-participating pharmacy (either at a retail pharmacy or with Orchard Pharmaceutical Services, the Fund's mail order pharmacy provider), you will be responsible for paying the following co-pays for up to a 30-day supply (with some exceptions, limitations and exclusions - see below):

- Generic Drugs - $10.00
- Preferred Brand Name Drugs - $30.00
- Non-Preferred Brand Name Drugs - $60.00
- Specialty medications (except as noted below) - $60.00
- Embrel® and Humira® - $500.00

- Copaxone® - $2,000.00

***Note:*** Any prescription filled by an Envision participating pharmacy for more than an 84-day supply but less than a 91-day supply will be charged **two** co-pays - that is, *two co-pays for a three-month supply*. *This rule EXCLUDES specialty medications*, which can **only** be filled for 30-day supplies.

Envision provides specialty drug services through its affiliate, Orchard Specialty Pharmacy in North Canton, Ohio. It is mandatory that you use Orchard Specialty Pharmacy for specialty drugs. For information, call 1-877-437-9012.

Also, if your doctor writes "dispense as written" or "DAW" on your prescription (which requires that the pharmacy fill the prescription with the brand name drug your physician has ordered, even if an equivalent generic drug is available), unless the doctor provides a letter of medical necessity, you will be responsible for paying the full difference in cost between the brand name drug and the generic equivalent drug.

Thus, it is to your benefit to ask your doctor if there is a generic equivalent for any drug prescribed for you and whether it would be appropriate for you instead of the brand name drug.

**2. Out-of-Network Benefits**

If you have your prescription filled at a non-Envision participating pharmacy, you will have to pay the full cost of the prescription up-front, at the time you pick up the prescription, and then you have to submit your detailed receipt to Envision. Envision will then reimburse you the amount that Envision would have reimbursed the pharmacy if you had the prescription filled at an in-network pharmacy (not to exceed what was actually paid), less the applicable copayment. Thus, all the same limitations, exclusions, co-payments, etc., that are applicable in-network are applicable out-of-network, with the two exceptions below. Note that if an out-of-network pharmacy charges you more than Envision would have paid an in-network pharmacy, you will **not** be reimbursed for that higher amount – out-of-network benefits are capped at what Envision would have paid, less your copayment.

The first exception to the above is that you cannot receive an 84 – 90 day supply for only two copayments - that discount is *not available* if you have your prescription filled at a non-Envision participating pharmacy.

The other exception is that there is **no** mail order option that is out-of-network.

**3. Exceptions, Exclusions and Limitations**

The following drugs and products are covered with **no** copayment:

- All FDA-approved contraceptive medications and methods (for women only – prescription required
- Insulin needles and syringes, and lancets

- Aspirin to prevent cardiovascular disease (for men between age 45 – 79, and women between age 55 – 79. Over-the-counter requires prescription)
- Multivitamins with folic acid (for women only, over-the-counter requires prescription)
- Liquid iron supplements (for children between 0 – 12 months old, over-the-counter requires prescription)
- Smoking deterrents (Over-the-counter requires prescription)
- Vaccinations administered at a pharmacy by pharmacist (Age restrictions apply to some vaccinations. Vaccinations may also be covered under medical coverage if administered in an office visit by a health care provider)
- Vitamin D 400 I.U. twice per day (only for patients age 65 and older residing at home, generic only, over-the-counter requires prescription)
- Oral fluoride supplements (prescription only - for children between 0 – 5 years old)

The following drug classifications have **50%** copayments and/or **quantity limitations** - *If you are affected by any of these, please contact Envision for information on coverage requirements*:

- Impotency drugs
- Migraine medication
- Certain opiod pain medications
- Certain opiod dependency treatments
- Certain inhalant antibiotics for cystic fibrosis and other lung diseases

The following medications require pre-authorization, letters of medical necessity, and/or proof that certain specific medical criteria have been met from your physician to be covered at all. *If you are affected by any of these, please contact Envision for information on coverage requirements*:

- Acne medications after age 26
- Compounded medications
- Aspirin for anti-platelet therapy (covered with no copayment for men between age 45 – 79, women between age 55 – 79. Over-the-counter requires prescription)
- Anti-seizure medications
- Anti-neoplastics
- Stimulants
- Folic acid supplements (covered with no copayment for women only, over-the-counter requires prescription)
- Iron supplements (covered with no copayment for children between 0 – 12 months old, over-the-counter requires prescription)
- Smoking deterrents (covered with no copayment. Over-the-counter requires prescription)
- Oral fluoride supplements (covered with no copayment for children between 0 – 5 years old)
- Certain medications and medications for the following diseases:
    - ADD/ADHD
    - Acromegaly, Profuse Diarrhea
    - Asthma

- Benign Prostatic Hypertrophy
- Corticotrophin
- Cushing's Disease
- Cystic Fibrosis
- Fabry Disease
- GAA Deficiency
- Gout
- Growth hormone and growth hormone releasing hormone
- Hepatitis C
- Hereditary Tyrosinemia
- Homocytinuria
- Hyperammonemia treatment
- Mucopolysaccharidosis
- Multiple sclerosis
- Neutrophil formation
- Opioid addiction
- Oral oncology agents
- Osteoporosis
- Pain management with fentanyl
- Phenylketonuria treatment
- Pseudoulbar Affect
- Red blood cell formation
- Rheumatoid Arthritis/psoriatic arthritis
- Systemic lupus erythematosis
- Anabolic steroids
- Vimovo
- Acne treatment
- Gralise
- Horizant
- Lyrica
- Savella
- Vitamin B-12
- Testosterone

Step-Therapy: The following drug classifications require that other products be tried first without success. *If you are affected by any of these, please contact Envision for information on coverage requirements*:

- Angiotensin receptor blockers
- Insomnia agents
- Osteoporosis
- Transdermal ADD
- Proton pump inhibitor
- Cholesterol/statins
- Cholesterol/Fibric acid derivative
- Gout

- Cox II inhibitor
- Selective serotonin reuptake inhibitor
- Antidepressants

The following medications are **excluded** from coverage

- Drugs for fertility or infertility treatment.
- Compounded medications made from bulk powders or chemicals (that is, made with any ingredient that does not have an NDC code).
- Weight loss/weight control drugs.
- Allergens (may be covered under medical coverage).
- Blood product (may be covered under medical coverage)
- Over the counter allergy medications.
- Drugs that require a prescription by state law, but not Federal law.
- Administration of drugs or any drug consumed at the time and place of the prescription order (except vaccinations and self-injected medications).
- Refills not authorized by a physician.
- 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).
- Refills dispensed after one year from the date of the original prescription.

There are a number of other exclusions from the Fund's prescription drug coverage. You should review "Exclusions and General Limitations" beginning on page 71 of this summary before seeking prescription drug benefits.

## DENTAL AND ORTHODONTIC BENEFITS

Dental and Orthodontic benefits vary based on your benefit/coverage classification – please review the following carefully to be certain that you are referencing the benefits applicable to *your* benefit/coverage classification.

### 1. Dental Coverage

A. Percent Co-payments and Dollar Maximum

**For Construction Employees, Production Journeymen, Residential/Light Commercial Journeymen, Architectural Metal Journeymen (PPO coverage), Owner-Member Employees, and Non-Bargaining Unit Employees (PPO coverage):**

The Fund will pay **80%** of the usual and customary charge for **routine dental work** (described below), and **50% of all other dental work**, but no more than **$1,000 per eligible person per calendar year**. *Dependent children under age 16 are excluded from the above dollar limit for routine oral examination benefits only*. See the information below on enhanced coverage if routine dental work is received from a DenteMax participating provider.

**For Non-Medicare-eligible Retirees with PPO Coverage, Surviving Spouses and Dependents of Surviving Spouses:**

The Fund will pay **80%** of the usual and customary charge for **routine dental work** (described below), and **50% of all other dental work**, but no more than **$500 per eligible person per calendar year**. *Dependent children under age 16 are excluded from the above dollar limit for routine oral examination benefits only*. See the information below on enhanced coverage if routine dental work is received from a DenteMax participating provider.

**DenteMax - PPO**: To help reduce your costs, you may choose to obtain dental services from a DenteMax participating provider. DenteMax is a dental preferred provider organization (PPO). Reduced fees will be charged to all eligible Fund participants and dependents who get services from a DenteMax participating provider while the Fund continues to participate with this dental PPO. Also, **routine dental services** (described below) are covered **100% when provided by a DenteMax participating provider (versus 80% if provided by a non-DenteMax participating provider**). However, eligible persons are not required to go to a DenteMax 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 DenteMax-participating providers by the Fund. The Fund Office can provide you with a DenteMax directory to find a participating dentist near you, or to find out if your dentist is a DenteMax participating provider.

B. Benefits

Routine Dental Benefits include the following, with the listed limitations:

1. Oral Examinations (limited to one every six months)
2. Cleaning and Prophylaxis (limited to one every six months)
3. Bitewing X-Rays (limited to one every six months)
4. Full Mouth X-Rays (no more frequently than once every thirty-six (36) months)
5. Panoramic X-Rays
6. Periapical X-Rays
7. Tomographic X-Rays
8. Space maintainer
9. Preparation of Complete Treatment Plan
10. Fluoride (limited to one every six months)

Other Dental Benefits are the following, with applicable limitations:

1. Amalgams/composite fillings - no "downgrading" from white composite (porcelain) to amalgam (metal) is covered.
2. Anesthesia (local and general, including IV and nitrous oxide sedation)
3. Crowns (gold, porcelain, metal) – replacements are limited to once in five years and no "downgrading" from white composite (porcelain) to amalgam (metal) is covered.
4. Bridges - replacements are limited to once in five years.
5. Dental implants
6. Cephlametric x-ray

7. Dentures (full or partial) – replacements are limited to once in five years; no limit on denture re-lining.
8. Emergency palliative treatment
9. Non-routine visits, such as for emergencies, consultations, office visits or specialist examinations.
10. Simple or bony/impacted extractions
11. Frenectomy/biopsies
12. Full month debridement
13. Inlays/Onlays – replacements are limited to once in five years.
14. Mouthguards/bite/occlusal guards
15. Oral surgery
16. Periodontal Treatment (limited to every four months)
17. Re-cement of prosthetics
18. Replacement of teeth
19. Root Canal Therapy
20. Scaling and root planing (periodontic)
21. Sealants
22. Veneers

C. Exclusions.

No benefits shall be paid for the following dental care and services:

1. resulting from any injury relating to the occupation of the eligible person, or for which benefits are payable under any Workers' Compensation Act, Occupational Disease Law or similar legislation **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 hereunder out of monies recovered; or

2. resulting from war, declared or undeclared, or any act of war or aggression; or

3. paid for, furnished by, or at the direction of, any government agency, but only to the extent so paid or furnished; or

4. rendered solely for cosmetic purposes, unless resulting from accidental bodily injuries; or

5. covered by any other part of this Plan; or

6. for treatment of temporomandibular joint (TMJ) disease; or

7. for habit-breaking appliances; or

8. resulting from an auto accident or accident involving motor vehicles licensed to be on the road.

## 2. Orthodontia Coverage

**For Construction Employees, Owner-Member Employees and Non-Bargaining Unit Employees (PPO coverage):**

Benefits are payable for orthodontic benefits for *dependent children* at **50%** of the usual and customary charge, with a **$1,000 annual maximum and a $1,750 lifetime maximum per dependent child**.

Orthodontia for persons other than dependent children is covered **only** for purposes of pre-surgical treatment of temporomandibular joint (TMJ) syndrome at the regular medical limits and subject to deductibles and co-pays set forth above in the "Medical, Hospital and Surgical Benefits" section.

**For Production Journeymen, Residential/Light Commercial Journeymen, and Architectural Metal Journeymen (PPO coverage):**

Benefits are payable for orthodontic benefits for dependent children at **50%** of the usual and customary charge, with a **$1,000 annual maximum and a $1,000 lifetime maximum per dependent child**.

Orthodontia for persons other than dependent children is covered **only** for purposes of pre-surgical treatment of temporomandibular joint (TMJ) syndrome at the regular medical limits and subject to deductibles and co-pays set forth above in the "Medical, Hospital and Surgical Benefits" section.

**For Non-Medicare Eligible Early Retirees, Surviving Spouses and Dependents of Surviving Spouses:**

Non-Medicare Eligible Early Retirees, Surviving Spouses and Dependents of Surviving Spouses are **not** eligible for orthodontic benefits coverage.

## VISION EXPENSE BENEFITS

The Fund has discount agreements with three vision benefit providers – VSP, SVS Vision and Henry Ford OptimEyes. If you decide to use any of these providers, show your Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund card, and you may be entitled to discounts on examinations and/or products.

Vision benefit claims are processed by the Fund Office. After you incur one of the covered expenses above, submit a claim for benefits, accompanied by proof of your payment and all other required documentation, to the Fund Office, which will process your claim, and if eligible, issue payment. Claims for Vision Expense Benefits must be submitted within 12 months from

the date the participant or dependent incurred vision expenses for which payment is sought.

The amounts and limitations are listed below:

| Benefit | Amount |
|---|---|
| Eye Exams once every 12 months | |
| Ophthalmologist | $ 60.00 |
| Optometrist | $ 50.00 |
| Refraction | combined with examination charge |
| Lenses twice every 48 months | |
| Single | $ 60.00 |
| Bifocal | $ 80.00 |
| Trifocal | $100.00 |
| Lenticular | $125.00 |
| Frames twice every 48 months | $ 75.00 |
| Contact lenses twice every 48 months | $100.00 |

Exclusions

The Plan does **not** cover sunglasses, "transition" lenses (glasses that change into sunglasses in bright light), safety glasses, scratch coating or tints.

The Plan does **not** cover LASIK, retinal kerototomy or any other vision correction surgery.

**WEEKLY DISABILITY BENEFITS (Active Employees only, excludes Owner-Member Employees)**

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 until 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.

Benefits are payable from the first day of a disability caused by an accident and from the eighth day of a disability caused by an illness, including pregnancy; 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 six weeks prior to the due date through six weeks after delivery. You must provide medical documentation of disability as

defined herein to receive more than twelve weeks of Weekly Disability Benefits for a pregnancy. In no case shall Weekly Disability Benefits exceed the 26-week continuous maximum.

You may receive no more than 26 weeks of Weekly Disability Benefits for disability due to the same or related cause. 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.

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.

Benefits are not payable after you retire under the Sheet Metal Workers' Local Union No. 80 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 are not eligible for Weekly Disability Benefits.

**DEATH BENEFITS**

The amount of the Death Benefit payable from the Fund varies based on whether you are an Active Employee or Retiree when you die, 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 your respective 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 the Employee or retiree and such spouse. The former spouse shall be recognized as a beneficiary following the entry of such judgment or decree only if designated by the Employee or retiree 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.

The Fund's Death Benefit is subject to federal income tax. The Fund will send the beneficiary(ies) an IRS Form 1099 on or before January 31 of the year following the year in which a Death Benefit is paid.

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

**1. All Active Employees**

For these benefit classes, a Death Benefit of $15,000 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 $15,000 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**
**Surviving Spouses**

A Death Benefit of $5,000 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 $5,000 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.

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Active Employees only)**

The principal sum, $15,000, 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, $7,500, 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.

The Fund's Accidental Death Benefit is subject to federal income tax. The Fund will send an IRS Form 1099 on or before January 31 of the year following the year in which a benefit is paid hereunder to the recipient(s).

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.) (Active Employees and families only)**

The Fund has contracted with Gessert and Associates to provide employee assistance services to participants and their families.

M.A.P. provides assistance to participants and their families who are experiencing difficulty with alcohol and/or drugs or who have a concern about another's alcohol and/or drug use or who are in need of information about other social or emotional problems.

M.A.P. is provided at no cost to you. You may contact Gessert and Associates at (734) 395-1693.

## 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 for Medicare Parts A and B and pay all premiums immediately when you reach age 65, even if you are still working; 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 above.

### 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 BCBSM's Medicare Plus Blue PPO program. At the time of this Summary, when you become eligible for Medicare, your available coverage will change to BCBSM's Medicare Plus Blue PPO program, 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.

## 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 these coordination 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 (available to Active employees only).

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, fund, policy, contract, program or statutory payer shall pay first:

(a) the plan covering the child's parent who has the earlier birthdate anniversary in the calendar year shall be primary;

(b) if both parents have the same birthdate, the plan that covered the child for the longer period of time shall be primary;

(c) if the child's parents are divorced, or legally separated, the plan covering the parent who is financially responsible for the health care of the child pursuant to court decree shall be primary. If there is no court decree, the plan covering the custodial parent shall be primary. If the custodial parent is remarried, the plan covering the spouse of the custodial parent is primary over that which covers the non-custodial parent.

**SUBROGATION AND REIMBURSEMENT**

In the event of any payments of 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)) 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)), 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)) may owe, and before that person (or his representative(s)) pays any other individual, organization or entity out of that full or partial recovery (i.e., the Fund has first priority with respect to its rights under this provision). Such monies recovered shall be deemed to be held in constructive trust for the benefit of the Fund, regardless of who holds those monies. That person (or his representative(s)) may take no action which would prejudice the Fund and/or any of the Fund's designees' rights, and that person (or his representative(s)) hereby agrees to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Board of Trustees may require to facilitate the enforcement of the Fund's rights. The Fund and/or any of the Fund's designees will not be responsible for attorney's fees or costs incurred and/or paid by or on behalf of that person (or his representative(s)) unless the Fund and/or any of the Fund's designees has agreed in writing to pay such fees or costs or some portion thereof.

If the Fund and/or any of the Fund's designees pays benefits on behalf of any person and that person (or his representative(s)) receives a settlement, that person (or his representative(s)) must repay the Fund and/or any of the Fund's designees up to the amount of benefits it/they have paid. If that person (or his representative(s)) does not do so, the Fund and/or any of the Fund's designees has the right to treat the amount of benefits paid as a debt of that person (or his

representative(s)) to the Fund and/or any of the Fund's designees and may pursue recovery of said amount from that person (or his representative(s)) and/or reduce any future benefits payable on behalf of that person (or his representative(s)) in this amount until this debt has been cancelled.

## CLAIMS APPLICATIONS, LIMITS AND APPEALS

### 1. Applying for Benefits and Time Limit for Claims

All medical, hospital and surgical claims are submitted to HAP for pricing and network determination, which will then forward the claim to BeneSys for processing and payment.

Non-network claims paid by the participant must be submitted to BeneSys and in conformity with the requirements of BeneSys, including all time limits and proofs. The documentation should include the patient's name; the participant's (subscriber's) name and contract number from your HAP'S Alliance Health and Life PPO card; the provider's name, address, phone number and federal tax ID number; paid receipt reflecting the date and description of services, diagnosis (nature of illness or injury) and admission and discharge dates for hospitalization. The claim documentation should be sent to BeneSys at:

| Street Address: | Mailing Address: |
|---|---|
| 700 Tower Drive, Suite 300 | P.O. Box 1408 |
| Troy, MI 48098-2808 | Troy, Michigan 48099-1408 |

Medical, hospital and surgical claims must be submitted **within 12 months of the date of service**.

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

Claim forms for prescription drug benefits are available from Envision, and all such forms and supporting documentation must be submitted **within 6 months from the fill date.**

If a claimant disagrees with a determination made by Envision, he must appeal directly to Envision and comply with Envision's claims appeal process.

Form to apply for the other benefits administered by the Fund Office are available from the Fund Office, and all such forms and supporting documentation must be submitted within the following time periods established by this Plan for such benefits. Those benefits and time periods are as follows:

- **Death Benefit** claims must be submitted within two years from the eligible individual's death.
- **Accidental Death and Dismemberment Benefit** claims must be submitted within two years from the Active Employee's loss or death.

- **Weekly Disability Benefit** claims must be submitted within 20 days from the onset of the Active Employee's disability.
- **Dental Expense Benefit** claims must be submitted within 12 months from the date the service was provided for which payment is sought.
- **Vision Expense Benefit** claims must be submitted within 12 months from the date the service was provided for which payment is sought.

If processing of a claim cannot be completed because of missing information, the Fund Office will notify the claimant and advise him or her 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 the claimant's responsibility to gather this information and submit it within the required time period.

If a claim for benefits under this Plan is completely or partially denied by the Fund Office, the Fund Office will notify the claimant and advise him or her of the specific reasons for denial. Notice of denial will normally be sent within 90 days after the claim has been received by the Fund Office. In a few unusual circumstances, the Fund Office may require additional time to process the claim, in which case it will notify the claimant that additional time is required to process the claim and the date on which it expects to make a final decision. The Fund Office may take as long as 90 additional days to complete the processing the claim.

Late proof may be accepted only if, under the particular circumstances, it was furnished as soon as was reasonably possible, and, in any event except in the absence of the claimant's legal capacity, within two years after the time it was otherwise required.

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, Surgical, Prescription Drug, Dental and Vision Benefits

Most questions or concerns about decisions BeneSys or Envision 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.

In accordance with the Affordable Care Act, the Plan provides for a two-step appeal process for denial of claims for Medical, Hospital, Surgical, Prescription Drug, Dental and Vision Benefits. The first step is an internal appeal to the Board of Trustees or its designee. The second step is an external review by an Independent Review Organization ("IRO").

(2) Internal Appeal.

You may appeal a denial of a claim for Medical, Hospital, Surgical, Prescription Drug, Dental and Vision Benefits by writing out the reasons for your disagreement and the facts on which you rely for your claim to benefits and mailing your appeal within 180 days of the notice of denial to the Board of Trustees, 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.

**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.**

(3) External Review.

You may request external review for a denial of any appeal for Medical, Hospital, Surgical, Prescription Drug, Dental and Vision Benefits s ("request"). 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 (available to Active employees only), Weekly Disability Benefits (available to Active employees only) and Member's Assistance Program Benefits (available to Active employees only)

You may appeal a denial of a claim related to an eligibility determination or a claim for Death Benefits, Accidental Death and Dismemberment Benefits (available to Active employees only), Weekly Disability Benefits (available to Active employees only), and/or Member's Assistance Program Benefits (available to Active employees only) 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 not 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.**

## 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.) The foregoing exclusion will not apply to an Eligible Retiree who makes an additional self-payment amount to be determined by the Board of Trustees from time to time, who is injured in a motor vehicle accident prior to his/her reaching age 65; however, the Fund will pay claims only after the maximum insurance coverage allowable under the State law of his/her residence for a Bodily Injury Liability Policy, Personal Protection Insurance Policy and any other available policy has been incurred with respect to those injuries, irrespective of whether the Eligible Retiree holds such policies in the maximum amounts, and irrespective of what those policy issuers have paid.

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 except as set forth in the section on Orthodontia.

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, except as provided under the Plan's contract with Blue Cross/Blue Shield of Michigan's Medicare Plus Blue PPO program.

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.

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.

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

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 hospital confinements or medical expenses due to pregnancy of dependent children.

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

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

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

## 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 HAP'S Alliance Health and Life 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 HAP'S Alliance Health and Life 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. There may be additional amounts payable by the Fund that have been excluded. 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.***

## 9. Altered or Forged Claims

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

# 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 will become prohibited beginning in 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.

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

EFFECTIVE DATE: September 23, 2013

## 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 Envision 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.

**Effective Date:** January 1, 2006.

## 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.

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

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:_____