SHEET METAL WORKERS' LOCAL NO. 292

HEALTH FUND

SUMMARY PLAN DESCRIPTION

SHEET METAL | AIR | RAIL | TRANSPORTATION

October 1, 2023

SHEET METAL WORKERS' LOCAL NO. 292 HEALTH FUND

SUMMARY PLAN DESCRIPTION

IMPORTANT NOTICE

This summary plan description booklet describes the Plan for the Sheet Metal Workers' Local No. 292 Health Fund as it is in effect on October 1, 2023. If you have questions about the Plan or your rights under the Plan, contact the Fund Office.

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

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

SHEET METAL WORKERS' LOCAL NO. 292 HEALTH FUND
BOARD OF TRUSTEES

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The Board of Trustees is the legal Plan Administrator.

FUND OFFICE/ADMINISTRATIVE MANAGER
BeneSys, Inc.
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(248) 641-4992

MAILING ADDRESS
P.O. Box 189
Troy, MI 48099-0189

OFFICE HOURS
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AGENT DESIGNATED FOR SERVICE OF LEGAL PROCESS
Joseph R. Pawlick, Esq.
Watkins, Pawlick, Calati & Prifti, PC
1423 E. Twelve Mile Road
Madison Heights, MI 48071

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

Contacting Blue Cross Blue Shield of Michigan (BCBSM)

When you call BCBSM Customer Service, please be ready to provide your contract number (as listed on your BCBSM ID card). If you are inquiring about a claim, you will need to provide the following information:

- Patient's name
- Provider's name (hospital, doctor, laboratory, other)
- Date of service and type of service (surgery, office call visit, X-ray, other)
- Provider's charge for each service

Please remember, BCBSM follows strict privacy policies in accordance with state and federal law. For example, BCBSM will never release your health information to anyone, unless you have authorized BCBSM in writing to do so. You can find the necessary release documents and forms at bcbsm.com.

To call BCBSM, please use the phone number on the back of your ID card. You can also find this number on your Explanation of Benefit Payments statement, or Explanation of Benefits ("EOB"). Customer service hours are Monday through Friday from 8:30 to 5 p.m.

Hearing- or speech-impaired members, please call:
Area codes 248, 313, 586, 734, 810 and 947: 313-225-6903
Area codes 231, 269 and 616: 1-800-867-8980

You can also visit one of BCBSM's walk-in customer service centers for personal, face-to-face service. Customer service representatives are available weekdays to assist you. For a list of walk-in customer service centers and hours of operation, go to bcbsm.com or call BCBSM Customer Service.

To write BCBSM, please use the address in the upper right-hand corner of your EOB. If you do not have an EOB, call BCBSM Customer Service for assistance.

Contacting Humana

If you need to contact Humana regarding your Medicare Advantage Plan, contact them at www.humana.com/medicare or call 1-800-733-9064. They are available Monday through Friday, from 8:30 a.m. to 5 p.m. EST.

For more information about Medicare, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, seven days a week. Or, visit **www.medicare.gov** on the web.

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INTRODUCTION

To All Participants and Dependents:

We are pleased to provide you with this summary description of the Sheet Metal Workers' Local No. 292 Health Plan as in effect on October 1, 2023. If you have questions about the Plan or your rights under the Plan, contact the Fund Office.

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.

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

Board of Trustees

Michael Asher
Tracy Roberts
David Flynn
Paul Gualdoni
Antonio Silvestri
Charles Garry

October 2023

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

GENERAL INFORMATION

The Sheet Metal Workers' Local No. 292 Health Fund was created through collective bargaining. It is sponsored and administered by a board of six Trustees, three of whom are designated by the Sheet Metal Workers Local No. 292 (the "Union") and three of whom are designated by the Associated Metal Fabricators and Engineers (the "Association").

The Board of Trustees is the legal Plan Administrator and it has engaged the firm of BeneSys, Inc., as Administrative Manager to operate the program on a day-to-day basis.

The Fund has been assigned an Employer Identification Number by the Internal Revenue Service. It is 38-1433000. The Plan Number is 501.

The Fund operates on an April 1 through March 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 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 Trustees pending the payment of benefits and administrative expenses. Employees, retirees, spouses and other dependents may be required to make payments to the Fund under certain circumstances described below in order to continue eligibility. Any participant, surviving spouse, or beneficiary may receive, upon written request to the Fund Office, information about whether a particular employer is contributing to the Fund and, if so, the employer's address. You have a right to receive a copy of a collective bargaining agreement or to read it at the Fund Office.

Medical, hospital and surgical benefits, prescription drug benefits, dental benefits and vision benefits are insured through Blue Cross Blue Shield of Michigan (group number 7016912). Life Insurance benefits and the accidental death and dismemberment benefits are insured through Union Labor Life Insurance Company (Ullico) (policy number G-3299 and C-4565). All other benefits are paid directly from the Trust and are "self funded."

As circumstances require, 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 right to any benefit provided by the Fund, now or at any time in the future.*

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

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

Your rights under federal law as a participant in this program are the same as they are in respect to other fringe benefit programs. You are urged to read the ERISA RIGHTS section of this booklet, which you are urged to read and which begins on page 59.

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 and sole and exclusive discretion to increase, reduce, or eliminate benefits and to change the eligibility rules and all 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 book will be provided to each participant within the time required by any applicable regulations. Before incurring any non-emergency expense, you should contact the Fund Office to confirm your current entitlement to coverage.

This book is intended to give you an accurate summary of the benefits and provisions of the Fund's Plan. It does not describe Plan changes that occurred after the book was printed. The Plan and the Agreement and Declaration of Trust, which you can read at the Fund Office or other specified locations, contain a detailed description of the rules, regulations, benefits, and provisions of the Fund. If any discrepancy exists between this book and the Plan documents (including any insurance contracts entered into by the Fund), 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 book. 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 person, agent, representative, officer, or other person from the Union, the Association, or an Employer has any authority to speak for the Board of Trustees or to act contrary to the written terms of the governing Plan documents.

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

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

DOING YOUR PART

You have certain responsibilities in order to protect your rights and eligibility and receive benefits from the Fund.

Read this booklet. You, your spouse and your adult dependent children 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. Failure to make certain that the Fund Office always has current and accurate information about you and your dependents can result in loss of COBRA rights, missed notices from the Fund Office, transfer of responsibility for medical expenses from the Fund to you, and your being legally liable for expenses the Fund paid which the Fund should not have paid.

When you write to the Fund Office, always include your name, any identifying number provided by the Fund, your trade and your union in your letter. If you call, be sure to have the identifying number provided by the Fund handy.

When you become a participant:

First, complete a Vital Information Form, beneficiary designation and other materials immediately and return it to the Fund Office with any required documentation.

Then, inform the Fund Office whenever any of the information on the Vital Information Form, the beneficiary card or other materials changes **immediately**. 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 life insurance benefit in a manner that was unintended. Some of the important changes include the following:

- Change of address
- Changes in your family, such as your marriage, birth, adoption, any death or divorce or a child losing dependent status
- Change in your beneficiary designation for purposes of the Fund's Life Insurance Benefit. Remember to designate a new beneficiary if your beneficiary dies, or if your beneficiary is your spouse, and you divorce.
- Other important things you should tell the Fund Office are:
- Disability due to accident or illness, including pregnancy and childbirth
- Termination of disability

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- Termination of your employment with a contributing Employer
- Application for family or medical leave from a contributing Employer
- A court or the friend of the court issuing a qualified medical child support order directing that health care coverage be provided for your child(ren) through the Fund
- Eligibility for or receipt of benefits under any other health care plan, insurance contract, program, or statute by you and/or your dependents
- Eligibility for Social Security benefits and/or Medicare coverage by you and/or your dependents (Note: 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)
- Working outside the Local 292 area (Note: If your employer is making health care contributions on your behalf, you may be able to have those contributions related to that work transferred to this Fund)
- You or your dependent joining the armed forces of any country

Keep documents that you receive from the Fund, such as:

- **Bills and Explanations of Benefits ("EOBs").** 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.
- **Notices.** After the publication of this book, you will receive notices of benefit changes as they occur. You should keep those together with this book in order for you to have a complete record of the Plan's communications to you on your benefits.

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

If your employer has failed to submit contributions on your behalf for hours you have worked, tell the Fund Office immediately. You may have to make a self-payment to continue your eligibility, but the Fund routinely pursues 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.

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

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.

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

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

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

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

All fraud reports are confidential, and you remain anonymous.

ADMINISTRATIVE RESPONSIBILITIES AND BENEFIT PAYMENTS

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 different areas of responsibility, and has delegated them to the Fund Office, Blue Cross Blue Shield of Michigan (BCBSM), Humana, Ullico and Ulliance.

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

- Day-to-day details of running the Fund, including financial and record-keeping functions
- All matters pertaining to eligibility
- Self-payments, including actives, retirees, surviving spouse, and COBRA

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- Forwarding claims for Life Insurance and Accidental Death and Dismemberment Benefits to the commercial insurance carrier
- Wellness Promotion Benefit
- Health Reimbursement Arrangement Benefits
- Reviewing and presenting appeals concerning eligibility and benefits which are administered at the Fund Office to the Board of Trustees

Blue Cross Blue Shield of Michigan: The Fund has an insurance contract with Blue Cross Blue Shield of Michigan to administer and pay all medical, surgical, and hospital claims in accordance with the Simply Blue PPO schedule of benefits for Active Participants and the Community Blue PPO for non-Medicare eligible retirees, as applicable, and to administer and pay all outpatient prescription drug claims, dental claims and vision claims for active and non-Medicare eligible retirees.

Humana: The Fund has an insurance contract with Humana to administer and pay all medical, surgical, and hospital claims in accordance with the Humana Medicare Employer PPO Plan for Medicare-eligible participants, as applicable.

Ullico: The Fund has a contract with Ullico to provide Life Insurance and Accidental Death & Dismemberment insurance to eligible participants.

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

TruHearing: The Fund has a contract with TruHearing to provide Active Participants, non- Medicare eligible retirees and their dependents with access to hearing aids and related hearing benefits.

ELIGIBILITY AND COVERAGE

HOURS OF COVERED EMPLOYMENT AND EMPLOYER CONTRIBUTIONS

As you know, different work classifications and different contracts have different contribution rates. The amount of credit for eligibility granted for hours worked (with employer contributions) depends on the status of the Fund's financial reserves, as determined by the Administrative Manager, as follows:

(1) During periods of time when the Fund has at least three months of financial reserves (that is, when the Board has determined that the Fund is financially stable), you will be credited with one hour of Covered Employment for each hour for which the Fund receives the full hourly Employer contribution due under the terms of the collective bargaining agreement under which you worked.

(2) During periods of time when the Fund has less than three months of reserves (that is, when the Board has determined that the Fund is financially stressed), you will be credited with one hour of Covered Employment for each hour for which the Fund receives the full hourly Employer contribution due under the terms of the collective bargaining agreement under which you worked, multiplied by a fraction, the numerator of which is the hourly Employer contribution rate due under the terms of the collective bargaining agreement under which you worked, and the denominator of which is the

hourly Employer contribution rate applicable to journeymen, which fraction shall not exceed one.

The result of this is that when the Board has determined that the Fund is financially stressed, hours worked under any classification in the collective bargaining agreements, which have Health Fund contribution rates less than the full journeyman rate, will be credited on a pro-rata basis. But when the Board has determined that the Fund is financially stable, hours worked under any classifications in the collective bargaining agreements will be credited on a full hourly basis.

INITIAL ELIGIBILITY REQUIREMENTS

You will establish eligibility for benefits provided by the Fund when you are credited with at least 420 hours of covered employment (with Employer contributions) during any period of six consecutive months or less. Because the Administrative Manager does not receive the Employer's report of hours worked and Employer contributions until the month following the month in which the work was performed, you will not be eligible for coverage until the first day of the second month following the month in which you are credited with the 420 hours of Covered Employment and Employer contributions in six months requirement.

> **Example:** If you are a Journeyman credited with a total of at least 420 hours (for which all contributions have been received by the Fund) in April, May, June, July, August, and September, you will become eligible for benefits beginning November 1, which is the first day of the second month following September.

When you become eligible, you will be furnished with a Vital Information Card to report all of your eligible dependents. This Card should be completed and returned to the Fund Office as quickly as possible with any required documentation. Be certain to report all changes to your dependents (such as additions and deletions) to the Fund Office immediately. When you become eligible for benefits, you also must complete an "Information and Certification Regarding Coordination of Benefits and Dependents" questionnaire.

If you become disabled as a result of injury that is determined to be compensable under Workers' Compensation before you establish initial eligibility for benefits, the months during which you receive Workers' Compensation benefits and are unable to work will be disregarded in the determination of the six consecutive months. This provision is intended to prevent the loss of hours of work that you have accrued toward initial eligibility prior to injury so that those pre-injury hours may be considered after you return to work.

CONTINUING ELIGIBILITY REQUIREMENTS

1. Continuation by Working

Once you have established initial eligibility for benefits, you will continue to be eligible for benefits in the third month after the month in which you were credited with 140 hours of work for which employer contributions were received ("eligibility month").

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

Hours worked during the month below …	will determine 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

Example: You will continue your coverage for the December eligibility month if you work (and contributions are received for) a total of at least 140 hours in September.

2. Hourly Reserve Bank

Once you have established initial eligibility for benefits, you can continue your eligibility based on months when you have **not** been credited with 140 hours of work for which employer contributions were received by drawing on your Hourly Reserve Bank.

When you first become eligible for benefits, you are given credit for 140 hours in your "Hourly Reserve Bank". These hours will be withdrawn automatically as needed by the Fund Office to continue your eligibility for benefits.

You are given credit in your Hourly Reserve Bank for any hours of work and contributions over 140 hours received on your behalf in any month. However, the Hourly Reserve Bank cannot exceed 420 hours.

The following three examples illustrate how the Hourly Reserve Bank works:

Example: You have 80 hours of work and contributions based on work for a contributing Employer in July and 420 hours in your Hourly Reserve Bank. In order to continue your eligibility for October, the Fund Office would withdraw 60 hours from your Hourly Reserve Bank to give you the 140 hours needed for continuing eligibility. This would then leave you with a balance of 360 hours in your Hourly Reserve Bank.

Example: You have 200 hours of work and contributions based on work for a contributing Employer in August and 300 hours in your Hourly Reserve Bank. In order to continue your eligibility for November, the Fund Office would apply 140 of the 200

hours to continue your eligibility for that month, and the other 60 hours are deposited in your Hourly Reserve Bank to bring your balance to 360 hours.

Example: You have 200 hours of work and contributions based on work for a contributing Employer in August and 400 hours in your Hourly Reserve Bank. In order to continue your eligibility for November, the Fund Office would apply 140 of the 200 hours to continue your eligibility for that month, but only 20 of the remaining 60 hours can be credited to your Hourly Reserve Bank because you have reached the maximum balance of 420 hours.

3. Continuation by Self-Payments

When your eligibility would otherwise terminate, you may elect to maintain eligibility by making monthly self-payments to the Fund pursuant to the provisions on **COBRA continuation coverage**, in which case, the amount of the self-payment, the coverage provided, and the coverage period shall be governed by the COBRA continuation provisions of the Plan.

If you are registered on the Union's Out-of-Work List, you may elect, as an alternative to COBRA continuation coverage, to make self-payments for six months ("**alternative coverage**"). You will be charged a *reduced* self-pay rate for the number of months that you were eligible through working immediately prior to your current period of ineligibility, up to a maximum of six months. The benefits under alternative coverage are the same as those provided under COBRA continuation coverage (that is, medical, surgical, hospital, prescription drug benefits only) **except** that you *will* be eligible for Life Insurance Benefits and Accidental Death and Dismemberment Benefits during the initial period of alternative coverage up to the number of months of eligibility you secured by use of your Hourly Reserve Bank during your most recent period of unemployment.

You should contact the Fund Office before your eligibility terminates for information about your options for continuation of coverage, the amount and due dates of the self-payments. If, at any time while you are maintaining eligibility through COBRA continuation coverage or alternative coverage, you elect not to make self-payments and, as a result, your eligibility is terminated, you shall not again be eligible to make self-payments until you have met the requirements for reinstatement of eligibility or eligibility is re-established.

DISABILITY ELIGIBILITY

If, while eligible for benefits as described below, you become disabled and unemployable as a result of an illness or injury, either on or off the job, your eligibility for all benefits will be continued without self-payment and without withdrawing any hours from your Hourly Reserve Bank for a maximum period of six consecutive months following the month in which disability commences, provided that disability continues during that period. During the period of disability, you will be credited with hours of work (equivalent to 140 hours per month) for each week you are disabled for up to 26 weeks.

If you remain disabled after 26 weeks, then you may exhaust the extended eligibility you accrued while working. If you continue to be disabled thereafter, hours will be withdrawn as needed from your Hourly Reserve Bank to continue eligibility.

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Finally, if you remain disabled after you have exhausted your Hourly Reserve Bank, you may continue coverage for up to an additional 18 or 29 consecutive months by making payments under COBRA (see page 21 of this Summary).

Only participants who are eligible because of work performed and Employer contributions received on their behalf, withdrawal of hours from their Hourly Reserve Banks, or self-payments for alternative coverage described above may qualify for disability eligibility. You cannot qualify for disability eligibility if you are a covered retiree or if you have elected COBRA continuation coverage.

Disability due to pregnancy is normally considered to be for a period running from six weeks prior to the due date to six weeks after the delivery date without the requirement of further medical proof beyond the due date for the birth of the child and the date of the birth of the child. If additional weeks of extended eligibility due to disability is sought (up to the six-month maximum), you must provide medical documentation of disability as defined herein for those additional weeks.

In order to qualify for disability eligibility, you must submit satisfactory evidence of such disability, as determined by the Board of Trustees, to the Administrative Manager. Such evidence must be in the form of a written opinion signed by a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.).

Disability eligibility shall be effective beginning with the month in which the disability commences. Any hours worked in Covered Employment (with Employer contributions) received during that month on behalf of such Participant will be credited in your Hourly Reserve Bank, subject to the applicable hour/contribution maximum, or, if such hours and contributions would bring his Hourly Reserve Bank above the applicable hour/contribution maximum, they may be applied to satisfy the 140 hour/contribution requirement for the first month in which you return to Covered Employment.

TERMINATION OF ELIGIBILITY

Your eligibility for benefits will terminate on the last day of the month following the month in which you are credited with fewer than 140 hours of work for which employer contributions were received *and* you have insufficient hours on deposit in your Hourly Reserve Bank to make up the difference, unless you elect to make self-payments as explained on page 9.

If you are making self-payments, your eligibility for benefits will terminate if you fail to make a self-payment or the last day of the self-payment period, whichever is later, unless you elect COBRA continuation coverage, as provided on page 21.

You will retain credit for any hours remaining in your Hourly Reserve Bank at the time of termination for a maximum of 12 months after termination, after which your Hourly Reserve Bank will be terminated.

REINSTATEMENT OF ELIGIBILITY

If you have been eligible for benefits under the Fund within the last 12 months, then you will be eligible for benefits again on the first day of the third month following the month in which you are credited with 140 hours of work and contributions.

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RE-ESTABLISHMENT OF ELIGIBILITY

If you have **not** been eligible for benefits under the Fund within the last 12 months, then you will be eligible for benefits when you satisfy the full Initial Eligibility Requirements, as set forth on page 8.

RECIPROCITY

The Fund has entered into reciprocity agreements with other health and welfare funds covering sheet metal workers throughout the country. Under these reciprocity agreements, employer contributions made on your behalf may be transferred to your Home Fund upon your submitting written request and authorization with the out-of-town fund or union. 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 *must* request, in writing, that such contributions be transferred to this Fund under the reciprocity agreement *before* you perform the work in the jurisdiction of the other fund. That request must be submitted to the fund or union in the jurisdiction where you are working. It is up to you to determine the proper procedure for this.

However, contribution rates may be lower in another fund. If the dollar amount transferred to this Fund on your behalf from the other fund is less than a Local 292 signatory employer would have had to pay for sufficient hours to maintain your eligibility, you will be required to make a self-payment to this Fund to maintain your eligibility. It is your responsibility to make sure that the Fund Office knows how to get in touch with you to send you a self-pay notice if necessary.

You should contact the Fund Office to find out whether there is a reciprocity agreement between this Fund and the fund in whose jurisdiction you are working. You should contact the other fund or union to find out where you need to sign the necessary request form to have contributions transferred.

ELIGIBILITY OF DEPENDENTS

1. Coverage of Spouse and Children

Generally, your dependents are eligible anytime you are eligible for benefits. Dependents are **never** eligible for Accidental Death and Dismemberment Benefits or Loss-of-Time Benefits.

Your Dependents under the Plan are:

(1) Your current lawful spouse.

Your spouse's Dependent status ends immediately upon divorce from you. By enrolling a spouse for Dependent coverage, you and your spouse are agreeing that each of you will be personally liable to the Fund for any amounts the Fund pays in benefits for services rendered to or on behalf of any former spouse after the date of the entry of the judgment or decree of divorce but prior to notifying the Fund of the divorce, irrespective of whether you are still eligible for benefits at the time of the Fund's discovery of the divorce, demand for repayment or at any time of reference.

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(2) Your children, as defined and limited immediately below, at the Participant's election, regardless of the child's marital status. A Participant's election to disenroll a child who was previously covered as a Dependent hereunder must be 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.

"Child" is defined herein as your biological children, adopted children (including children placed for adoption) and step-children, prior to the last day of the calendar month in which such child reaches age twenty-six (26) years. 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 either from 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) years shall continue to be eligible as a Dependent for as long as the disability exists.

(3) A person who has not yet attained age eighteen (18) years of whom a Participant or spouse is named full legal guardian (other than a limited or temporary guardian). Notwithstanding the preceding sentence, a person who is not the biological or adoptive child of a Participant or spouse shall not be a "Dependent" under this subsection unless (a) the biological or adoptive parents of such child do not claim the child as a dependent for income tax purposes; and (b) the Participant or spouse's adjusted gross income is higher than the highest adjusted gross income of any of the person's biological or adoptive parents. The Fund shall require proof that this requirement is satisfied prior to any individual being considered a Dependent hereunder.

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, physicians' statements, birth certificates, marriage certificates, qualified medical child support orders and judgments of divorce. The Board of Trustees shall be the sole judge of whether proof provided is adequate.

Qualified Medical Child Support Orders: Under federal law, the Plan must recognize qualified medical child support orders (QMCSO) mandating continuation of health care coverage for certain dependent children. A QMCSO is a court order recognizing 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 participants. A QMCSO is usually issued in a divorce where the participant is ordered by the court to continue to provide medical child support for the children where the children are not residing with the participant.

When the Fund receives an order that may include a QMCSO, it will send the order to the Fund's legal counsel for review and determination as to the order's qualified status. The participant and the child's custodial parent will then be notified of the determination. EOBs and benefit payments made by the Fund pursuant to a QMCSO will be sent to the child's custodial parent.

2. Enrollment of New Dependent Spouse and Children

At your election, your Dependents are eligible for dependent benefits at any time during which you are eligible for benefits. The only exceptions are (1) when a Dependent enters the armed forces of any country, or when a Dependent becomes eligible for coverage as a Participant in his/her own right, in which cases the Dependent's eligibility for benefits terminates or (2) when a Retired Participant or a Participant continuing coverage under COBRA elects not to cover his or her Dependents and (in the case of COBRA) the Dependent does not elect and pay for his/her own COBRA continuation coverage.

You may enroll a new Dependent for coverage under the Plan by giving notice to the Administrative Manager within **thirty days of the date such person becomes a Dependent**, in which case coverage will be extended retroactive to the date the person becomes a Dependent. If you give notice later than thirty days of the date such person becomes a Dependent, coverage will begin on the first day of the month after the month within which your notice is received by the Fund.

When you enroll a Dependent for coverage, you must include copies of the marriage certificate (for a spouse), birth certificate or other proof of parentage for children such as an order of filiation or adoption order, marriage certificates, and divorce judgments establishing responsibility for health care for stepchild(ren). As noted above, eligibility for new dependents will begin no sooner than 30 days prior to the date on which notice is received (but not earlier than you acquired your new dependent), so it is to your benefit to provide notice to the Fund Office as quickly as possible.

If you do not enroll one or more of your eligible dependent(s) for coverage at the time of your initial eligibility, or the acquisition of the dependent if later, because such dependent(s) has other health coverage, you may enroll such eligible dependent(s) upon the subsequent loss of that other coverage provided that the enrollment is made within 30 days of the loss of the other coverage.

If you seek to re-enroll a Dependent child whom you previously elected to disenroll, then the Dependent child shall be eligible for coverage as soon as administratively feasible, but not before the first day of the month following the month within which the election is received by the Fund.

Eligibility for benefits for each of your Dependents shall terminate when he or she is no longer a Dependent under the terms of the Plan or, if earlier, at the same time as your eligibility terminates.

Special notice regarding other health care coverage: If your spouse or dependent children are eligible for health care coverage from his/her employment, it is encouraged that your spouse and dependent children accept that coverage. If you have children covered under this Plan that are also eligible for coverage under your spouse's plan, it is encouraged that your spouse accept this coverage for those children. With respect to children, the Plan will use the "Birthday Rule" to determine which health care coverage is primary. The "Birthday Rule" provides that the health care coverage of whichever parent whose birthday is earlier in the calendar year is primary for the children. Neither you nor your spouse will suffer any loss of benefits by accepting all available coverage, but the Fund will be able to coordinate the payment of benefits with your other insurance, and the Fund will experience a substantial savings as a result. When you, your spouse and dependent children become eligible for benefits, you must complete a "Information and Certification Regarding Coordination of Benefits and Dependents" questionnaire. If your spouse or your dependent child becomes eligible for health care coverage from his/her employment after their initial enrollment, they must also complete that questionnaire. You, your

spouse and your dependent children are strongly encouraged to complete the questionnaire accurately and return it promptly. The Board of Trustees will vigorously pursue recovery of any amounts paid based on an inaccurate or late response.

3. Termination of Dependent Eligibility

A. Termination of Coverage for Spouses

A spouse's coverage ends immediately upon divorce from you. **It is your legal obligation and that of your former spouse to notify the Fund immediately upon your divorce. If you or your former spouse delay in providing written proof of your divorce to the Fund for any reason, and the Fund pays benefits on behalf of your ineligible former spouse, you and your former spouse will be legally responsible to repay the Fund for any amounts paid by the Fund.** The Fund reserves the right to recover the amount of any benefits paid on behalf of your former spouse from you, from your former spouse, and from both of you, through offsetting the amount paid on behalf of your former spouse from any future benefits payable to you, through litigation, through termination of your participation in the Fund, and through any other lawful means.

After the date of entry by the court of a judgment of divorce, coverage for a former spouse is only available under the terms of COBRA continuation coverage. If the Fund Office is not notified of a divorce within 60 days of the date of its entry, the Fund has no obligation to offer COBRA coverage. See page 21 for details on COBRA continuation coverage.

A spouse's coverage also ends on the earliest of the following dates:

- the date on which the participant loses coverage (unless the spouse is eligible for and elects COBRA or Surviving Spouse coverage); or
- the date on which the spouse becomes eligible for benefits from the Fund as a result of hours worked by the spouse in covered employment (that is, becomes a participant in his/her own right); or
- the date on which the spouse enters the armed forces of any country; or
- upon the failure to make any required self-payments.

B. Termination of Coverage for Children

A child's dependent coverage ends on the earliest of the following dates:

- the date you lose coverage (unless the child is eligible for and elects COBRA coverage or the child's surviving parent is eligible for and elects Surviving Spouse coverage that includes the child); or
- the end of the calendar month in which the child reaches the age of 26, unless the child is totally and permanently disabled either from 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) years, in

which case the child shall continue to be eligible as a Dependent for as long as the disability exists; or

- the date on which the child becomes eligible for benefits from the Fund as a result of hours worked and employer contributions received by the Fund based on the child's work in covered employment (that is, becomes a participant in his/her own right); or

- the date on which the child enters the armed forces of any country, or

- upon the failure to make any required self-payments.

C. Termination of Coverage for Wards (Guardianship)

For a person that is not your or your spouse's biological or adoptive child, of whom you or spouse are named full legal guardian (other than a limited or temporary guardian), dependent coverage ends on the earliest of the following dates:

- the last day of the calendar month in which the person reaches age eighteen (18),

- when you fail to provide adequate proof that the parents of such child do not claim the child as a dependent for income tax purposes, or

- the Participant fails to provide adequate proof that the Participant or spouse's adjusted gross income is not higher than the highest adjusted gross income of any of the person's parents.

ELIGIBILITY OF RETIREES

1. Right of Board of Trustees to Change, Reduce or Eliminate Retiree Coverage

The right to change, reduce, or eliminate permanently any and all aspects of coverage or 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. The Board of Trustees has the right to make those changes immediate – that is, applicable to currently covered as well as future retirees. *The Board of Trustees makes no representation that any benefits, including retiree medical coverage, are "permanent" or "lifetime" in nature.*

The eligibility rules for retirees as of the date of this Summary follow.

2. Eligibility of Participants Receiving Normal or Early Retirement or Disability Benefits

If you retire and are receiving Normal or Early Retirement or Disability benefits from the Sheet Metal Workers Local No. 292 Pension Fund ("Pension Fund") **and** you meet each one of the following requirements, you will be eligible for retiree coverage under the Plan:

- You are eligible for benefits under this Fund on the effective date of your commencement of benefit from the Pension Fund (only eligibility based on work or self-payment – not eligibility under COBRA continuation coverage – is considered for this purpose), and

- Your Hourly Reserve Bank is below 140 hours (if your Hourly Reserve Bank is above 140 hours, you can continue coverage by running out your Hourly Reserve Bank, just as if you were an Active Participant), and

- You have accrued at least 10 Credit Years with the Pension Fund, and

- The Health Fund has received at least 2,500 hours (and employer contributions) on your behalf in the five year period or 5,000 hours (and employer contributions) on your behalf in the ten year period, immediately preceding the effective date of your retirement, and

- You have been eligible for benefits from the Health Fund for at least one month during the 24 months preceding the month in which you retired (only eligibility based on work or self-payment – not eligibility under COBRA continuation coverage – is considered for this purpose), and

- You must be eligible for the Medicare Supplement from the Sheet Metal Workers National Pension Fund (or would be upon reaching Medicare eligibility age), but for any limitation or exclusion based on the current employer contribution rate to that Fund, and

- You complete and submit an application within 30 days after your retirement date or within 30 days after your Hourly Reserve Bank falls below 140 hours, whichever is later, and

- You make self-payments according to the procedures determined by the Trustees in an amount determined by the Trustees.

If you are eligible for retiree coverage at the time of your commencement of benefits from the Pension Fund, but you do not submit the application for it (or the notice for delayed retiree or dependent enrollment, below) ***within 30 days of your retirement (or within 30 days after you run out your Hourly Reserve Bank), you will never again have the opportunity to do so, unless you return to covered employment and either reinstate or re-establish eligibility.***

Retiree coverage consists of Medical, Hospital and Surgical Benefits, Prescription Drug Benefits, Hearing Benefits and reduced Life Insurance Benefits. If you are a non-Medicare Eligible retiree, you are also eligible for Dental and Vision benefits. Retiree coverage does not include Life Insurance Benefits for Dependents, Loss-of-Time Benefits or Accidental Death and Dismemberment Benefits.

All Retired Participants and spouses of Retired Participants covered under this Plan who are eligible for Medicare must participate in both Medicare Parts A and B.

Special Delayed Retiree Enrollment: If you are covered by health insurance through your spouse's employer when you commence receiving benefits from the Pension Fund, you may request delayed enrollment for retiree coverage until no later than **30 days** after the date on which your coverage under your spouse's employer-provided group health care coverage terminates, and you must provide proof

that you maintained continuity of health insurance coverage from the date of the end of your coverage under this Fund through the date of your requested reentry into this Fund. **You must make this request for special delayed enrollment within 30 days of your commencement of benefits from the Pension Fund (or within 30 days after you run out your Hourly Reserve Bank).**

Special Delayed Spousal Enrollment: You may choose either to cover yourself only or to cover your eligible dependents as well as a retiree. The choice, once made, cannot be changed. The only exception is that if your spouse is covered by another group health plan at the time of your retirement, you may delay enrolling your spouse on your retiree coverage until no later than **30 days** after your spouse's coverage under the other group health plan terminate, and you must provide proof that your spouse maintained full health insurance coverage from the date of the end of your coverage under this Fund through the date of your spouse's reentry into this Fund. **You must make this request within 30 days of your retirement (or within 30 days after you run out your Hourly Reserve Bank).**

Post-Retirement Marriage: If you get married after you retire, you will be permitted to add your new spouse to your coverage under the Plan on the first day of the month following your marriage provided that an application is filed with the Fund Office within **30 days** of your marriage with sufficient evidence of such marriage.

3. Termination of Retiree Eligibility

Your retiree coverage will terminate on the earliest date if one of the following occurs:

- you fail to pay the required self-payment amount when due; or
- you return to active employment and/or withdraw from retirement (see below); or
- retiree coverage is eliminated by the Board of Trustees, which is within its discretion to do at any time.

Eligibility for Medical, Hospital and Surgical Benefits and Prescription Drug Benefits for Medicare-eligible Retired Participants or Medicare-eligible spouses of Retired Participants shall terminate upon enrollment in a Medicare Part D prescription drug plan.

4. Reinstatement in Active Employee Plan - Return to Covered Employment by Retiree

If you re-enter covered employment for 40 or more hours in any month, you are ineligible to continue retiree coverage and make self-payments at the retiree rate for that month. However, you may continue your eligibility under the Plan by making self-payments at a special rate set by the Board of Trustees until either:

(a) you are credited with 140 hours of work and contributions per month (at which point you will re-establish eligibility by working as an Active Participant) or

(b) you work less than 40 hours in a month (at which point you will again be eligible for making self-payments at the retiree rate).

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When you subsequently work less than 40 hours per month in covered employment, you must resume making self-payments at the full retiree rate to maintain eligibility.

ELIGIBILITY OF DEPENDENTS AFTER YOUR DEATH (SURVIVOR COVERAGE)

The following provisions for Dependent coverage after your death are alternatives to Dependents' rights, if any, to COBRA continuation coverage, which is set out in more detail after this Section.

1. Right of Board of Trustees to Change, Reduce or Eliminate Survivor Coverage

The right to change, reduce, or eliminate permanently any and all aspects of coverage or 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. The Board of Trustees has the right to make those changes immediate – that is, applicable to currently covered as well as future survivors. *The Board of Trustees makes no representation that any benefits, including survivor medical coverage, are "permanent" or "lifetime" in nature.*

2. Survivors of Active Participants (ineligible for retirement) with <u>fewer than five years</u> of continuous participation

If an Active Participant dies while eligible for coverage from the Health Fund, who has been eligible for fewer than the five immediately preceding years without break prior to death, and who is not receiving or eligible to receive benefits from the Sheet Metal Workers Local No. 292 Pension Fund, his or her surviving spouse and dependent children shall continue to be eligible for coverage from the Health Fund until the deceased Active Participant's Hourly Reserve Bank, if any, falls below 140 hours.

The surviving spouse and dependent children may continue to receive coverage from the Fund for up to an additional six months at the self-payment rate established by the Board of Trustees, and for a further 36 months under the provisions of COBRA at the then-applicable full month COBRA rate.

The election for up to six months of coverage at the reduced self-payment rate must be elected within 30 days after the later of:

- the date of the deceased participant's death; or
- the date the deceased participant's Hourly Reserve Bank, if any, falls below 140 hours.

If during the six months of coverage at the self-payment rate, the children cease to meet the Plan's definition of a "dependent", they may continue coverage pursuant to and subject to all provisions regarding COBRA for an additional 36 months at the full monthly COBRA rates then applicable.

If the surviving spouse or dependent children become covered by another health care plan before the time periods above expire, coverage under this Plan will terminate at that time.

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3. Survivors of Active Participants with at least five years of continuous participation at the time of their death, Active Participants who are eligible to retire, Retired Participants, or Participants Receiving Disability Retirement Benefits

The surviving spouse and dependent children of the following participants shall be eligible to continue coverage under this Plan:

- Active Participants who at the time of death were covered by the Fund for at least the five immediately preceding years without break prior to death and who were neither eligible for nor receiving benefits from the Sheet Metal Workers Local No. 292 Pension Fund ("Pension Fund"); and

- Active Participants who at the time of death were eligible to retire under the normal or early retirement provisions of the Pension Fund and had been eligible under this Fund through Employer contributions for at least one month during the twenty-four months immediately preceding the Active Participant's death.

- Retired participants who at the time of death were receiving normal or early retirement benefits from the Pension Fund and were eligible for coverage from the Health Fund at the time of their death; and

- Participants who at the time of death were receiving disability retirement benefits from the Pension Fund and were eligible for coverage from the Health Fund at the time of their death.

The surviving spouse and dependent children of those participants shall continue to be eligible for coverage from the Health Fund until the deceased participant's Hourly Reserve Bank, if any, falls below 140 hours.

The surviving spouse and dependent children of those participants may continue to receive coverage from the Fund by means of self-payment. This coverage must be elected within 30 days after the later of the following dates:

- the date of the deceased participant's death; or

- the date the deceased participant's Hourly Reserve Bank, if any, falls below 140 hours.

A surviving spouse and/or dependent children of those participants may delay Survivor Coverage if they have other health care coverage, only if they notify the Fund Office of the other coverage within the 30-day period for electing Survivor Coverage. They must enroll in Survivor Coverage no later than **30 days** after the other health care coverage terminates (for dependent children, providing also that they continue to meet the Plan's definition of dependent). Proof of the other health care coverage and its termination date will be required for re-enrollment.

Self-payments for survivors of Active Participants must begin for the month that the deceased Active Participant's coverage would end based on his work and his Hourly Reserve Bank. Self-payments for survivors of retired participants must begin for the first month after the retired participant's death. If the surviving spouse continues to make the required self-payments when due, coverage for the spouse and

any dependent children of the deceased participant (including children of a male deceased participant born to his surviving spouse within nine months after his death) will continue until the earliest of, as applicable:

- the surviving spouse remarries;
- the surviving spouse or child becomes eligible under another group health care plan; or
- the dependent child no longer meets the Plan's definition of a "dependent".

The self-payment rates will be determined by the Board of Trustees from time to time and may vary depending on whether the surviving spouse is covered by Medicare and on whether there are any dependent children. A surviving spouse who is eligible for Medicare will be expected to participate in both Medicare Parts A and B. The Fund will not pay any expense that would normally be paid by Medicare (whether or not the Medicare-eligible person has actually signed up for Parts A and B), with two very limited exceptions set out on pages 24 and 48.

If the surviving spouse and/or dependent children elect not to maintain coverage under these provisions, then they may continue coverage pursuant to and subject to all provisions regarding COBRA for 36 months under the terms of COBRA at the monthly COBRA rates then applicable. If Survivor Coverage is elected and children lose coverage because they no longer meet the Plan's definition of a "dependent", they may also continue coverage pursuant to and subject to all provisions regarding COBRA for an additional 36 months at the monthly COBRA rates then applicable.

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, Sheet Metal Workers Local No. 292 Health Fund, 700 Tower Drive, Suite 300, Troy, Michigan 48098, (248) 641-4992 Please use the following mailing address for the Board of Trustees and the Administrative Manager: Sheet Metal Workers Local No. 292 Health Fund, P.O. Box 189, Troy, MI 48099-0189.

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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 (Loss-of-Time Benefits, Life Insurance, Accidental Death and Dismemberment Benefits and Member's Assistance Program Benefits) are not available under COBRA.***

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

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

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

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

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

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

- The parent-Employee (or parent-Retiree) dies;

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- 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 13); 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 (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 Divorce, death certificate or birth certificate. You must send notification to the Fund Office, Sheet Metal Workers Local No. 292 Health Fund, P.O. Box 189, Troy, MI 48099-0189. ***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 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 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).

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

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

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

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

  If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must send this notice to the Fund Office, Sheet Metal Workers Local No. 292 Health Fund, P.O. Box 189, Troy, MI 48099-0189.

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

  If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the Employee or former Employee dies, or gets divorced, or 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, Sheet Metal Workers Local No. 292 Health Fund, P.O. Box 189, Troy, MI 48099-0189.**

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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.

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, Sheet Metal Workers Local No. 292 Health Fund, P.O. Box 189, Troy, MI 48099-0189. 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 Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Fund Office informed of any changes in your address and the addresses of family members, and in the event of any changes in your family (births, deaths, divorce, entitlement to Medicare, etc.) You should also keep a copy, for your records, of any notices you send to the Fund Office. 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 contributing Employer (1) for at least 12 months and (2) for at least 1,250 hours in the 12 months before the leave starts and if your contributing Employer (1) is covered by the Act and (2) has at least 50 employees within 75 miles of where you work.

Whether you are eligible for family or medical leave is determined by your contributing 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 if your Employer makes all required Employer 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 requires that the Fund permit you to elect to continue your and your dependents' eligibility with the Fund (except for Life Insurance, Accidental Death and Dismemberment, and Loss-of-Time Benefits).

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

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

If the Fund Office is not notified in the manner above that you have departed for service (or, if it is not feasible for you to provide notice, then within 30 days from when it becomes feasible for you 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 No. 292 Health Fund, P.O. Box 189, Troy, MI 48099-0189.

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

If you serve for 31 days or more, and you (or 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 full monthly 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 the time periods applicable to the election of COBRA continuation coverage. You may continue coverage by either:

- Making monthly self-payments from the beginning date of your service without using the hours in your Hourly Reserve Bank, in which case your Hourly Reserve Bank will be available to you upon your return to availability for work, as explained below, or

- Drawing on your Hourly Reserve Bank, if any, in which case your Hourly Reserve Bank will either be reduced or eliminated over the duration of your service, and as a result may not be available to you upon your return to availability for work 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 5 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 insufficient hours in your Hourly Reserve Bank.

If you did <u>not</u> elect to draw on your Hourly Reserve Bank 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 you have in your Hourly Reserve Bank, if any, and if you make the decision to have the Fund utilize it to continue your coverage during your service, how many months of coverage it will provide for before you need to begin making the monthly self-payments.

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

BENEFITS

MEDICAL, HOSPITAL AND SURGICAL BENEFITS (NON-MEDICARE ELIGIBLE PARTICIPANTS)

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 58), and

b. Not excluded from coverage.

A list describing some of the exclusions can be found on page 55 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 flat-fee copays, deductibles and percent copays (co-insurance) amounts. Those details are provided in the next sections, below.

2. Operation of BCBSM's Simply Blue PPO for Active Participants and BCBSM's Community Blue PPO for non-Medicare Eligible Retirees

The Fund has an insurance contract for BCBSM's Simply Blue PPO for Active Participants and their dependents. The Fund has an insurance contract for BCBSM's Community Blue PPO for Non-Medicare Eligible Retirees and their dependents. You and your dependents will receive medical, hospital and surgical benefits as set forth in the schedules of benefits in the Fund's agreements with the Blue Cross Blue Shield of Michigan (BCBSM) Preferred Provider Organization (PPO) Network. Detailed information regarding these benefits can be found in the Benefits at a Glance document, which is attached at the end of this SPD.

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.bcbsm.com for a listing of Blue Preferred PPO providers by county, or you may simply contact health care providers directly to see if they are participating.

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

A. In-Network Benefits

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

the Benefit at a Glance document attached at the end of the SPD for a detailed description of deductibles and copays.

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

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

B. Out-of-Network Benefits

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

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

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

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

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

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

C. Coverage Outside of BCBSM PPO Coverage Area

When you need medical care outside of the service area for BCBSM PPO, but in the country, use the contact information on the back of your card, and you will be given the nearest participating physician or hospital. You are responsible for paying applicable deductible and copays and for services not covered by this Plan, within the BCBSM PPO Network for in-network coverage, and outside of the BCBSM

PPO Network for out-of-network coverage. However, you will not be expected to pay any out-of-network copays or deductibles if you receive treatment for an accidental injury or a medical emergency.

> ***Important:*** You may need to submit itemized receipts directly to the Fund Office 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 copays that may apply. Only emergency treatment and emergency inpatient care received outside the country are covered at the in-network levels; all other treatment is covered as out-of-network care.

MEDICAL, HOSPITAL AND SURGICAL BENEFITS (MEDICARE ELIGIBLE PARTICIPANTS)

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 58), and

b. Not excluded from coverage.

A list describing some of the exclusions can be found on page 55 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 flat-fee copays, deductibles and percent copays (co-insurance) amounts. Those details are provided in the next sections, below.

2. Operation of Humana's Medicare Employer PPO Plan for Medicare Retirees

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

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

The Fund has an insurance contract for Humana's Medicare Employer PPO. Under this PPO program, some providers are "in-network" and some providers are "out-of-network". You may contact the Fund

Office or bcbsm.com for a listing of Medicare Plus Blue PPO providers by county, or you may simply contact health care providers directly to see if they are in-network.

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

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

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

Detailed information regarding these benefits can be found in the Medicare Employer PPO Benefits at a Glance document, which is attached at the end of this SPD.

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

PRESCRIPTION DRUG BENEFITS (NON-MEDICARE ELIGIBLE PARTICIPANTS)

Prescription drug benefits under the Plan are subject to deductible, copayment, co-insurance and, in some instances, self-payment requirements. You will receive coverage under the Plan through BCBSM. The Fund covers only prescription drugs covered under BCBSM's formulary, which is subject to change at any time. Please refer to the Benefit at a Glance document attached at the end of the SPD for a detailed description of deductibles and copays.

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

Contact the Fund Office for a specific list of prescription drugs that are not covered or otherwise limited. You should also review "Exclusions and General Limitations" on page 55 before seeking prescription drug benefits.

Special Notices for Medicare-Eligible Individuals: It has been determined that the Fund's prescription drug program is on average at least as good as that being provided by Medicare Part D. This means that if you do not sign up for Medicare Part D when you become Medicare eligible, and you remain covered by the Fund, you will *not* have to pay a higher premium for Medicare Part D if you sign up later. If you sign up for separate Medicare Part D coverage, you will no longer be eligible for any coverage from the Fund.

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

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

PRESCRIPTION DRUG BENEFITS (MEDICARE ELIGIBLE PARTICIPANTS)

Prescription drug benefits under the Plan are subject to deductible, copayment, co-insurance and, in some instances, self-payment requirements. You will receive coverage under the Plan through Humana. The Fund covers only prescription drugs covered under Humana's formulary, which is subject to change at any time. Please refer to the Benefit at a Glance document attached at the end of the SPD for a detailed description of deductibles and copays.

Special Notices for Medicare-Eligible Individuals: It has been determined that the Fund's prescription drug program is on average at least as good as that being provided by Medicare Part D. This means that if you do not sign up for Medicare Part D now, and you remain covered by the Fund, you will *not* have to pay a higher premium for Medicare Part D if you sign up later. If you sign up for separate Medicare Part D coverage, you will no longer be eligible for any coverage from the Fund.

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

DENTAL BENEFITS (All Active Participants and non-Medicare Eligible Retirees)

Dental benefits under the Plan are subject to deductible, copayment, co-insurance and, in some instances, self-payment requirements. You will receive dental coverage under the Plan through BCBSM. Please refer to the applicable Benefit at a Glance document attached at the end of the SPD for a detailed description of deductibles and copays.

The Fund does not provide Dental Benefits if you are a Medicare Eligible Retiree.

VISION BENEFITS (All Active Participants and non-Medicare Eligible Retirees)

Vision benefits under the Plan are subject to deductible, copayment, co-insurance and, in some instances, self-payment requirements. You will receive vision coverage under the Plan through BCBSM Please refer to the applicable Benefit at a Glance document attached at the end of the SPD for a detailed description of deductibles and copays.

The Fund does not provide Vision Benefits if you are a Medicare Eligible Retiree.

HEARING BENEFITS

Hearing benefits under the Plan are subject to deductible, copayment, co-insurance and, in some instances, self-payment requirements.

If you are an Active Participant or a non-Medicare Eligible Retiree, you will be eligible for hearing benefits through TruHearing. Every three years, you can get a free hearing exam, plus a $1,500 allowance

for hearing aids if you need them. TruHearing offers additional services, like a free one-year follow-up visit and a 60-day trial period for hearing aids. Please refer to the applicable Benefit at a Glance document attached at the end of the SPD for a detailed description of deductibles and copays.

If you are a Medicare Eligible Retiree, you will be eligible for hearing benefits through Humana for Medicare Eligible Participants covered under the MAPD Plan. Every two years, you can get a hearing exam covered up to $50. Every three years, you receive a $3,000 allowance for hearing aids if you need them, after meeting your annual deductible. Please refer to the applicable Benefit at a Glance document attached at the end of the SPD for a detailed description of deductibles and copays.

HEALTH REIMBURSEMENT ARRANGEMENT (All Participants and Retirees)

The Board has established a Health Reimbursement Arrangement (HRA) account as a bookkeeping account for each active eligible Participant, which the Participant, his surviving spouse and his Dependents may use to pay for incurred expenses described below. HRA account is a bookkeeping account only – participants cannot cash it out at any time, and it does not vest – the Board may terminate the account at any time. HRA accounts can only be used for such purposes as are set forth below, and they are subject to cancellation, also as set out below. Retirees may use the HRA account for up to twenty-four (24) months after the termination of the coverage as a Participant, subject to the other rules on cancellation of coverage, below.

1. Amounts Credited

The HRA accounts are credited with a portion of the employer contribution, based on hours worked and employer contributions received, at the following rates, determined by the Board of Trustees and subject to change at any time:

- Journeymen and Apprentices: HRA credit of $1.05 per hour worked with employer contributions received. During periods of time when the Fund has zero or fewer months of financial reserves, as determined by the Administrative Manager, no HRA credit shall be granted.

- Classified Workers: HRA credit of $0.75 per hour worked with employer contributions received. During periods of time when the Fund has zero or fewer months of financial reserves zero or fewer months of financial reserves, as determined by the Administrative Manager, no HRA credit shall be granted.

- Light Industrial participants: During periods of time when the Fund has at least three months of financial reserves, as determined by the Administrative Manager, HRA credit of $0.75 per hour worked with Employer contributions received. During periods of time when the Fund has less than three months of financial reserves, as determined by the Administrative Manager, no HRA credit shall be granted.

2. Limitations of HRA Account

Credit balances in HRA accounts may not exceed $6,000 for Journeymen and Apprentices, and may not exceed $3,000 for Classified Workers and Light Industrial participants. If any participant's HRA credit

account balance reaches $6,000 for Journeymen and Apprentices or $3,000 for Classified Workers and Light Industrial participants, no further credit shall be granted to such participant. Crediting shall resume accruing based on work when his HRA account balance is less than $6,000 or $3,000 depending on classification due to usage, and shall accrue based on the accrual rules then in place, and as may be amended by the Board in its sole and exclusive discretion.

If you reach the $6,000 or $3,000 limit depending on classification, the amount of contributions owed by your employer to the Fund will not change – the full contribution amount is still due from your employer to the Fund.

3. Use of HRA Account

A Participant, his surviving spouse and his Dependents may use the HRA account to reimburse amounts incurred by any of them for qualified medical, dental, vision or prescription drug expenses, as defined in Section 213(d) of the Internal Revenue Code, which are not covered by the Fund, due to copayments, maximum benefit allowed, or medical services that are not payable under the Plan, and to pay self-payment amounts which may be due to continue coverage.

A Participant, his surviving spouse and/or his Dependents, as applicable, shall complete and submit an HRA Claim Form accompanied by all written proofs that the Fund administrative office shall request in order apply for HRA benefits. The Fund Office may also provide a "Benny Card" – a specialized type of debit card, which you can use at the point of purchase to use your HRA account on qualifying purchases, and the amounts used are directly deducted from your HRA.

Upon use of the HRA account for the purposes described above, an equal amount will be cancelled from the available HRA account balance.

4. Cancellation of Credits

Credits shall be cancelled upon the earliest of the following to occur:

- Their use as set out above;
- Twenty-four months after the termination of the Participant's coverage;
- Immediately upon a Participant's written election to waive future use of the Credits, which is permitted each January 1;
- Immediately upon a Former Participant's written election to waive future use of the Credits;
- The later of:
    a) the death of the Participant, or
    b) the death of the Surviving Spouse;
- The termination of the Health Reimbursement Arrangement provisions of the Plan by the Board of Trustees.

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

Cancellation of HRA credits for any reason does not affect the amount of contributions owed by your employer to the Fund – the full contribution amount is still due from your employer to the Fund based on hours you work.

WELLNESS PROMOTION BENEFIT (All Participants and Retirees)

The Fund will reimburse to participants and retirees only (not dependents or surviving spouses) the **lesser of** the full annual cost per family or $100 per year per family to offset the cost of membership in one gym/health club facility if such participant provides both 1) proof of payment in full for a one-year membership and 2) a signed form provided by the Fund indemnifying the Fund from any claims arising in connection with such membership.

Note: The Fund will reimburse participants for a maximum of $100 per purchase, regardless of the number of years of the membership purchased. For example, a five-year membership costing $500 purchased on October 1, 2022 will be reimbursed in a one-time amount of $100 only, and will not be reimbursed at $500 or at $100 per year for five years.

The Fund will not be liable for any condition or injury arising directly or indirectly from participation in activities at any gym/health club for which the cost of membership was fully or partially reimbursed by the Fund.

LOSS-OF-TIME BENEFITS (Participants covered by Working/Hour Bank only)

If you are eligible for coverage under this Fund and are unable to work because of an accident occurring **off** the job (excluding motor vehicle accidents and non-accidental injuries) or any illness **not** connected with employment, you will be entitled to weekly Loss-of-Time benefits in the amount shown below for a period of 26 continuous weeks or the period of your disability, whichever is shorter, beginning no earlier than the dates set forth below. You must file a Loss-of-Time form with the Fund Office to receive these benefits.

1. **Amount**

The weekly benefit amounts are currently as follows. The amounts are determined by the Board of Trustees and are subject to change at any time:

WEEKLY BENEFIT FOR JOURNEYMEN AND CLASSIFIED WORKERS

Journeyman	$600
Classified Worker A	$432
Classified Worker B	$390
Classified Worker C	$300

WEEKLY BENEFIT FOR APPRENTICES

Apprentice 8th Semester	$480
Apprentice 7th Semester	$450

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

Apprentice 6th Semester	$420
Apprentice 5th Semester	$390
Apprentice 4th Semester	$360
Apprentice 3rd Semester	$330
Apprentice 2nd Semester	$300
Apprentice 1st Semester	$270

However, an Apprentice who is receiving a base wage rate that is the rate for a Classified Worker A, B or C will receive a weekly benefit equivalent to that corresponding to the Classified Worker A, B or C, respectively, if that weekly benefit is higher than the weekly benefit payable to such Apprentice based on his semester/level.

> **Example:** An Apprentice who is in the 6th Semester and is being paid at the Classified Worker A rate will receive the weekly benefit payable to a Classified Worker A ($432) rather than the weekly benefit payable to an Apprentice 6th Semester ($420).

2. Commencement of, Duration of and Limitations on Benefits

Benefits begin on the first day of disability due to an injury and due to an illness that results in either inpatient or outpatient hospitalization. Benefits begin on the eighth day of disability due to an illness that does not result in hospitalization, including pregnancy-related disability for which the participant is not hospitalized. Benefits begin on the eighth day of the first period of inpatient substance abuse treatment, and on the fifth day of the second period of inpatient substance abuse treatment.

A Loss-of-Time form must be filed with the Fund Office before benefits will be paid. All claims for Loss-of-Time Benefits must be filed **within 30 days from the onset of disability.**

Loss-of-Time benefits due to your pregnancy shall be granted 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 Loss-of-Time benefits for a pregnancy.

In no case shall Loss-of-Time benefits exceed the 26-week continuous maximum. Under no circumstances will you be eligible for more than one 26-week period of loss of time benefits due to the same illness or injury.

If you are unable to work because you are receiving inpatient substance abuse treatment, you shall be entitled to a weekly Loss-of-Time benefit of 100% of the amount shown above if you are in your first course of treatment and 75% of the amount shown above if you are in the your second course of treatment, for a period of 26 continuous weeks or the period of disability, whichever is shorter. No Loss-of-Time benefits are payable for the third or any subsequent course of treatment.

Payment for any one payable day of disability benefits is 1/7th of the weekly benefit amount.

Only participants who are eligible because of work performed and Employer contributions received on their behalf, or based on withdrawal of hours from their Hourly Reserve Banks are eligible for Loss-of-Time benefits. Loss-of-Time Benefits are not payable after you retire under the Sheet Metal Workers

Local Union No. 292 Pension Fund. Dependents, retirees, and participants maintaining eligibility by any form of self-payment are not eligible for Loss-of-Time benefits.

LIFE INSURANCE (All Participants and Retirees)

The Life Insurance benefit is insured with a policy issued by a commercial insurance company and is subject to all exclusions of that policy. Benefits are payable based on the policy of the commercial insurance company with which the Fund contracts. *Where any term below conflicts with the policy issued by the commercial insurance company, the terms of the policy shall control.*

Eligibility: Eligibility for Life Insurance Benefits begins 30 days after eligibility under the Plan for Participants.

Benefit Amount: The amount varies based on your work classification, whether you are active or retired, and whether you are eligible based on work and Employer contributions (with or without use of your Hour Bank), or by self-payment (*excluding* COBRA – no life insurance benefit is provided for you or any dependent who covered based on COBRA).

The various amounts of the Life Insurance Benefit payable are set forth below (except as may be reduced by the amount of any accelerated benefit paid as set forth below). The Life Insurance Benefit is only payable on behalf of these persons – no other categories of persons are eligible.

DECEDENT	**BENEFIT AMOUNT**
Journeyman (while covered by working/Hour Bank)	$40,000
Apprentice (while covered by working/Hour Bank)	$40,000
Classified Worker (while covered by working/Hour Bank)	$30,000
Participant active by self-payment (covered by self-payments ***excluding*** COBRA)	$15,000
Normal or Early Retiree or Disabled Participant under the Sheet Metal Workers Local No. 292 Pension Fund (covered by self-payments ***excluding*** COBRA)	$ 5,000
Dependent Child of a Participant (while covered by working/Hour Bank)	
6 months and older	$ 2,000
14 days to 6 months	$ 100
(No benefits are available on behalf of a dependent child under 14 days old, or any dependent child of a Participant covered by any form of self-payment)	
Dependent Spouse of a Journeyman, Apprentice or Classified Worker (while the Participant is covered by working/Hour Bank only - no coverage if the Participant is covered by any form of self-payment)	$ 2,000

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

Up to $500 of the above benefit amounts (as applicable) may be paid to any person or entity that incurred expenses related to the death and burial of the deceased. That amount will be deducted from any Life Insurance Benefit payable.

Benefit Termination: Your Life Insurance Benefit coverage terminates immediately when your coverage under this Plan terminates. Also, your Life Insurance Benefit coverage terminates immediately upon your coverage under COBRA.

Your dependent's Life Insurance Benefit coverage terminates on the *earliest* of the following to occur: (1) the date your dependent no longer meets the Plan's definition of dependent, (2) the 31st day after your coverage terminates, (3) when you begin coverage by self-payment, (4) when you begin coverage as a retiree. If your coverage terminates due to your death, and your dependents continue to be covered by using your Hourly Reserve Bank, they will continue to have life insurance coverage until your Hourly Reserve Bank falls below 140 hours.

Living Benefits (Accelerated Benefit): A Participant may apply for and receive a lump sum from your Life Insurance Benefit. The amount of the benefit and all other terms, conditions, requirements and limitations of the accelerated life insurance benefit are as set forth in the policies of insurance, which are incorporated by reference as if printed verbatim herein

Beneficiary: You may designate as your beneficiary any person or persons you choose. You may change your beneficiary at any time by completing forms that 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), the commercial life insurance company will pay your Life Insurance Benefit in accordance with the terms of its Policy.

What if you get divorced? Please be aware that under the terms of the insurance policy, your Life Insurance Benefit will be payable to the person designated as the beneficiary on your beneficiary card, *even* if that person is your former spouse and *even* if the judgment of divorce states that your former spouse is not entitled to any life insurance benefits payable on your behalf. ***Therefore, if you have designated your spouse as your beneficiary and then you are divorced, you must complete a new beneficiary card if you want your life insurance benefits to be paid to someone other than your former spouse.***

Time for Filing: Written notice of your death or the death of your beneficiary must be received by the Fund Office within 90 days of that death for Life Insurance to be payable.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Journeymen, Apprentices and Classified Workers eligible based on working and employer contributions, with or without Hour Reserve Bank, only)

Accidental Death and Dismemberment Benefits are insured with a policy issued by a commercial insurance company and are subject to all terms and exclusions of that policy.

Accidental Death and Dismemberment benefits are payable on behalf of Journeymen, Apprentices and Classified Workers who are covered by Working/Hour Bank **only**. Dependents are not covered by this benefit, nor any retiree or participant eligible by self-payment.

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

The amount of basic benefits is set out in the table below. The "Principal Sum" is the Life Insurance Benefit (currently, $40,000 for Journeymen and Apprentices and $30,000 for Classified Workers).

Loss	Benefit
Loss of Life	Principal Sum
Loss of Both Hands	Principal Sum
Loss of Both Feet	Principal Sum
Loss of Entire Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Entire Sight of One Eye	Principal Sum
Loss of One Foot and Entire Sight of One Eye	Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Entire Sight of One Eye	One-half Principal Sum
Loss of Speech or Hearing (both ears)	One-half Principal Sum
Loss of One Hand or One Foot	One-half Principal Sum
Loss of Thumb and Index Finger of same Hand	One-fourth Principal Sum
Quadriplegia (Paralysis of both upper and lower limbs)	Principal Sum
Triplegia (Paralysis of three limbs)	Three-quarters Principal Sum
Paraplegia (Paralysis of both lower limbs)	One-half Principal Sum
Hemiplegia (Paralysis of an upper and a lower limb)	One-half Principal Sum
Uniplegia (Paralysis of a limb)	One-fourth Principal Sum

MEMBER'S ASSISTANCE PROGRAM (All Participants and Retirees)

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

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

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

- Relationship and family concerns
- Death of a loved one
- Stress, anxiety and depression
- Substance Abuse

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

- Eldercare or childcare referrals
- Financial or legal referrals

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

You can reach Ulliance at its toll-free number 800-448-8326 for free, confidential assistance. You can also visit their website, www.LifeAdvisorEAP.com for more information and a wide variety of resources. To login, simply enter "Local 292" as your employer and "Troy" as your city of employment. We hope you and your dependents take advantage of the many services Life Advisor EAP has to offer.

CLAIMS APPLICATIONS, LIMITS AND APPEALS

APPLYING FOR BENEFITS

Eligibility Determinations

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

Claims for Medical, Hospital, Surgical, Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, Health Reimbursement Arrangement Benefits, Wellness Promotion Benefits, Loss-of-Time Benefits, Life Insurance Benefits, Accidental Death and Dismemberment Benefits, and Member's Assistance Programs Benefits.

Blue Cross Blue Shield of Michigan (BCBSM) is responsible for the processing and determination of all claims for Medical, Hospital and Surgical Benefits for Active Participants, Early Retirees and their Dependents; Prescription Drug Benefits for Active Participants, Early Retirees and their Dependents; Dental Benefits; and Vision Benefits.

Humana is responsible for the processing and determination of all claims for Medical, Hospital and Surgical Benefits for Medicare Eligible Retirees and their Medicare Eligible Retirees Dependent and Prescription Drug Benefits for Medicare Eligible Retirees and their Medicare Eligible Dependents.

The Fund Office is responsible for the processing and determination of all claims for Health Reimbursement Arrangement Benefits, Wellness Promotion Benefits, and Loss-of-Time Benefits.

Union Labor Life Insurance Company (Ullico) is responsible for the processing and determination of all claims for Life Insurance Benefits and Accidental Death and Dismemberment Benefits.

Ulliance is responsible for the processing and determination of all Member's Assistance Program Benefits.

Claim forms for benefits administered by the Fund Office are available from the Fund Office. All such forms and supporting documentation must be submitted within the following time periods:

(1) Claims for Medical, Hospital and Surgical administered by Blue Cross Blue Shield of Michigan must be submitted within 12 months from the date you or your dependent received the hospital and facility services for which payment is sought, and within 15 months from the date you or your dependent received professional services (such as physician services).

(2) Claims for Prescription Drug Benefits administered by Blue Cross Blue Shield of Michigan must be submitted within one year from the date you or your dependent received the services for which payment is sought.

(3) Claims for Dental Benefits administered by Blue Cross Blue Shield of Michigan must be submitted within twenty-four months from the date you or your dependent received the services for which payment is sought.

(4) Claims for Vision Benefits administered by Blue Cross Blue Shield of Michigan must be submitted within twelve months from the date you or your dependent received the services for which payment is sought.

(5) Claims for Health Reimbursement Arrangement Benefits must be submitted within one year of the date the expense for which reimbursement is sought was incurred.

(6) Claims for the Wellness Promotion Benefit must be submitted for reimbursement within 1 year of the date of service (or 1 year of the billing date for the Wellness Promotion Benefit).

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

(8) Claims for Life Insurance and Accidental Death and Dismemberment Benefits must be submitted within 90 days of the date of the death or loss.

After these time limits have passed, the Fund and its service providers are no longer obligated to pay or reimburse the amount of the claim.

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

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

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

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

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

DENIAL OF CLAIMS

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

APPEALING A DENIAL OF YOUR BENEFIT CLAIM

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

A. Appeals Regarding Medical, Hospital, Surgical Benefits, Prescription Drug Benefits, Dental Benefits and Vision Benefits

If Blue Cross Blue Shield of Michigan (BCBSM), for non-Medicare eligible participants or Humana for Medicare eligible participants, denies a claim, in whole or in part for reasons other than ineligibility of the claimant, the claimant may appeal the denial in the manner set forth in the Fund's policies of insurance, group enrollments, coverage agreements, administrative services agreements or other documentation with or from its service provider(s), which are incorporated by reference as if printed verbatim herein. Refer to your Explanation of Benefits (EOB) for more information.

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

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

B. Appeals Regarding Life Insurance Benefits and Accidental Death and Dismemberment Benefits

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

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

C. Appeals Regarding Eligibility Matters, Health Reimbursement Arrangement Benefits, Wellness Promotion Benefits, Loss-of-Time Benefits and Member's Assistance Program Benefits

You or your family member ("claimant") may appeal a denial of any claim for eligibility, Health Reimbursement Arrangement Benefits, Wellness Benefits, Loss-of-Time Benefits, or Member's Assistance Program Benefits within 180 days of the notice of denial to the Board of Trustees, Sheet Metal Workers Local No. 292 Health Fund, P.O. Box 189, Troy, MI 48099-0189. The appeal should be in writing. No special form is required. Just be sure that what the claimant has written explains the claimant's position as clearly as possible. The claimant has the right to appoint someone else (such as a lawyer) to prepare and submit your appeal to the Board of Trustees. Make sure your name, the identifying number provided by the Fund, your trade, your union and the name of the claimant if different from you (such as your spouse or child) are included to avoid delays in processing your appeal.

The claimant, or his representative, will have the opportunity to review pertinent documents and other information relevant to the claim free of charge upon submission of 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).

The claimant, or his representative, may submit issues, comments, additional legal arguments, and new information in writing to the Board of Trustees for its consideration in the appeal. The Board of Trustees' review of the appeal will take into account all materials and information received before the review and the decision of the Board of Trustees on the appeal, whether or not that information was previously submitted or considered by the Fund Office in the initial determination on the claim.

The Board of Trustees reviews the claim on appeal de novo (which means "anew" and without deference to the original determination) and it will review the additional materials and information submitted, if any.

The claimant may request a personal appearance before the Board of Trustees, which they may grant or deny at their sole and exclusive discretion. 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 own expense.

The Board of Trustees will respond to appeals of denials of claims 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 5 days after the Board of Trustees' first regularly scheduled meeting after receiving an appeal of a claim for **post-service care**, unless the 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 BCBSM are addressed in the prior section.)

If, due to special circumstances, the Board of Trustees requires additional time to review the 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 therefor in writing within 5 days after it makes its decision on the appeal.

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's decision was based.

The Board of Trustees has the sole and exclusive discretion to interpret and to apply the rules of the Plan, the Trust, and other rules and regulations.

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

You should seek legal advice 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, but are not limited to, one or more of the following:

- The person receiving the services or seeking the benefit was not eligible for the specific benefit sought and/or any benefit under the Plan when the expense was incurred.
- The claim was not received by the Fund within the applicable time limit.
- The expense was for services not medically necessary, not covered by the Fund or the expense was not actually incurred.

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

- The person for whom the claim was filed had not yet satisfied all required deductibles and percent copayment requirements 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, above).

- Eligibility rules were changed, coverage was eliminated, or the benefit was reduced or discontinued by action of the Board of Trustees before the services were received.

- 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, and be certain to review the section above regarding Appeals to avoid loss of rights.

ADMINISTRATIVE MATTERS

NOTICE OF HOURS WORKED

Each month, the Fund Office will mail you a status slip listing the hours that were reported to the Fund Office with Employer contributions on your behalf. This report provides you with a summary of hours worked during that month so that you may compare the Fund's records to your pay stubs.

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

If your Employer failed to remit contributions based on your work, the Fund will pursue collection, but you are responsible for maintaining your coverage by self-payment. Sometimes the Fund will be unable to collect the full amount due. 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. But remember that the Fund must actually receive all Employer contributions based on your hours of work as a condition of recognizing those hours of work for fulfilling any eligibility requirement.

EXAMINATIONS

The Board of Trustees may condition payment of benefits on the result of an examination of a person for whom benefits are being claimed by a doctor chosen by the Board of Trustees. The Board of Trustees also has the right to examine any and all hospital or medical records relating to a claim.

FREE CHOICE OF PROVIDER

You may choose any health care provider you wish to provide your health care. However, the amount of benefits paid by the Fund, if any, may vary widely and may be severely limited based on the provider you choose and the provider's participation in a preferred provider organization utilized by the Fund.

BOARD OF TRUSTEES INTERPRETATION AND AUTHORITY and 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 Board of Trustee responsibility has been delegated to others, its delegates, will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Board of Trustees or its authorized delegates is challenged in court, the Trust Agreement provides 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 they 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. 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, since coverage for retirees and their dependents, like all of the benefits from the Fund, is not an accrued or vested benefit. The Board of Trustees has the authority to amend or terminate such benefits and to modify or increase the self-payment amount for coverage at any time. Any such change shall be effective even though an employee has already become a retiree, or has met the eligibility requirements to retire now or in the future.

WORKERS' COMPENSATION NOT AFFECTED

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

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

PLAN DISCONTINUATION OR TERMINATION

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

RIGHT OF OFFSET

If any payment is made by the Fund to or on behalf of a person who is not entitled to the payment or to the full amount of such payment, the Fund has the right to reduce future payments to that person or to the person responsible for the erroneous payment by the amount of the erroneous payment. In situations where the Fund has been intentionally misled, the Fund has the right to deny, either temporarily or permanently, such persons' coverage under the Fund. These rights of offset and termination will not limit the right of the Fund to recover such erroneous payments in any other legal manner.

LEGAL ACTIONS – IMPORTANT NOTICE

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

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

ALTERED OR FORGED CLAIMS

Any claim form or other materials submitted by or on behalf of any 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 is deemed appropriate, which could include a finding of criminal liability under Michigan's Health Care False Claims Act. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any manner or to apply sanctions including expulsion from the Fund.

SPECIAL PROVISIONS FOR PARTICIPANTS REGARDING 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.

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

The Social Security Administration is the sole authority for determining your Medicare eligibility. If you are enrolled in this coverage, you are called a "beneficiary."

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

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

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

You must enroll in both Medicare Part A and Part B and pay all premiums immediately as soon as you become eligible (unless you are currently covered under another plan as an Active Participant); but you are <u>not</u> 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 <u>continue to</u> pay the Part "B" Medicare premium for your own protection. Failure to pay the Part "B" premium on time will result in the loss of Medicare protection for physician's services and other medical services and items. However, if you are working at age 65, you may be able to delay enrollment in Medicare Part B, without a penalty, until you stop working.

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

If you enroll in Medicare prescription drug coverage, you will <u>lose</u> all coverage with the Sheet Metal Workers Local No. 292 Health Fund. The Sheet Metal Workers Local No. 292 Health Fund will not provide any coverage for participants who enroll in Medicare prescription drug coverage.

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 <u>prior</u> to 30 months of coverage;

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

- Certain disabled individuals who are covered *because* of the individual's (or a family member's) *current* employment status; and

- Certain individuals (age 65 or older) who are Medicare-eligible and are working as employees, or certain dependents of such employees.

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

- Certain individuals with end stage renal disease after 30 months of coverage;

- Certain disabled individuals who are covered, but *not* because of the individual's (or a family member's) current employment status; and

- Certain former employees or certain dependents of such individuals.

For information on COBRA continuation coverage and Medicare, see COBRA provision on page 21 of this SPD.

DEPENDENTS ON MEDICARE

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

COORDINATION WITH MEDICAID

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

COORDINATION OF BENEFITS/NON-DUPLICATION OF BENEFITS

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

How COB works

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

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- Your primary plan is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.

- Your secondary plan is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by both carriers.

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

Guidelines to determine primary and secondary plans

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

Contract Holder Versus Dependent Coverage

The plan that covers the patient as the employee (participant or contract holder) is primary and pays before a plan that covers the patient as a dependent.

Contract Holder (Multiple Contracts)

If you are the contract holder of more than one health care plan, your primary plan is the one for which you are an active member (such as an employee or participant), and your secondary plan is the one for which you are an inactive member (such as a retiree).

Dependents (The "Birthday Rule")

If a child is covered under both the mother's and father's health care plan, the plan of the parent (or legal guardian) whose birthday (month and day only) is earlier in the year is primary. If the parents' birthdates are identical, the plan that has covered the dependent longest is primary.

Children of Divorced or Separated Parents

If the child's parents are divorced, separated or never married, benefits will be paid according to any court decree. If no such decree exists, benefits are determined in the following order unless a court order places financial responsibility on one parent:

1. Custodial parent (physical custody)

2. Custodial stepparent (if remarried)

3. Non-custodial parent

4. Non-custodial stepparent (if remarried)

If the primary plan cannot be determined by using the guidelines above, then the "Birthday Rule" will be used to determine primary liability.

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

Filing secondary COB claims

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

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

5. Obtain an EOB from the primary carrier. Make sure the EOB matches the receipts being submitted.

6. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.

7. If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.

8. Make sure the provider's name and complete address are on all receipts.

    a. If the provider's office is in Michigan, include the provider's BCBSM Provider Identification Number (PIN).

    b. If the provider's office is located outside of Michigan, include the provider's tax ID number.

9. Keep copies of all statements, receipts and forms for your personal files. Enclose the original billing statement with your claim form.

10. Mail all claims and receipts to:

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

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

Updating COB information is your responsibility.

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

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

SUBROGATION AND REIMBURSEMENT

Subrogation regarding BCBSM Benefits

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

> Example: A Blues participant is injured in a store, or other commercial property, due to negligence on the part of the store or property. BCBSM pays for the services to the injured person, as required by their health care contract. Later, the member sues the store. The Blues' subrogation unit would attempt to recover the money paid for medical services in that lawsuit.

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

- Workers' compensation
- Personal injury
- Medical malpractice

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

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

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

Subrogation regarding All Other Fund Benefits

In the event of any payments for services to or on behalf of any person under this Plan, the Fund shall, to the extent of such payments, be subrogated to all rights of recovery of that person (or his representative(s) or successor(s) in interest) arising out of any claim or cause of action which may accrue against a third party, including any occupationally related claim or cause of action covered by the Michigan Workers' Disability Compensation Act or Occupational Disease Act or similar federal or state statutes. That person (or his representative(s) or successor(s) in interest), by acceptance of benefits provided by this Fund, hereby agrees to reimburse the Fund for any benefits so paid hereunder out of monies recovered, fully or partially, from such third party as the result of judgment, settlement or otherwise, irrespective of how differentiated, without any offset for expenses, including legal fees,

that person (or his representative(s) or successor(s) in interest) may owe, and before that person (or his representative(s) or successor(s) in interest) pays any other individual, organization or entity out of that full or partial recovery. That person (or his representative(s) or successor(s) in interest) may take no action which would prejudice the rights of this Fund (and/or its service provider(s) and/or its designee(s)), and that person (or his representative(s) or successor(s) in interest) hereby agrees to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Trustees may require to facilitate the enforcement of the Fund's rights, including periodic updates of the status of the underlying case as well as notice of any settlement. Neither the Fund (nor its service provider(s) nor its designee(s)) will be responsible for any attorney's fees or costs incurred and/or paid by or on behalf of that person (or his representative(s) or successor(s) in interest) unless the Fund (and/or its service provider(s) and/or its designee(s)) has agreed in writing in advance to pay such fees or costs or some portion thereof.

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

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

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

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

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

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 and not recovered as (1) 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)); (2) an advance on future claims payable on behalf of that person (or his representative(s)); or (3) an amount held by that person (or his representative(s)) in constructive trust on behalf of the Fund.

RESTITUTION WHERE BENEFITS IMPROPERLY RECEIVED

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

RIGHT TO BENEFITS

No employee, participant, former participant, beneficiary, retiree, spouse, or any other person claiming by or through any such person, shall have any right, interest or title to any benefits under the Trust Agreement, the Plan, or the Fund, except as such right, interest, or title shall have been specifically granted pursuant to the terms of the Plan.

RIGHT TO OBTAIN AND REQUIRE INFORMATION

The Trustees shall have the right to require, as a condition precedent to the payment of any benefit under the Plan, all information which they reasonably deem necessary, including records of employment, proof of dates of birth and death, marital status, independent medical examinations of any person for whom benefits are being claimed, any and all medical records relating to a claim, etc., and no benefit dependent in any way upon such information shall be payable unless and until such information so required shall be furnished. Such evidence shall be furnished by the Union, the Association, employers, employees, participants, dependents, beneficiaries, alternate recipients, or the representative of any of them.

RIGHT TO RELY ON INFORMATION

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

RIGHT OF RECOVERY

Whenever payments have been made by the Fund with respect to allowable expenses in a total amount, at any time, in excess of the amount covered, the Fund shall have the right to recover such payments to the extent of such excess, from among one or more of the following, as the Fund shall determine: any

persons to or for or with respect to whom such payments were made, any insurance company, and/or any other organizations.

EXCLUSIONS AND GENERAL LIMITATIONS

Medical, hospital and surgical benefits, prescription drug benefits, dental benefits and vision benefits provided through contracts with Blue Cross/Blue Shield of Michigan, and life insurance and accidental death and dismemberment benefits insured through Ulliance are exclusively governed by the policies entered into with the Fund and they have their own exclusions, some of which are listed earlier in this Summary and some of which are contained in their insurance contract.

Except as may be provided for under the terms of the Plan or the foregoing insurance contracts, the Plan shall not provide the following benefits:

- **The Plan will NOT provide payment for any self-funded benefit (Loss-of-Time benefits, etc.) based on injuries sustained in a motor vehicle accident or other motor vehicle licensed to be on the road or complications resulting from such injuries or accident.**

- 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, or any accidental bodily injury for which a third party may be responsible **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.

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

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

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

- The Plan will **NOT** provide for expenses resulting from self-inflicted injuries, unless the injuries resulted from a medical condition such as depression.

- The Plan will **NOT** provide for installation of air conditioners, humidifiers/dehumidifiers, 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.

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

- 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.

- The Plan will **NOT** provide for care and services payable by government-sponsored health care programs such as Medicare or TRICARE. However, the Plan will provide for prescription drugs that are payable by a Medicare Part D prescription drug plan. This exclusion does not prohibit the Plan from providing reimbursement of the difference between a copay paid to obtain prescription drugs through governmental prescription drug programs that would otherwise be covered under this Plan and the prescription drug copay that would have been charged by the Plan for that prescription drug.

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

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

- 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.

- The Plan will **NOT** provide for pre-marital examinations; physical examinations and neuropsychological evaluations for litigation purposes; school physicals or camp physicals, immunization injections (except to age 16), or any examination not necessary by reason of sickness, injury or disease.

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

- The Plan will **NOT** provide for any expenses or pay Loss-of-Time Benefits for disabilities resulting from causes other than sickness, accidental injury, or disease, except those incurred as a result of domestic violence. In case of questionable claims of this type, the Board of Trustees will require a copy of any police report and full details regarding the incident.

- The Plan will **NOT** provide for any expenses or pay Loss-of-Time Benefits arising from injuries sustained while the person is engaged in any unlawful act, except those incurred as a result of domestic violence.

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

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

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

- The Plan will **NOT** provide for refills not authorized by a physician.
- The Plan will **NOT** provide for more than a 30-day supply of prescription drugs (except for specified maintenance drugs that are covered for 90 days).
- The Plan will **NOT** provide for refills dispensed after one year from the date of the original prescription.
- The Plan will **NOT** provide for drugs dispensed for cosmetic purposes.
- The Plan will **NOT** provide for comprehensive nutritional programs or for visits with specialists in endocrinology when required solely for the purpose of weight loss or for treatment of obesity only or for expense incurred for dietary supplements, nutritional lectures, or weight loss programs and clinics, unless such benefits are provided in connection with covered cardiac rehabilitation services.
- The Plan will **NOT** provide for drugs for fertility and infertility treatment.
- The Plan will **NOT** provide for acupuncture services.
- The Plan will **NOT** provide for smoking cessation treatment, except as provided under the prescription drug benefits provisions.
- The Plan will **NOT** provide coverage for reversal of sterilization.
- The Plan will **NOT** provide coverage for compounded medications made from bulk powders or chemicals (that is, made with any ingredient that does not have an NDC code).
- The Plan will **NOT** provide coverage for weight loss/weight control drugs.
- The Plan will **NOT** provide coverage for allergens (may be covered under medical coverage).
- The Plan will **NOT** provide coverage for blood product (may be covered under medical coverage).
- The Plan will **NOT** provide coverage for over-the-counter allergy medications.
- The Plan will **NOT** provide for expenses due to the children of dependent children. However, the Plan will provide for expenses due to pregnancy of dependent children.

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 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 Sheet Metal Workers Local No. 292 Health Fund, P.O. Box 189, Troy, MI 48099-0189, (248) 641-4992.

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 co-insurance 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 Sheet Metal Workers Local No. 292 Health Fund, P.O. Box 189, Troy, MI 48099-0189, (248) 641-4992.

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

ERISA RIGHTS

As a participant in the Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Note: There are limitations on plans' imposing a preexisting condition exclusion, and such exclusions are prohibited as of 2014 under the Affordable Care Act.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may

fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Assistance with Your Questions

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

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

NOTICE OF PRIVACY PRACTICES

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

The Fund 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 Fund is also required to give you this notice regarding (1) the uses and disclosures of health information that may be made by the Plan of the Sheet Metal Workers Local No. 292 Health Fund, and (2) your rights and the Plan's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA. Please be advised that BCBSM or other Fund service providers may issue a separate Notice regarding disclosure of health information that is maintained on the Plan's behalf by that entity.

How The Fund May Use and Disclose Health Information About You

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

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

For Health Care Operations. The Fund may use and disclose health information about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Fund may use health information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Plan administrative activities.

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

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

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

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

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

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

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Fund 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 Fund has made a reasonable effort to notify you about the request, or to obtain an order protecting your health information.

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

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

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

In the Event of a Serious Threat to Health or Safety. The Fund may disclose your health information if necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person.

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

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

For Other Purposes. Other uses and disclosures of your health information not covered by this Notice or the laws that apply to the Fund will be made only if you provide a written authorization. If you provide the Fund with written authorization to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, the

Fund will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that the Fund is unable to take back any disclosures that it has already made with your permission.

The Fund may use or disclose your health information for other purposes not set forth in this Notice which the Fund is permitted to do so without your written authorization or consent.

Your Rights Regarding the Privacy of Your Personal Health Information

You have the following rights:

The right to request restrictions or limitations on the health information the Fund uses or discloses about you for treatment, payment, or health care operations. The Fund is not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Fund's Privacy Officer. In your request, you must tell the Fund (1) what information you want to limit, (2) whether you want to limit the Fund's use, disclosure, or both; and (3) to whom the limits apply.

The right to request to receive confidential communication of your health information by an alternative means or at an alternative location if a disclosure of your health information could endanger you. The request must be made in writing to the Fund's Privacy Officer and must specify the alternative location or other method of communication that you prefer (for example, using an alternate address). Your request must include a statement that the restriction is necessary to prevent a disclosure that could endanger you. The Fund 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 for inspection and/or copying. Your request for access to documents with your health information must be in writing to the Fund's Privacy Officer. When a request for access is accepted (in whole or in part), you will be notified of the decisions and you may then inspect the health information, copy it, or both, in the form or format requested at a time and place convenient to you and the Fund. If you would like, you may receive a summary of the requested health information instead of your entire record, for a reasonable fee. You may also receive a copy of your health information by mail if you prefer. (The Fund 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 health information or for processing the participant's request for access.) When a request for access is denied (in whole or in part), the Fund will grant access to health information for which there are no grounds to deny access. The Fund 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 Fund and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, the Fund 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.

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

The right to request to amend your health information if it is inaccurate or incomplete. You may request that your health information be amended. That request must be in writing to the Fund's Privacy Officer and include a reason why your health information should be amended. If you do not include a reason, the Fund will not act on the request. When a request for amendment is accepted (in whole or in part), the Fund will inform you that your request for amendment has been accepted. The Fund will request from you permission to contact other individuals or health care entities that you identify that need to be informed of the amendment(s), and will inform them and other entities with whom the Fund does business who may rely on the disputed health information to your detriment. The Fund will identify the record(s) that are the subject of the amendment request and will append the amendment to the record. When a request for amendment is denied, you will be notified why the request was denied (e.g., the information requested was not created by the Fund, is accurate and complete, is not part of the record, or may not legally be changed such as information compiled in anticipation of a civil, criminal, or administrative proceeding), how to file a statement of disagreement or a request that the Fund provide the request for amendment and the denial in any future release of the disputed health information, and how to file a complaint with the Fund or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, the Fund may write a rebuttal statement and will provide a copy to the participant, and it will include the request for amendment, denial letter, statement of disagreement, and rebuttal (if any), with any future disclosures of the disputed health information. If you do not choose to write a statement of disagreement with the denial decision, the Fund is not required to include the request for amendment and denial decision letter with future disclosures of the disputed health information unless you request that the Fund do so. Receipt of notification of amendment: When the Fund receive notification that your health information has been amended, the Fund will ensure that the amendment is appended to your records, and will inform entities with whom it does business that may use or rely on your health information of the amendment and require them to make the necessary corrections.

The right to obtain an accounting of disclosures of your health information. The right to an accounting extends to disclosures, other than disclosures made (1) for the purposes of treatment, payment, or health care operations, including those made to business associates, (2) to individual about their own health information, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for national security or intelligence purposes; (8) to correctional institutions or law enforcement officials; and (9) those made prior to April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Fund's Privacy Officer. Your request must specify a time period, which may not be longer than six 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 Fund will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The right to receive a paper copy of this Notice and any revisions to this Notice. You may request a copy of this Notice in writing to the Fund's Privacy Officer at any time. Even if

you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Legal Duties of the Sheet Metal Workers Local No. 292 Health Fund Regarding Your Health Information

The Sheet Metal Workers Local No. 292 Health Fund is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Sheet Metal Workers Local No. 292 Health Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Sheet Metal Workers Local No. 292 Health Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information the Fund has about you as well as any information it receives in the future. If the Sheet Metal Workers Local No. 292 Health Fund changes its policies and procedures, the Sheet Metal Workers Local No. 292 Health Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Sheet Metal Workers Local No. 292 Health Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Sheet Metal Workers Local No. 292 Health Fund should be made in writing to the Fund's Privacy Officer. The Sheet Metal Workers Local No. 292 Health Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

For questions about this Notice, to exercise your privacy rights, or to file a complaint, contact the Fund's Privacy Officer, Sheet Metal Workers Local No. 292 Health Fund, P.O. Box 189, Troy, MI 48099-0189, (248) 641-4992.

SOCIAL SECURITY NUMBER PRIVACY POLICY

The Social Security Number Privacy Act makes it unlawful, with respect to all or any more than four sequential digits of an individual's social security number, to do any of the following:

Publicly display more than 4 sequential digits of the Social Security number. The term "publicly display" is broadly defined to mean exhibit, hold up, post, or make visible such as on a computer screen, network, or other electronic medium.

- Use a person's social security number as an individual account number,
- Print a Social Security number on the outside of any envelope or package mailed or sent to an individual,
- Require use or transmission of more than 4 sequential digits of a Social Security number over the internet or a computer network, unless the connection is secure or the transmission is encrypted, or

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

- Require use or transmission of more than 4 sequential digits of a Social Security number to gain access to a website or computer system or network, unless the connection is secure and the transmission is encrypted, or protected by a password or other unique personal ID number or authentication device.

The statute also prohibits including all or more than 4 sequential digits of a Social Security number in any document or information mailed to a person, unless certain conditions, including the following, apply:

- A state or federal law or rule or court order authorizes, permits, or requires the Social Security number's use,

- The document sent is part of an application or enrollment initiated by the individual,

- The document is sent to establish, confirm service, amend or terminate an account, contract, policy, or employee or health insurance benefit; or

- The document is mailed by a public body in certain circumstances.

The restrictions do not apply to use of a Social Security number that is "authorized or required by state or federal statue, by court order, or pursuant to legal discovery or process."

It is not a violation of the Act to use a Social Security number to "verify an individual's identity, identify an individual, or do another similar administrative purpose related to," proposed employment or employment. Use of Social Security numbers to provide or administer health insurance, membership benefits, or retirement programs is also permissible. An entity may also use all or part of a Social Security number to "lawfully pursue or enforce a person's legal rights," which may include "audit, collection, investigation, or transfer of a tax, employee benefit, debit, claim" or account.

To comply with the Social Security Number Privacy Act, to protect the confidentiality of the Funds' participants' and beneficiaries' social security numbers, and to prevent to the extent possible their disclosure to persons who would use them unlawfully, the Board of Trustees of the Sheet Metal Workers Local 292 Health Fund, along with the Boards of Trustees of the Sheet Metal Workers Local No. 292 Pension Fund, the Sheet Metal Workers Local No. 292 Annuity Fund and the Sheet Metal Workers Local No. 292 Supplemental Unemployment Benefit Fund, have adopted the following Social Security Number Privacy Policy:

- All Fund service providers and their agents and employees are hereby directed to ensure to the extent practicable the confidentiality of all Social Security numbers.

- All Fund service providers and their agents and employees are hereby prohibited from making any disclosure of Social Security numbers contrary to the provisions of the law as set out above.

- All Fund service providers and their agents and employees are directed to limit who has access to information or documents that contain the Social Security numbers strictly to those individuals for whom such information is necessary for the provision and administration of

the Funds' health, welfare, or retirement programs. Information in any form, written or electronic, which contains Social Security numbers will be handled only by those persons whose job duties require them to have access to that information for the provision and administration of the Funds' health, welfare, or retirement programs. If such information is contained in documents, the documents will be securely stored, with access limited to those persons whose job duties require them to have access to that information. If such information is in electronic form, access to any computer or computer files will be limited, through the use of passwords and/or other technology, to those persons whose job duties require them to have access to that information.

- Documents which contain Social Security numbers and which are no longer needed will be disposed of, whether by shredding or otherwise, in a manner which will insure that the numbers are protected. Each Fund service provider shall be responsible for supervising this process.

- Fund service providers who violate this privacy policy will be subject to disciplinary action, up to and including termination.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

What is balance billing?

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

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

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

<u>You are protected from balance billing for:</u>

Emergency services

If you have an emergency medical condition and get emergency services from a nonparticipating provider or facility, the most the provider or facility may bill you is your plan's in-network out-of-pocket amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for

these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

Certain services at a participating hospital or ambulatory surgical center

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

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

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

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

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

SUBROGATION AGREEMENT

ASSIGNMENT OF ACKNOWLEDGMENT OF LIEN FOR THE BENEFIT OF THE SHEET METAL WORKERS LOCAL NO. 292 HEALTH FUND

I, _____ (Name of Participant), hereby make this Acknowledgment of Lien for the Benefit of the Sheet Metal Workers Local No. 292 Health Fund (hereafter the "Assignment"), as stated below.

WHEREAS, I and/or my dependent(s) have made application to Sheet Metal Workers Local No. 292 Health Fund (hereinafter referred to as the "Fund") for benefits, which may include payment of hospital and other medical expenses and weekly disability (loss-of-time) 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.

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

I further understand and agree that the intent of this assignment is to assure the Sheet Metal Workers Local No. 292 Health 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 No. 292 Health Fund
P.O. Box 189
Troy, MI 48099-0189
(248) 641-4992

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.

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

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 No. 292 Health Fund ("Fund") for all payments made by the Fund to or on behalf of the attorney's above-named Client(s) in connection with the Client's(s') injuries, including payments made for medical claims and wage loss.

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

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

ATTORNEY'S SIGNATURE

DATE: _____

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

NOTES

2024 PLAN OF

SHEET METAL WORKERS' LOCAL NO. 292 HEALTH FUND

(Restated Effective January 1, 2024)

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2024 PLAN OF THE
SHEET METAL WORKERS' LOCAL NO. 292 HEALTH FUND
(Restated Effective January 1, 2024)

Pursuant to the authority granted them by the Agreement and Declaration of the Trust, the Board of Trustees of the Sheet Metal Workers' Local No. 292 Health Fund have adopted a Plan and amended same from time to time. The Plan as in effect on January 1, 2012, was amended twelve times. The Board hereby restates the Fund's Plan effective January 1, 2024, incorporating all amendments to date.

PART I: DEFINITION OF TERMS

The following words and phrases shall have the following meanings when used in the Plan, unless a different meaning is plainly required by the context.

A. APPRENTICE

The term "Apprentice" shall have the same meaning as it does in the applicable Health Agreement.

B. ASSOCIATION

As used herein "Association" means the Associated Metal Fabricators and Engineers.

C. AVAILABLE FOR WORK

As used herein, "Available for Work" means registered on the Union's out-of-work list.

D. BLUE CROSS/BLUE SHIELD

The term "Blue Cross/Blue Shield" as used herein shall mean Blue Cross and Blue Shield of Michigan, with which the Fund has contracts of insurance for hospital, medical and surgical, prescription, dental and vision benefits.

E. CLASSIFIED WORKER

The term "Classified Worker" shall have the same meaning as it does in the applicable Health Agreement. Prior to April 1, 2015, this Plan referred to Classified Workers as Production.

F. COVERED EMPLOYMENT

As used herein, "Covered Employment" means work performed within the jurisdiction of the Union for a contributing Employer.

G. COVERAGE PERIOD

As used herein, "Coverage Period" means any period during which an Employee is eligible for the benefits provided by this Plan.

H. DEPENDENT

(1) The current lawful spouse of a Participant.

A spouse's Dependent status ends immediately upon divorce from the Participant. By enrolling a spouse for Dependent coverage, each Participant and their spouse agree that they each shall be personally liable to the Fund for any amounts the Fund pays in benefits for services rendered to or on behalf of the former spouse after the date of the entry of the judgment or decree of divorce but prior to notification to the Fund of the divorce, irrespective of whether such Participant continues to be eligible for benefits at the time of the Fund's discovery of the divorce, demand for repayment or at any time of reference.

(2) A child of a Participant, as defined immediately below, at the Participant's election, regardless of the child's marital status. A Participant's election to disenroll a child who was previously covered as a Dependent hereunder must be 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.

"Child" is defined herein as the Participant's biological sons and daughters, adopted children (including children placed for adoption) and step-children, prior to the last day of the calendar month in which such child reaches age twenty-six (26) years. No child shall be considered a Dependent under this Health 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 either from 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) years shall continue to be eligible as a Dependent for as long as the disability exists.

(3) A person who has not yet attained age eighteen (18) years of whom a Participant or spouse is named full legal guardian (other than a limited or temporary guardian). Notwithstanding the preceding sentence, a person who is not the child of a Participant or spouse shall not be a "Dependent" under this subsection unless (a) the parents of such child do not claim the child as a dependent for income tax purposes; and (b) the Participant or spouse's adjusted gross income is higher than the highest adjusted gross income of any of the person's parents. The Fund shall require proof that this requirement is satisfied prior to any individual being considered a Dependent hereunder.

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, physicians' statements, birth certificates, marriage certificates, qualified medical child support orders and judgments of divorce.

I. ELIGIBLE CHARGES

As used herein, "Eligible Charges" means those expenses described in Part VI-D, Part VI-E, Part VI-F and Part VI-G that are incurred by the Employee after the date of the commencement of the Employee's participation in the Plan during the Coverage Period. "Eligible Charges" also means those expenses described in Part VI-D, Part VI-E, Part VI-F and Part VI-G that are incurred by the Participant's Eligible Dependents during the Coverage Period.

J. ELIGIBLE DEPENDENT

As used herein, "Eligible Dependent" means any Dependent as described above who is eligible for benefits in accordance with the eligibility rules of the Fund adopted by the s as such rules may be in effect at the time of reference.

K. ELIGIBLE EMPLOYEE

As used herein, "Eligible Employee" means any Employee or former Employee of a contributing Employer who is eligible for benefits in accordance with the eligibility rules of the Fund as adopted by the Board of Trustees as such rules may be in effect at the time of reference.

L. ELIGIBLE PERSON

As used herein, "Eligible Person" means either an Eligible Employee or an Eligible Dependent.

M. EMPLOYEE

The term "Employee" shall mean:

(1) any person who is or has been employed by one or more Employer to perform tasks coming within the jurisdiction of the Union, and,

(2) any person employed by the Union, any board of trustees, committee or other agency established through collective bargaining by the Union and the Association to administer or be responsible for fringe benefit funds, educational or other programs, and whose Employer is required to remit contributions to the Fund in an amount determined by the Board of Trustees in conformity with the terms of a Health Agreement.

N. EMPLOYER

As used herein, an "Employer" shall mean:

(1) any member of the Association and any other individual, partnership, corporation or other business entity which uses or employs the services of individuals performing tasks coming within the work jurisdiction of the Union and which is legally obligated to contribute to the Fund on behalf of its Employees, and

(2) the Union or the Association when acting as an employer, solely for the purpose of making contributions on Employees of the Union or the Association, and

(3) any board of trustees, committee or other agency established to administer or be responsible for fringe benefit funds, educational or other programs established through collective bargaining by the Union and the Association, solely for the purpose of making contributions on Employees of the board of trustees, committee or other agency.

O. FUND

As used herein "Fund" means the Sheet Metal Workers Local Union No. 292 Health Fund.

P. HEALTH AGREEMENT

The term "Health Agreement" means any collective bargaining agreement or article thereof or other agreement which provides for Employer contributions to the Fund (or adopts, expressly or implicitly, a written agreement which so provides) and details the basis upon which such contributions are to be made and, with respect to Employees defined in Part I-K(2), the terms and conditions prescribed by the Board of Trustees for acceptance of such contributions.

Q. JOURNEYMAN

The term "Journeyman" shall have the same meaning as it does in the applicable "Health Agreement."

R. MEDICARE

The term "Medicare" as used herein shall mean Part A and Part B of Title XVIII of the Social Security Act Amendments of 1965 and any amendments thereto.

S. PARTICIPANT

As used herein, "Participant" means any Employee who has met the initial eligibility requirements set forth in Part II.

T. PLAN MANAGER

As used herein "Plan Manager" means the person appointed by the Board of Trustees to manage the day-to-day operation and administration of the Plan under the supervision of the Board of Trustees.

U. PLAN YEAR

As used herein, the "Plan Year" means the twelve-month accounting period of the Plan which begins on April 1 of each year and ends on March 31 of the following year.

V. PRONOUNS

Wherever used herein, masculine pronouns shall be deemed to include the feminine and vice versa and singular pronouns shall be deemed to include the plural wherever appropriate.

W. QUALIFIED MEDICAL CHILD SUPPORT ORDER

As used herein, "Qualified Medical Child Support Order" means a medical support order which:

(1) Creates or recognizes the existence of an alternate recipient's right to receive benefits for which an Eligible Dependent is eligible under this Plan, and

(2) Clearly specifies:

(a) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order,

(b) a reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient or the manner in which such type of coverage is to be determined,

(c) the period to which such order applies, and

(d) the legal name of this Fund.

X. RETIRED PARTICIPANT

As used herein, "Retired Participant" means any person who is eligible for benefits in accordance with the eligibility rules of the Fund adopted by the Board of Trustees set forth in Part II, Section M of this Plan, and as such rules may be in effect at the time of reference. The terms "Eligible Retiree" and "Retired Participant" are used interchangeably.

Y. SPOUSE

As used herein, "Spouse" means an individual who is legally married to an Active or Retired Participant. The designation of a Spouse as a Dependent or beneficiary of an Active or Retired Participant shall terminate immediately upon the entry of a judgment or decree of divorce between such Participant and his Spouse. A former Spouse shall be recognized as a beneficiary following the entry of such judgment or decree only if designated by the Participant as beneficiary after the entry of the judgment or decree on a form prescribed and furnished by the Board of Trustees.

Z. BOARD OF TRUSTEES

As used herein, "Board of Trustees" means the Board of Trustees of the Sheet Metal Workers Local No. 292 Health Fund.

AA. UNION

As used herein, "Union" means Local No. 292, Sheet Metal Workers' International Association, AFL-CIO.

PART II: ELIGIBILITY RULES

A. Hours of Covered Employment and Employer Contributions

Hours of Covered Employment are credited depending on the status of the Fund's reserves, as determined by the Plan Manager, as follows:

(1) During periods of time when the Fund has at least three months of reserves, an Employee shall be credited with one hour of Covered Employment for each hour for which the Fund receives the full hourly Employer contribution due under the terms of the Health Agreement under which the work was performed.

(2) During periods of time when the Fund has less than three months of reserves, an Employee shall be credited with one hour of Covered Employment for each hour for which the Fund receives the full hourly Employer contribution due under the terms of the Health Agreement under which the work was performed, multiplied by a fraction, the numerator of which is the hourly Employer contribution rate due under the terms of the Health Agreement under which the work was performed, and the denominator of which is the hourly Employer contribution rate applicable to journeymen, which fraction shall not exceed one.

B. Initial Eligibility

An Employee shall establish eligibility for benefits provided by the Fund when he or she is credited with at least 420 hours of Covered Employment and Employer contributions during any period of six consecutive months or less. If an Employee becomes disabled as a result of an injury compensable under Workers' Compensation before he establishes initial eligibility for benefits under

this Plan, the months during which the Employee receives Workers' Compensation benefits and is unable to work will be disregarded in the determination of the six consecutive months. This provision is intended to prevent the loss of hours of work and Employer contributions accrued toward initial eligibility by the Employee prior to injury such that those pre-injury hours and contributions may be considered after the Employee returns to work.

C. Date of Initial Eligibility

Because the Plan Manager does not receive the Employer's report of hours worked and Employer contributions until the month following the month in which the work was performed, the Participant shall not be eligible for coverage until the first day of the second month following the month in which he or she met the hours of Covered Employment and Employer contributions requirement.

D. Continuation of Eligibility

An Active Participant shall continue to be eligible for benefits under the Plan if he or she is credited with 140 hours of Covered Employment and Employer contributions each month. Continuing eligibility shall be effective on the first day of the third month following the month in which the foregoing requirement was met. If the number of hours of Covered Employment and Employer contributions received for a month is less than the required number of hours/contributions for continuation of eligibility, the number of hours/contributions needed to equal that number shall be withdrawn from the Participant's Hourly Reserve Bank.

E. Hourly Reserve Bank

The Fund shall maintain a record of hours of Covered Employment and Employer contributions received by the Fund for each Participant in excess of those required to establish or maintain such Participant's eligibility, which shall be that Participant's Hourly Reserve Bank. Notwithstanding the foregoing, the hours of Covered Employment and Employer contributions in any Participant's Hourly Reserve Bank shall never exceed 420.

F. Termination of Eligibility

A Participant's eligibility for benefits shall terminate on the last day of the month following the month in which the Participant is credited with fewer than the required number of hours of Covered Employment and Employer contributions for continuation of eligibility and does not have sufficient hours of Covered Employment and Employer contributions on deposit in his or her Hourly Reserve Bank to meet the requirements for continuation of eligibility, unless he or she elects to make self-payments in accordance with the provisions of Section G below. If the Participant elects to make self-payments, eligibility for benefits shall terminate if he or she fails to make a self-payment but no later than the last day of the sixth consecutive month of self-payment, unless the Participant elects COBRA continuation coverage, in which case payment, coverage and termination shall be governed by the provisions of Part IV of this Plan.

A Participant shall retain credit for any hours of Covered Employment and Employer contributions standing to his credit in his Hourly Reserve Bank at the time of termination for 12 months, after which his Hourly Reserve Bank will be terminated.

G. Self-Payment

When a Participant's eligibility would otherwise terminate, he or she may elect to maintain eligibility by making monthly self-payments to the Fund pursuant to the provisions on COBRA continuation coverage in which case payment, coverage and termination shall be governed by the provisions of Part IV of this Plan.

If the Participant is Available for Work and has exhausted the Participant's Hourly Reserve Bank, the Participant may elect, as an alternative to COBRA continuation coverage ("alternative coverage"), to pay a reduced self-pay rate for a period of time equal to the number of months of eligibility obtained by the Participant through use of the hours/contributions in the Participant's Hourly Reserve Bank during the Participant's most recent period of unemployment, and then to self-pay for additional months at a self-pay rate to be set by the Board of Trustees, such that the total period of alternative coverage shall not exceed six months. The benefits provided during the alternative coverage period are equivalent to that provided in conjunction with COBRA continuation coverage, with the exception that a Participant is eligible for Life Insurance Benefits and Accidental Death and Dismemberment Benefits during the initial period of self-payment, which is equal to the number of months of eligibility obtained by the Participant through use of the hours/contributions in the Participant's Hourly Reserve Bank during the Participant's most recent period of unemployment.

If, at any time while the Participant is maintaining eligibility through COBRA continuation coverage or alternative coverage, the Participant elects not to make self-payments and, as a result, his or her eligibility is terminated, he or she shall not again be eligible to make self-payments until such time as the requirements for reinstatement of eligibility have been met or eligibility is re-established.

The Fund Plan Manager shall issue a notice to the Participant at the last address on file with the Fund Plan Manager that he or she has the option to elect self-payments through COBRA continuation coverage and/or alternative coverage when his or her eligibility for benefits is about to terminate. The notice will specify a date by which the first such payment must be received at the Fund Plan Manager's office and the amount of payment required. If a Participant elects to continue coverage through COBRA continuation coverage or alternative coverage, the Fund Plan Manager shall send him a notice for each month he is eligible to make self-payments.

The rates for COBRA continuation coverage and alternative coverage are determined by the Board of Trustees, but shall not be in excess of the permissible maximum rates established by law.

H. Reinstatement of Eligibility

A Participant whose eligibility has terminated may, within twelve months of the effective date of that termination, reinstate his or her eligibility for benefits if he is credited with enough hours of Covered Employment and Employer contributions in a month which, when added to any unused hours/contributions in his or her Hourly Reserve Bank, equal or exceed 140 hours of Covered Employment and Employer contributions. Eligibility for benefits will be reinstated on the first day of the third month following the month in which the work is performed for which Employer contributions are received.

I. Re-establishment of Eligibility

A Participant whose eligibility was terminated and not reinstated within twelve months of termination will again be eligible for benefits only after once more meeting the requirements for initial eligibility.

J. Extended Eligibility Due to Disability

If, while eligible for benefits as described below, a Participant becomes disabled and unemployable as a result of an illness or injury, either on or off the job, his or her eligibility for all benefits will be continued without self-payment and without withdrawing any hours from his or her Hourly Reserve Bank for a maximum period of six consecutive months following the month in which disability commences, provided that disability continues during that period. If the disability lasts the full six-month period, hours will thereafter be withdrawn as needed from the Participant's Hourly Reserve Bank to continue eligibility.

Only participants who are eligible because of work performed and Employer contributions received on their behalf, withdrawal of hours from his or her Hourly Reserve Banks or self-payment for alternative coverage under Part II, Section G may qualify for extended eligibility due to disability. Retired Participants and Participants who have elected COBRA continuation coverage under Part IV may not qualify for extended eligibility due to disability.

Disability due to pregnancy is normally considered to be for a period running from six weeks prior to the due date to six weeks after the delivery date without the requirement of further medical proof beyond the due date for the birth of the child and the date of the birth of the child. If additional weeks of extended eligibility due to disability is sought (up to the six-month maximum), the Active Participant shall provide medical documentation of disability as defined herein for those additional weeks.

A Participant shall be entitled to disability eligibility only after submitting satisfactory evidence of such disability, as determined by the Board of Trustees, to the Fund Plan Manager. Such evidence must be in the form of a written opinion signed by a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.).

Disability eligibility shall be effective beginning with the month in which the disability commences. Any hours worked in Covered Employment and Employer contributions received during that month on behalf of such Participant shall be deposited in the Participant's Hourly Reserve Bank, subject to the applicable hour/contribution maximum, or, if such hours and contributions would bring this Hourly Reserve Bank above the applicable hour/contribution maximum, they may be applied to satisfy the hour/contribution requirement for the first month in which he returns to Covered Employment.

K. Eligibility of Dependents

At the Participant's election, a Participant's Dependents are eligible for dependent benefits at any time during which the Participant is eligible for benefits. The only exceptions are (1) when a Dependent enters the armed forces of any country or when a Dependent becomes eligible for coverage as a Participant, in which cases the Dependent's eligibility for benefits terminates or (2) when a Retired Participant or a Participant continuing coverage under Part IV of the Plan (COBRA

coverage) elects not to cover his or her Dependents and the Dependent does not pay for individual continuation coverage.

A Participant may enroll a new Dependent for coverage under the Plan by giving notice to the Fund Plan Manager within thirty days of the date such person becomes a Dependent. If the Participant fails to give notice within thirty days, the Dependent shall not be eligible for coverage before the first day of the month following the month within which notice is received by the Fund. If a Participant seeks to re-enroll a Dependent child whom the Participant previously elected to disenroll, then the Dependent child shall be eligible for coverage as soon as administratively feasible, but not before the first day of the month following the month within which the election is received by the Fund.

Eligibility for benefits for a Participant's Dependents shall terminate when the person is no longer a Dependent under the terms of the Plan or, if earlier, at the same time as the Participant's eligibility terminates.

L. Eligibility of Retired Participants

1. Eligibility Requirements

If, at the time an Eligible Employee begins receiving benefits from the Sheet Metal Workers Local No. 292 Pension Fund, the Employee satisfies the eligibility requirements set forth in this Part II-M, he or she shall be allowed a one-time only opportunity to elect to continue coverage for certain benefits under this Fund by means of monthly self-payments. This election must be made within 30 days after the effective date of benefits from the Pension Fund or, if applicable, within 30 days after the Eligible Employee's Hourly Reserve Bank is exhausted. If the Eligible Employee does not elect to enroll in retiree coverage within the applicable prescribed time, he or she may not elect to enroll in retiree coverage under this Plan unless he or she complies with the requirements for Special Delayed Enrollment described in this Part II-M, or returns to Covered Employment and reinstates eligibility under Part II-I of this Plan, or re-establishes eligibility under Part II-J of this Plan.

When an Eligible Employee begins receiving benefits from the Sheet Metal Workers Local No. 292 Pension Fund, he or she shall be entitled to continue coverage by use of the Retired Participant's Hourly Reserve Bank, if any, until it falls below 140 hours/contributions.

An individual receiving benefits from the Sheet Metal Workers Local No. 292 Pension Fund must satisfy all of the following eligibility requirements in order to be eligible for retiree coverage from this Fund:

(a) The Retired Participant must be eligible for benefits under this Plan on the effective date of his or her retirement from the Sheet Metal Workers Local No. 292 Pension Fund as a Normal or Early Retiree or on the effective date of his or her disability benefits from the Sheet Metal Workers Local No. 292 Pension Fund, and for at least one month during the 24 months preceding that date (Eligibility based on hours and employer contributions (Part II-D), use of the Hourly Reserve Bank (Part II-E) or based on Self-Payment for alternative coverage (Part II-H) is considered eligible for benefits for this purpose. Eligibility under COBRA Continuation Coverage (Part IV) is not considered eligible for this purpose.); and

(b) The Retired Participant must have 2,500 hours of work and employer contributions in the five (5) consecutive years, or 5,000 hours of work and employer contributions in the ten (10) consecutive years, immediately preceding the effective date of his or her benefits from the Sheet Metal Workers Local No. 292 Pension Fund. (Eligibility based on hours and employer contributions (Part II-D), use of the Hourly Reserve Bank (Part II-E), based on Self-Payment for alternative coverage (Part II-H), based on Extended Eligibility Due to Disability (Part II-K) or based on Eligibility While in Military Service (Part II-O) is considered eligible for benefits for this purpose. Eligibility under COBRA Continuation Coverage (Part IV) is not considered eligible for this purpose.); and

(c) The Retired Participant must have accrued at least 10 Credit Years with the Sheet Metal Workers Local No. 292 Pension Fund;

(d) The Retired Participant must be eligible for the Medicare Supplement from the Sheet Metal Workers National Pension Fund (or would be upon reaching Medicare eligibility age), but for any limitation or exclusion based on the current employer contribution rate to that Fund; and

(e) The Retired Participant must remit a monthly self-payment in an amount determined by the Board of Trustees, which may be adjusted from time to time.

All Retired Participants and spouses of Retired Participants covered under this Plan who are eligible for Medicare must participate in both Medicare Parts A and B.

The medical, hospital surgical and prescription drug benefits provided by the Fund to all Retired Participants (both Medicare-eligible and non-Medicare-eligible) and their dependents shall be determined in the sole discretion of the Board of Trustees and may be provided on a self-insured basis, an insured basis, or a combination of self-insured and insured. To the extent any benefits are provided pursuant to one or more agreement or policy of insurance, such agreements/policies of insurance are incorporated by reference as if printed verbatim herein, as they may be changed from time to time.

The Fund does not provide Retired Participants with Life Insurance benefits for Dependents (Part VI-A), Accidental Death and Dismemberment benefits (Part VI-B), Loss-of-Time benefits (Part VI-C).

2. Retiree Special Delayed Enrollment

A Retired Participant who has health care coverage available through his/her spouse's employer who otherwise meets all requirements for retiree coverage as set out in this Part II-M may elect to delay or temporarily terminate his/her retiree coverage ("retiree opt-out"). A retiree opt-out will only be permitted once for each Retired Participant. A Retired Participant may exercise the retiree opt-out by submitting a written request to the Fund Office. The effective date of the retiree opt-out shall be the first day of the calendar month next following the date on which the written request for the retiree opt-out is received by the Fund Office.

The Retired Participant will be permitted to enroll (or re-enroll, as the case may be) in retiree coverage under this Plan only if the Retired Participant applies for enrollment (or re-enrollment) in retiree coverage within 30 days of the date on which such other coverage terminates. The effective date of the retiree's enrollment or re-enrollment date shall be the first day of the calendar month next following the date on which the Retired Participant's written request to re-enroll is received by the Fund Office. In order to re-enroll after exercising the retiree opt-out, the Retired Participant must present written proof that s/he was continuously covered under his/her spouse's employer's plan from the date of the retiree opt-out until no more than 30 days prior to the date on which the request for enrollment or re-enrollment was received.

3. Spouse Special Delayed Enrollment

A. Spousal Opt-Out

If the spouse of a Retired Participant who is covered as a dependent under this Plan has or obtains health care coverage through such spouse's employer, the Retired Participant may request to continue coverage only for the Retired Participant, and remove his/her spouse from coverage ("spousal opt-out"). A spousal opt-out will only be permitted once for each Retired Participant. A Retired Participant may exercise the spousal opt-out by submitting a written request to the Fund Office. The effective date of the spousal opt-out shall be the first day of the calendar month next following the date on which the written request for spousal opt-out is received by the Fund Office.

The Retired Participant may subsequently re-enroll his spouse for whom he has exercised the spousal opt-out if the Fund Office receives from the Retired Participant, no later than 30 days after the date on which the spouse's coverage under his/her employer-provided group health care plan terminates, a written request to re-enroll the spouse. The effective date of the spouse's re-enrollment shall be the first day of the calendar month next following the date on which the Retired Participant's written request to re-enroll his/her spouse is received by the Fund Office. In order to re-enroll an eligible spouse after exercising the spousal opt-out, the Retired Participant must continue to be covered by this Plan, and the Retired Participant must present written proof that the spouse was continuously covered under his/her employer's plan from the date of the spousal opt-out election until no more than 30 days prior to the date on which the request for re-enrollment was received.

B. Post-Retirement Marriage

If the Retired Participant is not married at the time of retirement and subsequently marries, or was married at the time of retirement and, following divorce or the death of his or her spouse after retirement, remarries, the Retired Participant may apply to enroll his/her new spouse in retiree coverage within 30 days after the date of the marriage. Evidence of such marriage will be required.

4. Return to Covered Employment by Retiree

A Retired Participant is not eligible to make self-payments at the retiree rate for any month in which the Retired Participant works more than 40 hours in covered employment. However, the Retired Participant may maintain eligibility by making self-payments at a rate to be determined by the Board of Trustees until the Retired Participant reinstates eligibility under Part II-I of this Plan, re-establishes eligibility under Part II-J of this Plan or works less than 40 hours per month in covered employment. If the Retired Participant subsequently works less than 40 hours per month in covered

employment, the Retired Participant must resume making self-payments at the full retiree rate to maintain eligibility.

5. Termination of Retiree Coverage

Eligibility for benefits for a Retired Participant and the Retired Participant's Dependents shall terminate upon the earliest of the following

(a) when the Retired Participant fails to make a required self-payment in full and when due,

(b) when the Retired Participant reinstates eligibility under Part II-H or re-establishes eligibility under Part II-I of this Plan, or

(c) when the Plan is amended to no longer provide for retiree coverage.

Eligibility for Prescription Drug Benefits for Medicare-eligible Retired Participants or Medicare-eligible spouses of Retired Participants shall terminate upon enrollment in a Medicare Part D prescription drug plan.

M. Eligibility of Surviving Spouses and Dependent Children When Participant Dies

1. Active Participants (ineligible for retirement) with at least five years of continuous participation

If an Active Participant who has been covered by the Fund for at least the five immediately preceding years without break and who is neither eligible for nor receiving benefits for the Sheet Metal Workers Local Union No. 292 Pension Fund dies, his or her surviving spouse and Dependent children shall continue to be eligible for coverage hereunder until the deceased Active Participant's Hourly Reserve Bank, if any, falls below the required number of hours/contributions for continuation of eligibility

Thereafter, the surviving spouse and Dependent children may continue coverage after the exhaustion of the deceased Active Participant's Hourly Reserve Bank for certain benefits under this Fund by means of self-payment. This election must be made within 30 days after the later of the following dates:

A. the date of the deceased Active Participant's death; or

B. the date the deceased Active Participant's Hourly Reserve Bank, if any, falls below the required number of hours/contributions for continuation of eligibility.

If a surviving spouse and/or Dependent children notify the Fund Office within 30 days of the above date that they are declining this coverage because they have other insurance, they may enroll later if they wish, provided they do so within 30 days of such other insurance terminating (for Dependent children, providing also that they continue to meet the Plan's definition of "Dependent"). Proof of the other insurance and its termination date will be required for re-enrollment.

Self-payments must begin for the month that the deceased Active Participant would have become ineligible (or the first month after the health insurance covering the surviving spouse and

dependent children terminated). If the surviving spouse continues to make the required self-payments when due, the spouse and any Dependent children of the deceased Active Participant (including children of a male deceased Active Participant born to his surviving spouse within nine months after his death), coverage will continue until, as applicable:

A. the surviving spouse remarries;

B. the surviving spouse or child becomes eligible under another group health care plan; or

C. the Dependent child no longer meets the Plan's definition of a "Dependent".

The self-payment rates will be determined by the Board of Trustees from time to time in the exercise of its sole and exclusive discretion, and it may consider the Fund's experience, Medicare coverage, Dependent coverage, and such other factors as the Board determines are appropriate. A surviving spouse who is eligible for Medicare must participate in both Medicare Parts A and B. The Fund will not pay any expense which would normally be paid by Medicare, except Prescription Drug expenses for surviving spouses who do not enroll in a Medicare Part D prescription drug plan, and the Fund will not cover any expense which is not covered by Medicare for Medicare-eligible surviving spouses.

If the surviving spouse and/or Dependent children elect not to maintain coverage under these provisions, then they may continue coverage pursuant to and subject to all provisions regarding COBRA for 36 months under the terms of COBRA at the monthly COBRA rates then applicable. If coverage under the above provisions is elected and children lose coverage because they no longer meet the Plan's definition of a "Dependent", they may also continue coverage pursuant to and subject to all provisions regarding COBRA for an additional 36 months at the monthly COBRA rates then applicable.

2. Active Participants (ineligible for retirement) with fewer than five years of continuous participation

If an Active Participant who has not been covered by the Fund for at least the five immediately preceding years without break and who is neither eligible for nor receiving benefits for the Sheet Metal Workers Local Union No. 292 Pension Fund dies while eligible hereunder, his or her surviving spouse and Dependent children shall continue to be eligible for coverage hereunder until the deceased Active Participant's Hourly Reserve Bank, if any, falls below the required number of hours/contributions for continuation of eligibility.

Thereafter, the surviving spouse and Dependent children may continue coverage hereunder for up to an additional six months only at the self-payment rate established by the Board of Trustees and for a further 36 months under the provisions of COBRA at the then applicable COBRA rate. Such payments must begin with the month that the deceased Active Participant would have become ineligible. If during the six months of coverage at the self-payment rate, a child no longer meets the Plan's definition of a "Dependent", he may continue coverage pursuant to and subject to all provisions regarding COBRA for an additional 36 months at the monthly COBRA rates then applicable.

If the surviving spouse or Dependent children become covered by another health care plan before the time periods above expire, coverage under this Plan will terminate at that time.

3. Retired Participants or Participants Eligible to Retire

If, at the time of death, (a) an Active Participant was eligible to retire under the normal or early retirement provisions of the Sheet Metal Workers Local Union No. 292 Pension Fund and had been eligible under this Fund through Employer contributions for at least one month during the twenty-four months immediately preceding his death or (b) a Retired Participant was receiving normal or early retirement from the Pension Fund and was eligible hereunder or (c) a Participant was receiving disability retirement benefits from the Sheet Metal Workers Local Union No. 292 Pension Fund, his or her surviving spouse and Dependent children shall continue to be eligible for continued coverage hereunder until the deceased Active or Retired Participant's Hourly Reserve Bank, if any, falls below the required number of hours/contributions for continuation of eligibility.

Thereafter, the surviving spouse and Dependent children may continue coverage after the exhaustion of the deceased Active Participant's Hourly Reserve Bank for certain benefits under this Fund by means of self-payment. This election must be made within 30 days after the later of the following dates:

A. the date of the deceased Active Participant's death; or

B. the date the deceased Active Participant's Hourly Reserve Bank, if any, falls below the required number of hours/contributions for continuation of eligibility.

If a surviving spouse and/or Dependent children notify the Fund Office within 30 days of the above date that they are declining this coverage because they have other insurance, they may enroll later if they wish provided they do so within 30 days of such other insurance terminating (for Dependent children, providing also that they continue to meet the Plan's definition of "Dependent"). Proof of the other insurance and its termination date will be required for re-enrollment.

Such payments must begin with the month that the deceased Active Participant or Retired Participant would have become ineligible (or the first month after the health insurance covering the surviving spouse and Dependent children terminated). If the surviving spouse continues to make the required self-payments when due, the spouse and any Dependent children (including children of a male deceased Active Participant born to his surviving spouse within nine months after his death) will continue to be covered hereunder until, as applicable:

A. the surviving spouse remarries;

B. the surviving spouse or child becomes eligible under another group health care plan; or

C. the Dependent child no longer meets the Plan's definition of a "Dependent".

The self-payment rates will be determined by the Board of Trustees from time to time in the exercise of its sole and exclusive discretion, and it may consider the Fund's experience, Medicare coverage, Dependent coverage, and such other factors as the Board determines are appropriate. A

surviving spouse who is eligible for Medicare must participate in both Medicare Parts A and B. The Fund will not pay any expense which would normally be paid by Medicare, except Prescription Drug expenses for surviving spouses who do not enroll in a Medicare Part D prescription drug plan, and the Fund will not cover any expense which is not covered by Medicare for Medicare-eligible surviving spouses.

If the surviving spouse and/or Dependent children elect not to maintain coverage under these provisions, then they may continue coverage pursuant to and subject to all provisions regarding COBRA for 36 months under the terms of COBRA at the monthly COBRA rates then applicable. If coverage under the above provisions is elected and children lose coverage because they no longer meet the Plan's definition of a "Dependent" may continue, they may also continue coverage pursuant to and subject to all provisions regarding COBRA for an additional 36 months at the monthly COBRA rates then applicable.

N. Eligibility While in Military Service

An Active Participant who leaves covered employment to enter service in the Armed Forces or other Uniformed Services of the United States (hereinafter "Services") may elect to continue coverage for all benefits under the Plan except Life Insurance Benefits, Accidental Death and Dismemberment Benefits and Loss-of-Time Benefits, for a period which is the lesser of (a) the 24 month period beginning the last day of Covered Employment, or (b) the period of the Employee's service in the Services plus 90 days. An Active Participant who elects to continue coverage shall be charged a monthly self-payment not to exceed 102% of the Fund's costs to maintain coverage for himself and his Dependents, unless his period of service is less than 31 days, in which case he will receive coverage at no cost to him. An Active Participant may if he wishes use hours/contributions in his Hourly Reserve Bank in lieu of making self-payments for as long as he has sufficient hours/ contributions in his Hourly Reserve Bank to continue his coverage hereunder. In the alternative, a Participant may discontinue his coverage upon entry into the Services and elect to freeze his Hourly Reserve Bank for use upon discharge (unless the period of his service exceeds five (5) years).

If the Participant returns to covered employment or registers on the Union's Out-of-Work list within 90 days of his discharge under honorable conditions from the Services or within 24 months if he is recovering from an illness or injury incurred during or aggravated by his service in the Services, he will not be required to satisfy the Plan's initial eligibility requirements unless the period of service exceeds five (5) years, in which case initial eligibility requirements must be satisfied before coverage begins.

O. Reciprocity

The Board of Trustees has the authority to enter into reciprocity agreements with other health and welfare funds covering sheet metal workers throughout the country. Pursuant to these reciprocity agreements, hours and contributions on behalf of an employee may be transferred from one fund to another upon the written request and authorization of the employee to be credited toward meeting the continuing eligibility requirements of the recipient fund. Because of variances in contribution rates between funds, it is possible that even though the number of hours worked in another jurisdiction would be sufficient for an employee to continue eligibility under this Fund, the amount of contributions associated with those hours may not meet the continuing eligibility requirements of this Fund where

the contribution rate to the other Fund is less than the contribution rate to this Fund. In such a case, an employee may be required to pay the difference in order to continue his eligibility in this Fund.

P. Additional Special Enrollment Provisions

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

(A) 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

(B) 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.

PART III: 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 to employees who have worked for their employer (1) for at least 12 months and (2) for at least 1,250 hours in the 12 months before the leave starts and if the employer (1) is covered by the Act and (2) has at least 50 employees within 75 miles of where the employee works. Whether any employee or any employer is eligible for family or medical leave is determined by the employer, and not by the Fund or the Board of Trustees. Upon receipt of notice to the Fund together with certain other information as required by the Board of Trustees, coverage will be continued during the period of the family or medical leave, provided the employer makes contributions to the Fund at the same rate and in the same amount as if the employee were continuously employed during the period of the leave and fully complies with all other requirements established by the Board of Trustees.

PART IV: CONTINUATION COVERAGE

A. RIGHTS OF EMPLOYEES TO CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA), when an Eligible Employee's coverage hereunder terminates because he has not met the continuing eligibility requirements of Part II-D, he may elect to maintain eligibility by making monthly self-payments to the Fund for up to eighteen (18) consecutive months. The monthly self-payments will result in his maintaining eligibility for all benefits except Loss-of-Time Benefits and Life Insurance Benefits.

If the Employee or any of the Employee's Dependents is determined to be eligible to receive Social Security disability benefits when his eligibility terminates or within 60 days of that date, he may elect to continue coverage by making monthly self-payments for up to twenty-nine (29)

consecutive months. The Employee must notify the Fund of Social Security's determination within 60 days of its issuance and within the 18-month COBRA period. If at any time during this period, the required monthly self-payment is not received, his eligibility will be terminated and he shall not be eligible again until such time as he has met the requirements for re-establishment of eligibility pursuant to Part II-I.

B. RIGHTS OF DEPENDENTS TO CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA), when an eligible Dependent's coverage terminates because the Employee has not met the continuing eligibility requirements of Part II-C, because of the death or divorce of the Participant or because that Dependent child no longer meets the meets the definition of Dependent under the Plan, such Dependent shall have the right to continue coverage. Notwithstanding the foregoing, a Dependent's right to elect continuation coverage in the event of divorce of the Participant shall terminate unless the Fund receives a copy of the judgment or decree of divorce within 60 days after the date of its entry by the Court. Children born to, adopted by or placed for adoption with a Participant during his COBRA continuation period have the same right to elect continuation coverage as other Dependent children who no longer qualify as eligible Dependents, so long as the Fund receives notice of that birth, adoption or placement for adoption within 30 days.

Dependents who lose coverage because the Employee has not met the continuing eligibility requirements of Part II-C may continue coverage hereunder for up to eighteen (18) consecutive months by payment of a monthly self-payment. However, if the Employee becomes entitled to Medicare before he has not met the continuing eligibility requirements of Part II-C, Dependents may continue coverage hereunder for the greater of either a) 36 months from the date of the Employee's Medicare entitlement, or b) 18 months from the date the Employee has not met the continuing eligibility requirements of Part II-C. If a second event occurs which would qualify a Dependent for COBRA coverage during this eighteen (18) month period of COBRA coverage, the Dependent may continue coverage for up to 36 months from the date of the initial loss of coverage. If the Employee or any of the Employee's Dependents is determined to be eligible to receive Social Security disability benefits at the time his eligibility terminates or within 60 days of that date, the Dependent may elect to continue coverage by making monthly self-payments for up to twenty-nine (29) consecutive months from the date of the initial loss of coverage. A Dependent who loses coverage as a result of the death or divorce of the Employee or a Dependent child who no longer meets the definition of Dependent under the Plan may continue coverage for up to thirty-six (36) consecutive months by payment of a monthly self-payment.

C. SELF-PAYMENT AMOUNT

The self-payment amount shall be set by the Board of Trustees, may be adjusted by then from time to time, and shall not exceed 102% of the Fund's actual cost for coverage, except that for coverage from the 19th through the 29th month based on the Employee or any of the Employee's Dependents determination to be eligible to receive Social Security disability, the monthly self-payment amount shall not exceed 150% of the Fund's actual cost for coverage.

D. TERMINATION OF COBRA COVERAGE

COBRA continuation coverage will terminate at the earlier of the date on which:

1. The Fund no longer provides coverage for similarly situated persons.

2. Payment for continuation coverage is not received by the Fund in a timely fashion.

3. The Employee or the Dependent becomes covered under another group health plan that does not include a preexisting conditions clause that applies to the Employee or the Dependent.

4. The Employee or the Dependent is receiving COBRA continuation coverage because either the Employee or a Dependent are disabled as defined under the Social Security Act and Social Security determines that this person is no longer disabled.

5. The Employee becomes entitled to Medicare benefits. However, the Employee's entitlement to Medicare is a second event which would qualify a Dependent for COBRA coverage for up to 36 months from the date of the initial loss of coverage.

6. Written notice is received that the Employee or the Dependent wishes to discontinue COBRA continuation coverage.

7. The end of the 18, 29 or 36 month COBRA period, as set out above, after which the Employee or the Dependent will be allowed to enroll in an individual conversion health plan provided under the Plan if the Plan then provides for such conversion.

PART V: QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan shall provide benefits in accordance with any valid order of a court determined by the Board of Trustees to be a Qualified Medical Child Support Order under applicable federal law which creates or recognizes the right of an alternate recipient to benefits as an Eligible Dependent under the Plan, but only to the extent provided in such order and allowed by federal law.

PART VI: SCHEDULE OF BENEFITS

A. LIFE INSURANCE

Upon application in a form satisfactory to the Board of Trustees and the insurer, accompanied by proof of death acceptable to them, and subject to all terms, conditions, requirements and limitations of the life insurance policy, a life insurance benefit shall be paid upon the death of an Active Participant and certain Retirees and Dependents. The amount of the benefit and all other terms, conditions, requirements and limitations of the life insurance benefit, including the conditions and requirements for Participants and Retirees to obtain a conversion policy in the event of termination of the Fund's life insurance benefit, are as set forth in the policies of insurance, which are incorporated by reference as if printed verbatim herein.

A Participant could also be eligible to receive a lump sum accelerated life insurance benefit. The amount of the benefit and all other terms, conditions, requirements and limitations of the accelerated life insurance benefit are as set forth in the policies of insurance, which are incorporated by reference as if printed verbatim herein.

B. ACCIDENTAL DEATH AND DISMEMBERMENT FOR PARTICIPANTS

Upon application in a form satisfactory to the Board of Trustees and the insurer, accompanied by proof of loss acceptable to them, and subject to all terms, conditions, requirements and limitations of the insurance policy, an Accidental Death and Dismemberment benefit shall be paid upon a covered loss by an Active Participant. The amount of the benefit and all other terms, conditions, exclusions and requirements of this benefit, including the schedule of losses, are provided in the Fund's policy(ies) with the service provider insuring this benefit, which are incorporated by reference as if printed verbatim herein.

C. LOSS-OF-TIME BENEFITS

1. Weekly Benefits

If an Active Participant is wholly and continuously disabled and unemployable as a result of non-occupational illness or injury on the date he becomes eligible and remains disabled after the date of eligibility or if an Active Participant becomes wholly and continuously disabled and unemployable as a result of non-occupational illness or injury, the Active Participant shall be entitled to a weekly Loss-of-Time benefit in the amount shown below for a period of twenty-six (26) continuous weeks or the period of his disability, whichever is shorter.

WEEKLY BENEFIT FOR JOURNEYMEN AND CLASSIFIED WORKERS	
Journeyman	$600
Classified Worker A	$432
Classified Worker B	$390
Classified Worker C	$300

WEEKLY BENEFIT FOR APPRENTICES	
Apprentice 8th Semester	$480
Apprentice 7th Semester	$450
Apprentice 6th Semester	$420
Apprentice 5th Semester	$390
Apprentice 4th Semester	$360
Apprentice 3rd Semester	$330
Apprentice 2nd Semester	$300
Apprentice 1st Semester	$270

Notwithstanding the foregoing, an Apprentice who is receiving a base wage rate that is the rate for a Classified Worker A, B or C will receive a weekly benefit equivalent to that corresponding to the Classified Worker A, B or C, respectively, if that weekly benefit is higher than the weekly benefit payable to such Apprentice based on his semester/level. For example, an Apprentice who is in the 6th Semester and is being paid at the Classified Worker A rate will receive the weekly benefit payable to a Classified Worker A ($432) rather than the weekly benefit payable to an Apprentice 6th Semester ($420).

Loss-of-Time Benefits for disability due to the pregnancy of an Active Participant will be paid for the period six weeks prior to the due date to six weeks after the delivery date without the

requirement of further medical proof beyond the due date for the birth of the child and the date of birth of the child. If additional weeks of Loss-of-Time Benefits are sought (up to the twenty-six (26) continuous week maximum), the Active Participant shall provide medical documentation of disability as defined herein for those additional weeks.

If the Participant is unable to work because he is receiving in-patient substance abuse treatment, the Participant shall be entitled to a weekly Loss-of-Time benefit of 100% of the amount shown above for the first period of treatment and 75% of the amount shown above for the second period of treatment, for a period of twenty-six (26) continuous weeks or the period of disability, whichever is shorter. No Loss-of-Time benefits are payable for the third or any subsequent period of treatment.

Payment for any one payable day of disability benefits is 1/7th of the weekly benefit amount.

2. Commencement of Benefits

Benefits shall commence on the first day of disability due to an injury and on the eighth day of disability due to an illness, including pregnancy; provided, however, that benefits shall commence on the first day of disability due to an illness that results in either in-patient or out-patient hospitalization. Benefits shall commence on the eighth day of the first period of in-patient substance abuse treatment, and on the fifth day of the second period of in-patient substance abuse treatment.

A Loss-of-Time form must be filed with the Fund Plan Manager before benefits will be paid hereunder.

3. Limitation on Benefits Payable

Under no circumstances may a Participant be eligible for more than one twenty-six week period of loss of time benefits due to the same illness or injury.

4. Eligibility for Benefit

Benefits are payable only when the loss is sustained by a Participant who is eligible because of Employer contributions or by withdrawal of hours and contributions from his or her Hourly Reserve Bank.

Dependents, retirees and Participants maintaining eligibility by self-payment are not eligible for Loss-of-Time benefits.

5. Administration

The Fund is the Employer's agent for purposes of the payment of employment taxes on Loss-of-Time benefits as set forth in Treasury Regulation '31.6051-3.

D. MEDICAL, HOSPITAL AND SURGICAL BENEFITS

The Medical, Hospital and Surgical benefits provided by the Fund to Participants, pre-Medicare Retirees, and Dependents are set forth in the schedules of benefits in the Fund's agreement with Blue Cross/Blue Shield, which are incorporated by reference as if printed verbatim herein.

The Medical, Hospital and Surgical Benefits provided by the Fund to Medicare Eligible Retirees and their Medicare Eligible Dependents shall be set forth in the schedules of benefits set forth in the Fund's agreements with Humana and subject to the limitations and exclusions set forth therein, which agreements are incorporated by reference as if printed verbatim herein.

E. PRESCRIPTION DRUGS

The Prescription Drugs benefit provided by the Fund to Participants, pre-Medicare Retirees, and Dependents shall be set forth in the schedules of benefits set forth in the Fund's agreements with Blue Cross/Blue Shield and subject to the limitations and exclusions set forth therein, which agreements are incorporated by reference as if printed verbatim herein.

The Prescription Drugs benefit provided by the Fund to Medicare Eligible Retirees and their Medicare Eligible Dependents shall be set forth in the schedules of benefits set forth in the Fund's agreements with Humana and subject to the limitations and exclusions set forth therein, which agreements are incorporated by reference as if printed verbatim herein.

F. WELLNESS PROMOTION

1. Benefit

The Fund will reimburse to Participants the lesser of the full annual cost per family or $100 per year per family to offset the cost of membership in one gym/health club facility upon receipt of proof of payment in full for a one year membership and execution of a form indemnifying the Fund from any claims arising in connection therewith as set out in detail in section 3 below. A maximum of $100 per purchase is reimbursable hereunder, irrespective of the number of years of the membership purchased. For example, a five-year membership costing $500 purchased on June 1, 2000 will be reimbursed in a one-time amount of $100 only, and will not be reimbursed at $500 or at $100 per year for five years.

2. Eligibility

This benefit is available to Active Participants and Retired Participants only, not to dependents, surviving spouses or Disabled Participants.

3. Responsibility of Eligible Employee and Retired Participants and Indemnification of Fund

Provision of this benefit by the Fund is in no way to be considered an indication that any individual is physically able to participate in exercise. It is the sole and exclusive responsibility of any Active or Retired Participant or dependent who uses this benefit and participates in activities at the gym/health club to ascertain whether s/he is physically able to do so. The Fund will not be liable for any condition or injury arising directly or indirectly from participation in activities at any gym/health club the cost of membership in which was fully or partially reimbursed by the Fund. As a condition of reimbursement, the Active or Retired Participant will be required to execute a document setting out the foregoing waiver of all claims and hold the Fund harmless from any liability arising therefrom.

G. DENTAL

The Dental benefit provided by the Fund to Active Participants, pre-Medicare Retirees, and their Dependents shall be set forth in the schedules of benefits set forth in the Fund's agreements with Blue Cross/Blue Shield and subject to the limitations and exclusions set forth therein, which agreements are incorporated by reference as if printed verbatim herein. Dental Benefits are provided through Blue Dental PPO network. With Blue Dental PPO, an Eligible Person can select any licensed dentist anywhere. However, it will be more cost effective if a dentist who is a member of the Blue Dental PPO network is utilized. The program allows up to $1,000 of dental benefits per Eligible Person per calendar year. Orthodontic services are not covered.

H. VISION

The Vision benefit provided by the Fund to Active Participants, pre-Medicare Retirees, and their Dependents shall be set forth in the schedules of benefits set forth in the Fund's agreements with Blue Cross/Blue Shield and subject to the limitations and exclusions set forth therein, which agreements are incorporated by reference as if printed verbatim herein. Vision benefits are provided by Vision Service Plan (VSP), which is an independent company providing vision benefit services for BCBSM members. Coverage is provided for expenses incurred for eye examinations, eyeglass lenses, eyeglass frames and contact lenses, subject to copays and maximum allowances. Copays for a VSP network provider are as follows:

- Eye Exams - $10 Copay
- Lenses and/or Frames - combined $10 copay with $130 allowance on frames
- Medically necessary contacts - $10 copay
- Elective contacts - $130 allowance applied toward contact lens exam and the lenses.

The Fund will not be responsible for any additional costs charged if a non-VSP network provider is used.

PART VII: HEALTH REIMBURSEMENT ARRANGEMENT

A. Establishment of Health Reimbursement Arrangement

The Trustees shall establish a Health Reimbursement Arrangement (HRA) account as a bookkeeping account that will be established for each active eligible Participant, which the Participant, his surviving spouse and his Dependents may use to pay for incurred expenses described in Part VII-B below. The HRA account will be credited with a portion of the employer contribution, based on hours worked and employer contributions received, at a rate determined by the Board of Trustees. In addition, to get the HRA started, the Fund will credit all accounts with a one-time initial deposit as follows:

1. Journeymen and Apprentice participants:

    a. HRA credit of $1.05/per hour worked with employer contributions received.

    b. November 1, 2009: A one-time credit of $500 single, $1,000 two-party or family

2. Classified Workers:

   a. HRA credit of $0.75/per hour worked with employer contributions received.

   b. November 1, 2009: A one-time credit of $350 single, $750 two-party or family

3. Light Industrial participants:

   a. During periods of time when the Fund has at least three months of reserves, as determined by the Plan Manager, HRA credit of $0.75 per hour worked with Employer contributions received.

   b. During periods of time when the Fund has less than three months of reserves, as determined by the Plan Manager, no HRA credit shall be granted.

Notwithstanding the foregoing, during periods of time when the Fund has zero or less months of reserves, as determined by the Plan Manager, no HRA credit shall be credited for any classification.

HRA account is a bookkeeping account only – participants cannot cash it out at any time, and it does not vest – the Board may terminate the account at any time. HRA account can only be used for such purposes as are set forth in Part VII-B, and is subject to cancellation pursuant to Part VII-C.

B. Limitations of HRA Account

HRA account balances shall not exceed $6,000 for Journeymen and Apprentice Participants and $3,000 for Classified Workers ("the applicable limit"). Upon any Participant's HRA account balance reaching the applicable limit, no further credit shall be granted to such participant. Credit shall resume accruing when his HRA account balance is less than the applicable limit based on usage, and shall accrue based on the rules set out above and as may be amended by the Board of Trustees in its sole and exclusive discretion.

Under no circumstances shall the amount of contributions owed by an Employer to the Fund pursuant to the terms of the Health Agreement to which the Employer is bound be affected by the crediting, denial of crediting, maximum crediting or any other term or condition of this Part VII.

C. Use of HRA Account

A Participant, his surviving spouse and his Dependents may use the HRA account to reimburse amounts incurred by any of them for qualified medical, dental, vision or prescription drug expenses, as defined in Section 213(d) of the Internal Revenue Code, which are not covered by the Fund, due to co-payments, maximum benefit allowed, or services that are not payable under the Plan, and to pay self-payment amounts which may be due to continue his coverage.

A Participant, his surviving spouse and/or his Dependents, as applicable, shall complete and submit an HRA Claim Form accompanied by all written proofs that the Fund administrative office shall request in order apply for HRA benefits.

Upon use of the HRA account for the purposes described above, an equal amount will be cancelled from the available HRA account balance.

D. Cancellation of Credits

Credits shall be cancelled upon the earliest of the following to occur:

1. Their use as set out in Part VII-B;

2. Twenty-four months after the termination of the Participant's coverage;

3. Immediately upon a Participant's written election to waive future use of the Credits, which shall be permitted each January 1;

4. Immediately upon a Former Participant's written election to waive future use of the Credits;

5. The later of:

    (a) the death of the Participant, or

    (b) the death of the Surviving Spouse;

6. The termination of the Health Reimbursement Arrangement provisions of the Plan by the Board of Trustees.

PART VIII: CLAIMS PROCESSING

A. CLAIMS PROCESSING

1. Eligibility Determinations

Participant eligibility is determined by the Fund's Plan Manager based on receipt of hours/contributions, self-payments and all other relevant factors as set forth in Part II of this Plan. Claims for dependent eligibility are made on forms available from the Fund's Plan Manager, and all supporting documentation must be submitted within the time periods required by Part II of this Plan.

2. Claims for Loss-of-Time, Wellness Promotion, and HRA Benefits

Claim forms for benefits not covered by the Fund's agreement with Blue Cross/Blue Shield or the Life Insurance and Accidental Death and Dismemberment benefit provider are available from the Fund's Plan Manager and all such forms and supporting documentation must be submitted within the following time periods established by this Plan and the underlying policies of insurance for such benefits. Those benefits and time periods are as follows:

a. Claims for Loss-of-Time Benefits (Part VI-C) must be submitted within 30 days from the onset of disability.

b. Claims for Wellness Benefits must be submitted within one year from the date of purchase membership in a gym/health club facility.

c. Claims for HRA Benefits must be submitted within one year of the date the expense for which reimbursement is sought was incurred by the Participant, his surviving spouse and/or his Dependent, as applicable.

If processing of a claim cannot be completed because of missing information, the Fund's Plan Manager will notify the claimant and advise of the specific reason why the processing of the claim cannot be completed and what information is necessary to permit the processing of the claim to continue. It is 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's Plan Manager for any reason, the claimant will be notified with the specific reason for denial within the times periods required by applicable regulations. In unusual circumstances, additional time will be required to process the claim, in which case the claimant will be notified when additional time is needed.

3. Claims for Medical, Hospital, Surgical, Prescription, Dental or Vision Benefits

Claim forms for benefits covered by the Fund's agreement with Blue Cross/Blue Shield are available from that organization and all such forms and supporting documentation must be submitted to that organization and in conformity with the requirements of that organization, including all time limits and proofs. The Fund has no liability for any claim determination made by Blue Cross/Blue Shield. If a claimant disagrees with a determination made by that organization, he must appeal directly to that organization and comply with that organization's claims appeal process. Benefits covered by the Fund's agreement with Blue Cross/Blue Shield are the Medical, Hospital, Surgical Prescription, Dental and Vision Benefits (Part VI- D).

4. Claims for Life Insurance and Accidental Death and Dismemberment Benefit

Claim forms for benefits covered by the Fund's agreement with the Life Insurance and Accidental Death and Dismemberment benefit provider are available from that organization and all such forms and supporting documentation must be submitted to that organization and in conformity with the requirements of that organization, including all time limits and proofs. The Fund has no liability for any claim determination made by that organization. If a claimant disagrees with a determination made by that organization, he must appeal directly to that organization and comply with that organization's claims appeal process.

B. APPEALS PROCESSING

1. Appeals Regarding Claims for Eligibility, Loss-of-Time, Wellness Promotion and HRA Benefits

If a claim for eligibility (other than eligibility for Life Insurance and Accidental Death and Dismemberment benefits), Loss-of-Time, Wellness Promotion or HRA benefits is denied for any reason, the claimant may appeal such denial to the Board of Trustees.

Claimants may appeal a denial of any claim for benefits or eligibility by writing out the reasons for the disagreement and the facts on which the claimant relies for the claim to benefits and mailing this appeal to the Board of Trustees within 180 days from the date of the notice of denial. No special form is required. Claimants have the right to appoint someone else (such as a lawyer) to prepare and submit appeals to the Fund.

Appeals are considered within the time periods set forth in the applicable regulations by the Board of Trustees, which will review the appeal in accordance with the requirements of the applicable regulations.

Claimants are notified, in writing, of the Board's decision with respect to the appeals, including (if the appeal is denied) the reasons and specific references to Plan documents upon which the Board's decision was based.

2. Appeals Regarding Claims for Medical, Hospital, Surgical, Prescription, Dental or Vision Benefits

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

If Blue Cross/Blue Shield denies a claim for Medical, Hospital, Surgical. Prescription, Dental or Vision Benefits in whole or in part based on the claimant's ineligibility for benefits under the Plan at the relevant time, the claimant may appeal the ineligibility determination to the Board of Trustees, which appeal will be determined in accordance with all applicable and effective laws and regulations.

3. Appeals Regarding Claims for Life Insurance and Accidental Death and Dismemberment Benefits

If the Life Insurance and Accidental Death and Dismemberment benefit provider denies a claim for Life Insurance and Accidental Death and Dismemberment benefits in whole or in part, the claimant may appeal the denial in the manner set forth in the Fund's policies of insurance, group enrollments or other documentation with or from its service provider(s), which are incorporated by reference as if printed verbatim herein.

C. REQUIREMENT OF EXHAUSTION OF ADMINISTRATIVE REMEDIES

No lawsuit can be filed against the Fund in connection with any claim until the claimant has appealed, and the Board of Trustees has issued a written response denying that appeal.

D. ALTERED OR FORGED CLAIMS

Any claim form or other material 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 loses it suffers as a result of such material in any manner, including civil litigation.

E. 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 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, including civil litigation.

PART IX: EXCEPTIONS AND LIMITATIONS

Except as may be provided for under the terms of any commercial insurance policies entered into between the Fund and the carriers, the Fund will not provide payment for any of the following:

1. The Plan will **NOT** provide payment for any self-funded benefit (Loss-of-Time benefits, etc.) based on injuries sustained in a motor vehicle accident or other motor vehicle licensed to be on the road or complications resulting from such injuries or accident, except that the Fund will provide Loss of Time benefits (provided all other criteria are met) for injuries sustained in a motorcycle accident where there is no other source of Loss of Time benefits available.

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, or any accidental bodily injury for which a third party may be responsible 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.

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 veteran's, marine, or other federal hospital or any hospital maintained by any state or governmental agency.

5. The Plan will **NOT** provide for expenses resulting from self-inflicted injuries, unless the injuries resulted from a medical condition such as depression.

6. The Plan will **NOT** provide for installation of air conditioners, humidifiers/dehumidifiers, 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.

8. The Plan will **NOT** provide for care and services payable by government-sponsored health care programs such as Medicare. However, the Plan will provide for prescription drugs that are payable by a Medicare Part D prescription drug plan. This exclusion does not prohibit the Plan from providing reimbursement of the difference between a co-pay paid to obtain prescription drugs through governmental prescription drug programs that would otherwise be covered under this Plan and the prescription drug co-pay that would have been charged by the Plan for that prescription drug.

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 hospital confinements and/or treatment required by an order of any court of law, even when prescribed by a physician.

13. The Plan will **NOT** provide for any expenses or pay weekly disability benefits (Loss-of-Time benefits) for disabilities resulting from causes other than sickness, accidental injury, or disease, except those incurred as a result of domestic violence. In case of questionable claims of this type, the Board of Trustees will require a copy of any police report and full details regarding the incident.

14. The Plan will **NOT** provide for any expenses or pay weekly disability benefits (Loss-of-Time benefits) arising from injuries sustained while the person is engaged in any unlawful act, except those incurred as a result of domestic violence.

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

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

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

18. The Plan will **NOT** provide for more than a 30-day supply of prescription drugs (except for specified maintenance drugs that are covered for 90 days).

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

20. The Plan will **NOT** provide for drugs dispensed for cosmetic purposes.

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

22. The Plan will **NOT** provide for expenses due to the children of dependent children. However, the Plan will provide for expenses due to pregnancy of dependent children.

PART X: ADMINISTRATION OF THE PLAN

A. EXCLUSIVE POWER TO CONSTRUE PLAN

The Plan shall be administered solely by the Board of Trustees and employees or agents of the Board of Trustees, acting for them as authorized, and decisions of the Board of Trustees in all matters relating to the administration of the Plan shall be final. The Board of Trustees shall make such rules and prescribe such procedures for the administration of the Plan as it shall deem necessary and reasonable. The Board of Trustees has the sole and exclusive authority and discretion to interpret and apply the rules of the Plan, the Trust and any other rules and regulations, procedures or administrative rules adopted by the Trustees. Decisions of the Board of Trustees or, where its responsibility has been delegated to others, its delegates, will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Board of Trustees or its authorized delegates is challenged in court, such decision is to be upheld, unless a court with proper jurisdiction finds and issues a decision that it was arbitrary and capricious.

B. RIGHT TO BENEFITS

No Employee, Participant, former Participant, beneficiary or any other person claiming by or through any such person, shall have any right, interest or title to any benefits under the Trust Agreement, the Plan, or the Fund, except as such right, interest or title shall have been specifically granted pursuant to the terms of the Plan.

C. RIGHT TO OBTAIN AND REQUIRE INFORMATION

The Board of Trustees shall have the right to require, as a condition precedent to the payment of any benefit under the Plan, all information which it reasonably deems necessary, including records of employment, proof of dates of birth and death, marital status, independent medical examinations of any person for whom benefits are being claimed, any and all medical records relating to a claim, etc., and no benefit dependent in any way upon such information shall be payable unless and until such information so required shall be furnished. Such evidence shall be furnished by the Union, the Association, Employers, Employees, Participants, Dependents, beneficiaries, alternate recipients or the representative of any of them.

D. RIGHT TO RELY ON INFORMATION

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

E. NON-REVERSION TO EMPLOYERS

No Employer shall have any right, title or interest in the contributions made to the Fund and no part of the Fund shall revert to the Employers or any of them.

F. COMPLIANCE WITH APPLICABLE LAW

The Board of Trustees shall exercise such authority and responsibility as it deems appropriate in order to comply with the Internal Revenue Code, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and such other statutes or valid governmental regulations issued thereunder as may apply to this Fund.

G. MEDICARE SECONDARY PAYER RULES

1. If an Eligible Employee continues to work beyond the date he becomes eligible for Medicare, he and his Dependents, if any, shall be entitled to the same benefits offered to all other Eligible Employees and their Dependents. Medicare shall be the secondary payer, paying benefits only with respect to charges not covered by the Fund. However, when he ceases active employment, Medicare shall automatically become the primary payer after he is no longer eligible based on Employer contributions.

2. If an eligible Dependent of an Eligible Employee who is eligible based on Employer contributions is on Medicare either because of age or disability, the Fund will be the primary payer of benefits, and Medicare will be secondary.

H. MEDICAID AND TRICARE

The eligibility and benefit rights of an Eligible Person shall be determined under this Plan without regard to that person's eligibility for or entitlement to Medicaid or TRICARE and this Plan shall, subject to other relevant provisions hereof, be the primary payer of benefits to such person.

The Plan will comply with any assignment of rights made by or on behalf of an Eligible Person required by a state's Medicaid program and, further, will honor any subrogation rights a state may have as the result of having paid benefits on behalf of an eligible Participant or Dependent for which this Plan, as primary payer, was liable.

I. COORDINATION OF BENEFITS

1. All benefits from the Fund, except Life Insurance Benefits and Accidental Death and Dismemberment Benefits, are subject to and limited to benefits

payable in accordance with coordination of benefits provisions, the purpose of which is to avoid duplicate or overlapping payout of benefits. Coordination of benefits provisions apply whenever a person covered hereunder has coverage under another health and Health Plan, fund, policy, contract or program ("covered person").

2. Under the following provisions, the Fund will pay benefits hereunder if it is determined to be primary. If it is not, the other health and Health Plan, fund, policy, contract or program will be required to pay the benefits up to the maximum amount payable in accordance with its Schedule of Benefits and this Fund will then pay any remaining amounts not covered by such other plan 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 coordination of benefits provisions do not apply to benefits provided by an automobile insurance policy because the Plan excludes payment of benefits for injuries incurred in any motor vehicle accident, except as may be provided under the Fund's agreement with Blue Cross/Blue Shield.

   a. If the other health and Health Plan, fund, policy, contract or program has not adopted coordination of benefit provisions, it shall be required to pay as primary.

   b. If it has adopted coordination of benefit provisions, then

      (i) the plan in which the covered person is covered as an "employee" shall pay in accordance with its Schedule of Benefits as primary and the one in which the covered person is covered as a "dependent" shall pay any remaining balance up to its maximum Schedule of Benefits.

      (ii) the plan that covers the covered person as an active employee or dependent of an active employee shall pay in accordance with its benefits as primary and the plan that covers the individual as a COBRA participant shall pay any remaining balance up to its maximum Schedule of Benefits.

      (iii) where the covered person is an eligible dependent child, the following order of priority shall be followed in determining which health plan, fund, policy, contract or program shall pay as primary:

         (A) the plan covering the child's parent who has the earlier birth date anniversary in the calendar year shall be primary,

(B) if both parents have the same birth date, the plan which covered the child for the longer period of time shall be primary,

(C) If the child's parents are divorced or legally separated, benefits for the child will be determined in the following order of priority (unless a court decree places responsibility for coverage on only one of the parents, then the plan in which that parent is covered as an active employee shall be primary):

(1) The plan which covers the custodial parent;

(2) The plan of the custodial parent's new spouse (if remarried);

(3) The plan of the non-custodial parent;

(4) The plan of the non-custodial parent's new spouse (if remarried); or

(5) The plan covering the child the longest.

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

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

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

J. FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan have been made under any other plans, the Fund shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted, and amounts so paid shall be deemed to be benefits paid under this Plan, and, to the extent of such payments, the Fund shall be fully discharged from liability under this Plan.

K. RIGHT OF RECOVERY

Whenever payments have been made by the Fund with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time, the

Fund shall have the right to recover such payments to the extent of such excess, from among one or more of the following, as the Fund shall determine: any persons to or for or with respect to whom such payments were made, any other insurance companies, and/or any other organizations.

L. RESTITUTION WHERE BENEFITS IMPROPERLY RECEIVED

The Fund and its Board of Trustees shall have the right to pursue restitution from any person who receives benefits of any description from the Fund to which such person was not entitled, whether by virtue of the ineligibility of such person at the time services were rendered, by virtue of receipt of excluded benefits or otherwise. The Board may recover such overpayments by any lawful means, including, but not limited to, recoupment of such overpayments from any other current or future benefits paid by the Fund of any kind to which the participant or beneficiary of the overpayment is or may become entitled.

M. AUTHORITY TO ALTER AND AMEND BENEFITS

All benefits under the Plan are subject to the Board of Trustees' authority to change them. The Board of Trustees have the sole and exclusive discretion and authority to increase, decrease, change, amend and terminate benefits, eligibility rules or any other provisions of the Plan as it may determine to be in the best interests of the Plan Participants and Dependents. 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. The Board of Trustees has the authority to amend or terminate such benefits and modify or increase self-payment amounts for coverage at any time. Any such changes shall be effective even though an individual has already become a Participant, Dependent or Retiree, or has met the eligibility requirements to retire now or in the future.

N. TITLE AND RIGHTS TO FUND

No Employee, Employer, Participant, former Participant, Dependent, former Dependent, claimant, beneficiary or any other person claiming by or through any such person, shall have any right, interest or title to any benefits under the Trust Agreement, the Plan, or the Fund, except as such right, interest or title shall have been specifically granted pursuant to the terms of the Plan. No Employer shall have any right, title or interest in the contributions made to the Fund and no part of the Fund shall revert to the Employers or any of them.

O. UNCLAIMED BENEFITS

Any benefit payment under the terms of the Plan which is unclaimed or uncashed for a period of two years shall revert to and become part of the Fund.

P. 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 provisions of these laws will not be paid by the Plan merely because the employee fails to file a claim for benefits under the rules of such workers' compensation laws.

Q. HEALTH PRIVACY

The Fund (through its Plan Manager) and the Board of Trustees, who is the Plan Sponsor as that term is defined in ERISA) use and disclose health information that is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder, for purposes of treatment, payment or health care operations as permitted by the Standards for Privacy of Individually Identifiable Health Information promulgated by the United States Department of Health and Human Services and codified at 45 C.F.R. '160 and '164 ("Standards").

The Fund's Plan Manager may use and disclose protected health information to the Fund's Board of Trustees, who may use and disclose that protected health information and protected health information that it receives from any other source to any person, including the Fund's service providers or prospective service providers, only to the extent necessary for the Board of Trustees to perform administrative functions including, but not limited to, those functions related to coordination of treatment, facilitation of payment and health care operations; activities designed to improve health or reduce health care costs; accreditation, certification, licensing or credentialing activities; underwriting premium rating, bid solicitation or related functions to create, renew or replace service providers, health insurance or health benefits; review and auditing, including compliance reviews, medical reviews, legal services and compliance programs; business planning and development including cost management and planning-related analyses and formulary development; business management and general administrative activities of the Fund, including customer service and resolution of internal grievances; providing information to Participants and other covered persons on benefits and services; and reviewing appeals. The Board of Trustees may have access to summary health information so that it may solicit premium bids from health insurers and health maintenance organizations or to modify or amend the Plan or to terminate the Fund. The Board of Trustees may also have access to protected health information on whether a person is eligible for benefits under the terms of this Plan.

The Fund will disclose protected health information to the Board of Trustees only upon receipt of a certificate, in accordance with 45 C.F.R. '164.504(f)(2)(ii), that this provision regarding Health Privacy has been adopted and that the Board of Trustees agrees to abide by its terms. The Board of Trustees is subject to the following:

1. The Board of Trustees will not use or further disclose protected health information other than as permitted or required by this Plan document or as required by law.

2. The Board of Trustees will require that each of its agents, including subcontractors, to whom it provides protected health information agree to written contractual provisions that impose the same restrictions and conditions that apply to the Board of Trustees with respect to such information.

3. The Board of Trustees will not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit administered by the Board of Trustees.

4. The Board of Trustees will report to the Fund's Plan Manager any use or disclosure of the protected health information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

5. The Board of Trustees will provide Participants and other covered persons with protected health information in accordance with the rights accorded to them under Standards, including the right to access to protected health information, the right to an opportunity to amend protected health information and the right to an accounting of disclosures of protected health information.

6. The Board of Trustees will make the Fund's Plan Manager's internal practices, books, and records relating to the use and disclosure of protected health information available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with the Standards.

7. The Board of Trustees will, as is administratively feasible, return or destroy all protected health information received from the Fund's Plan Manager that the Board of Trustees maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. The Board of Trustees will use their best efforts to request only the minimum necessary type and amount of protected health information to carry out the functions for which information is requested.

9. The Board of Trustees will ensure that adequate separation occurs between the Fund's Plan Manager, who has been provided with access to the protected health information, and the Board of Trustees. The Board of Trustees has obtained an agreement from the Fund's Plan Manager to restrict access and use of such information to the administrative functions that the Board of Trustees has authorized the Fund's Plan Manager to perform. The Board of Trustees certifies that employees of the Fund's Plan Manager are the only employees to access and use protected health information as set forth above.

Anyone who suspects an improper use or disclosure of protected health information may report the occurrence to the Fund's Privacy Officer as designated by the Fund's Privacy Policy.

R. HEALTH INFORMATION SECURITY

The Fund (through its Plan Manager) and the Board of Trustees (who is the Plan Sponsor as that term is defined by ERISA) will comply with the security regulations issued pursuant to HIPAA, codified at 45 C.F.R. §§ 160, 162 and 164 ("Security Rule"), with regard to Electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Trustees on behalf of the Fund, except for the following types of ePHI:

(1) ePHI that it receives pursuant to an appropriate authorization (as described in 45 C.F.R. § 164.508), and

(2) ePHI that qualifies as Summary Health Information that it receives for the purpose of:

(i) obtaining premium bids for providing health insurance coverage under the Fund (as set forth in 45 C.F.R. § 164.504(f)(1)(ii)(A)), or

(ii) modifying, amending or terminating the Fund (as set forth in 45 C.F.R. § 164.504(f)(1)(ii)(B)), and

(3) ePHI that is information on whether an individual is participating in the Plan, or is enrolled or has disenrolled from the Plan, or is enrolled or has disenrolled from a health insurance issuer or HMO offered by the Plan (as set forth in 45 C.F.R. § 164.504(f)(1)(iii)).

The Trustees shall, in accordance with the Security Rule:

(1) Reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Trustees on behalf of the Fund,

(2) Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI they create, receive, maintain or transmit on behalf of the Fund,

(3) Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Trustees will use ePHI only for Fund administration activities and not for employment-related actions or for any purpose unrelated to Fund administration,

(4) Ensure that any agent, including a subcontractor, to whom the Trustees provide such information agrees to implement reasonable and appropriate security measures to protect the information, and

(5) Report to the Fund any Security Incident of which the Trustee(s) become(s) aware.

If other terms of the Plan conflict with the provisions of this Section, this Section shall control. The Security Rule is incorporated herein by reference. Unless defined in the Plan, all capitalized terms herein have the definition given to them by the Security Rule.

S. 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 any 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) 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 and not recovered as (1) 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)); (2) an advance on future claims payable on behalf of that person (or his representative(s)); or (3) an amount held by that person (or his representative(s)) in constructive trust on behalf of the Fund.

T. LIMITATION OF ACTIONS AND VENUE

No action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Notwithstanding any internal appeal process, 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 filled within three years after the first date the participant receives a determination of his rights and/or benefits under the terms of the Fund's Plan, unless a shorter period is established by applicable statue, regulation or case law.

Any action in law or equity brought by a participant or beneficiary against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to this Plan shall be brought in the United States District Court where the Plan is administered.

PART XI: AMENDMENT, TERMINATION AND MERGER

A. TERMINATION OF FUND

In the event the Fund and its benefits are discontinued or terminated, 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 exceed its assets, and benefit payments will be limited to the funds available. The Board of Trustees shall not be liable for the adequacy or inadequacy of such funds. Any assets remaining after payment of Fund liabilities, if any, will be used for purposes determined by the Board of Trustees according to the Trust Agreement.

B. AMENDMENT

This Plan may be amended in any respect, including termination of this Plan, by a majority vote of the Trustees, pursuant to the voting rules set forth in the Agreement and Declaration of Trust.

C. MERGER

The Fund may, by an instrument in writing executed by representatives of the Union and the Association, merge this Fund into another fund or cause another fund to be merged into this Fund.

IN WITNESS WHEREOF, this 2024 Plan of the Sheet Metal Workers' Local Union No. 292 Health Fund has been adopted by the Board of Trustees thereof as of this 14th day of December 2024.

FOR THE UNION TRUSTEES

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Paul Gualdoni, Chairman

FOR THE EMPLOYER TRUSTEES

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Michael Asher, Secretary

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