NATIONAL EMPLOYEES HEALTH PLAN

Summary Plan Description

Effective November 1, 2017

NATIONAL EMPLOYEES HEALTH PLAN

To All Eligible Participants:

We are pleased to present you with this updated booklet, which describes the major features of the NATIONAL EMPLOYEES' HEALTH PLAN ("NEHP" or "the Plan"). The terms of this booklet are effective November 1, 2017.

This booklet is designed to give you an easy-to-read description of the Plan. It covers the eligibility rules, benefits, claim procedures and the administration of the Plan as required by federal law. The Plan is governed by certain documents, including your collective bargaining agreement, the plan document, the trust agreement, participation agreements and insurance contracts. Such documents are always available for your inspection. We have tried to describe the benefits here just as they are written in those documents. However, if there is any difference between the terms of this booklet and those of the Plan documents, the Plan documents or contract provisions will control.

We believe the continued success of our program is due to the excellent cooperation from you, the participants, as well as from the Employers and the Unions. You can be assured that the Trustees will continue to administer the Plan so that you can receive the most comprehensive benefits possible within the resources available to the Plan.

Keep this booklet in a safe place for quick reference after you have read it. Of course, if you have any questions about your eligibility or the benefits to which you are entitled, please contact the Administrative Manager.

Sincerely,

NEHP BOARD OF TRUSTEES

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NATIONAL EMPLOYEES HEALTH PLAN

A Multiemployer Health and Welfare Benefit Plan

The National Employees Health Plan is sponsored and administered under the joint control of labor and management trustees. The Board of Trustees consists of both Union and Employer representatives, selected by the Unions and the Employers who have entered into collective bargaining agreements requiring contributions to the Plan.

The Plan is sponsored by the:

BOARD OF TRUSTEES

Members, as of November 1, 2017:

Union Trustees

Mr. Josh Zivalich
Teamsters Local 769
12365 W. Dixie Highway
North Miami, FL 33161
Office: (305) 642-6255
jzivalich@teamsterslocal769.org

Mr. Steve Nobles
11420 East 9 Mile
Warren, MI 48089
Office: (586) 755-8041
snobles@sbcglobal.net

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Mr. James Pope
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Naples, FL 34119
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West Palm Beach, FL 33406
Office: (561) 803-6135
Mobile: (954) 224-8736

Mr. Dion Grotkowski
Automated Benefit Services, Inc.
8220 Irving Road
Sterling Heights, Michigan 48312

The Plan is administered by the **BOARD OF TRUSTEES** with the assistance of the:

ADMINISTRATIVE MANAGER

Automated Benefit Services, Inc.
8220 Irving Rd.
Sterling Heights, Michigan 48312
(586) 693-4362 or 1-800-447-1032

Automated Benefit Services, Inc. ("ABS") handles the day to day administration for the Plan.

PLAN IDENTIFICATION INFORMATION

Federal Identification Number: 38-6440898
Plan Number: 501

PLAN YEAR

The Plan Year for purposes of federal law filing requirements runs from November 1st to October 31st of each year. The health benefits packages offered under the Plan are based on the calendar year beginning on January 1st each year.

FUND COUNSEL and AGENT FOR LEGAL PROCESS

Howard S. Susskind
Sugarman & Susskind, PA
100 Miracle Mile
Suite 300
Coral Gables, Florida 33134

Service of Process may also be made upon a plan trustee or the plan administrator.

GENERAL PLAN DESCRIPTION AND IMPORTANT INFORMATION

Health and Welfare Benefit Plan

The **National Employees Health Plan ("NEHP" or "the Plan")** is an employee benefit plan that provides medical, prescription drug, vision, dental, short term disability, life, accidental death and dismemberment, dependent life, and death benefits to eligible participants. The Plan is subject to and complies with the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

Funding Sources for Benefits

The Plan is primarily funded by employer contributions made as required under the terms of applicable collective bargaining agreements and by contributions made under the terms of participation agreements. Contributions are held in a Trust Fund managed by the Board of Trustees as provided in the Trust Agreement. The Trust Fund's assets include all contributions and investment earnings. All benefits and expenses of the Plan, including premiums for insurance policies obtained by the Board of Trustees as the method of providing benefits, are paid using Trust Fund assets.

Rights and Responsibilities of the Board of Trustees

The Board of Trustees has full and exclusive power and authority, in its sole discretion, to:

- construe and interpret the terms of the Plan,
- determine the status and rights of participants, beneficiaries and other persons,
- determine all questions of coverage and eligibility for benefits,
- make rulings and prescribe procedures,
- gather needed information,
- exercise all of the power and authority contemplated by ERISA with respect to the Plan,
- employ or appoint persons to help or advise in any administrative functions,
- appoint investment managers and trustees, and
- do all other things needed to operate, manage and administer the Plan.

Any decisions of the Board of Trustees shall be final and binding on all parties, including Employees, Dependents, Retirees, beneficiaries, Employers, unions, and all other persons involved or affected. In addition to the Board of Trustees the Plan may have other fiduciaries, advisors and service providers. The Board of Trustees may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan.

Plan Amendment and Termination

The Plan may be amended by the Trustees, in their discretion, upon majority vote of the Trustees in attendance and voting at that time. All amendments shall be in writing and signed by the Trustees. A Summary of Material Modifications will be distributed to all Plan participants if an amendment results in any material changes or modifications to the Plan.

The Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time:

(a) to terminate or amend either the amount or condition with respect to any benefits even though such termination or amendment affects claims which have already been incurred;
(b) to alter or postpone the method of payment of any benefit; and
(c) to amend or rescind any other provisions of the rules and regulations contained herein.

Circumstances under which the Plan may be terminated include, but are not limited to:

(a) When there are no longer sufficient assets to continue the benefits of the Plan.
(b) When there are no longer any Employers who are required to make contributions under an applicable Collective Bargaining Agreement; or
(c) When the last surviving Covered Person entitled to receive benefits has died.

In the event of termination of the Plan, the Board of Trustees shall, within the limits of the Fund's resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining assets of the Fund be used in a manner which best carries out the basic purpose for which the Fund was established.

Right to Examine Relevant Documents

The Plan is maintained pursuant to one or more collective bargaining agreements. Collective bargaining agreements are contracts between an employer and a union that may require certain health care benefits for employees. Copies of such agreements may be obtained by participants and beneficiaries by submitting a written request to the plan administrator. Copies of the agreements are also available for examination at the office of the Administrative Manager.

A complete list of the employers and employee organizations sponsoring this Plan may be obtained by participants and beneficiaries by submitting a written request to the plan administrator. The list is also available for examination by participants and beneficiaries at the office of the Administrative Manager. Participants and beneficiaries may also receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization participates in the Plan; if the employer or employee organization does participate in the Plan then contact information is also available.

You also have the right to examine documents governing the Plan at the office of the Administrative Manager, such as insurance contracts, and you have a right to examine the Plan's annual report (Form 5500 Series) that is filed each year.

PERSONS ELIGIBLE FOR BENEFITS

I. For Active Employees

In order to receive benefits under the Plan you must meet certain eligibility requirements. For active employees contributions are made to NEHP by your employer on your behalf pursuant to the terms of your collective bargaining agreement, which specifies contributions based on the number of hours, weeks or months that you work. Consult your collective bargaining agreement, or inquire with your Union or Employer to determine how contributions are being made to the Plan on your behalf.

A. Hourly Basis

The following eligibility rules apply to you if contributions are made to NEHP by your Employer on your behalf ***based on the number of hours that you work***.

Your Reserve Account

- Your eligibility for benefits is based on the number of hours credited to your "reserve account".
- Your Employer makes contributions to the Plan based on the number of hours that you work.
- Your reserve account is credited one hour for each hour that you work for a participating Employer and for which your Employer makes a contribution to the Plan, subject to a maximum accumulation of 780 hours in the preceding 12 consecutive months.

Initial Eligibility

- Your initial eligibility is effective when your reserve account is credited with 260 hours.
- Your initial coverage begins on the first day of the month following the month in which your reserve account is credited with 260 hours.

Continued Eligibility

Once your initial eligibility is established, your eligibility continues based on the number of hours credited to your reserve account. If you have at least 130 hours credited to your reserve account at the end of a month then you will be eligible for coverage for the following month. 130 hours will be deducted from your reserve account for each month's coverage, beginning with the first month that you become eligible for benefits.

Termination of Eligibility

Your eligibility for benefits will terminate on the earliest of: (i) the date of termination of the Plan; or (ii) the last day of any month in which the balance of your reserve account at the end of the month is fewer than 130 hours.

Reinstatement of Eligibility

If your coverage terminates because you had less than 130 hours in your reserve account at the end of a month, you will be eligible for reinstatement in the month following the month in which you have at least 130 hours in your reserve account at the end of the month, as long as there have been fewer than 12 consecutive months in which you did not have sufficient hours in your reserve account.

If you have less than 130 hours in your reserve account for a period of 12 consecutive months, however, you are not eligible for reinstatement until the first day of the month following the month in which you have at least 260 hours credited to your reserve account.

Re-Employment after Established Eligibility

If you have established eligibility for coverage, terminate employment with a participating Employer, and are later re-employed with a participating Employer within a 12 month period, you will be eligible for coverage on the first day of the month following the month in which you are re-employed and have at least 130 hours in your reserve account at the end of the month.

B. Weekly Basis

The following eligibility rules apply to you if contributions are made to NEHP by your Employer on your behalf ***based on the number of weeks that you work***.

Initial Eligibility

- Your Employer makes contributions to the Plan based on the number of weeks that you work.
- Your initial eligibility is effective on the Sunday following the week in which the Plan receives eight (8) straight weeks of contributions paid by your Employer on your behalf.
- Your eligibility may be effective earlier, however, based on the terms of your Collective Bargaining Agreement.

Continued Eligibility

- Once your initial eligibility is established, your eligibility continues on a weekly basis for each week for which your Employer timely pays required contributions to the Plan on your behalf.

Your Reserve Bank

The contributions that were paid by your Employer on your behalf for the eight weeks prior to the start of your eligibility are held in a reserve bank for your use upon termination of your employment or coverage.

Termination of Eligibility

Your eligibility for benefits terminates on the earliest of: (i) the date of termination of the Plan; or (ii) the last day of the last week for which your Employer made required contributions to the Plan on your behalf, including the last day of the week after the week in which contributions held in your reserve bank are depleted.

Re-Employment after Established Eligibility

If you have established your initial eligibility for coverage, subsequently terminate your employment with a participating Employer, and are then re-employed with any participating Employer within 26 weeks after your previous coverage ended, you will be eligible for coverage without having to re-establish initial eligibility.

If, however, you terminate your employment with a participating Employer and you are not re-employed by a participating Employer within 26 weeks after such termination, then you must satisfy the requirements of initial eligibility in order to reinstate your coverage after subsequent re-employment.

C. Monthly Basis

The following eligibility rules apply to you if contributions are made to NEHP by your Employer on your behalf ***on a monthly basis***.

Initial Eligibility

Your initial eligibility begins on the first day of the month for which your Employer pays required contributions to the Plan on your behalf.

Continued Eligibility

Your eligibility continues on a monthly basis for each month for which your Employer timely pays required contributions to the Plan on your behalf.

Termination of Eligibility

Your eligibility for benefits terminates on the earliest of: (i) the date of termination of the Plan; or (ii) the last day of the last month for which your Employer made required contributions to the Plan on your behalf.

D. Participation Agreements

The Board of Trustees has discretion to allow participation in the Plan for non-bargaining unit employees or employees covered under another trust fund pursuant to the terms of a Participation Agreement, as defined in the Plan Document. Eligibility requirements for persons eligible for benefits under the terms of a Participation Agreement are set forth in the applicable Participation Agreement.

II. For Retirees

The following eligibility rules apply to you if retiree coverage under the Plan has been made available to you and you qualify for retiree coverage, as described below.

Initial Eligibility

Except as set forth below for Retirees of Detroit Media Partnership, you are eligible for coverage as a Retiree if all of the following requirements are satisfied:

(a) You have at least 10 years of continuous service with a National Employee Health Plan Employer(s); and

(b) You are eligible for a Teamster pension benefit, or an Employer sponsored pension benefit as of the date of your retirement; and

(c) Immediately prior to the date of your retirement you are at least 55 years of age and a Covered Employee whose Employer is making or has made the required contributions for retiree coverage; and

(d) You have not reached age 65 on the date of retirement, and you are not eligible for Medicare (unless the your Employer has negotiated supplemental medical coverage); and

(e) Your Employer(s) has made contributions to the Plan for at least five (5) consecutive years immediately preceding your retirement; and

(f) You are not eligible to be covered as an Employee or as a Dependent of a Covered Employee on the date of your retirement.

If you are a Retiree of Detroit Media Partnership, you are eligible for coverage as a Retiree if all of the following requirements are satisfied:

(a) You retire under a Detroit Media Partnership sponsored retirement plan with at least 10 years of credit service; or

(b) You are already participating in a Detroit Media Partnership medical insurance program and have at least 5 years or more of credited service; and

(c) Upon your death, your surviving spouse and dependent children may continue coverage for a period of 2 years under the active employees plan at the then current COBRA rate; and

(d) If you otherwise meet these eligibility requirements you may re-enter the plan at open enrollment so long as permitted by IRS regulation provided that proof of creditable coverage is provided; and

(e) You were hired after October 13, 2003, and

(f) You are not eligible to be covered as an Employee or as a Dependent of a Covered Employee on the date of retirement.

Dependent Eligibility

Except as set forth below with regard to Retirees of Detroit Media Partnership, if you are eligible for benefits as a Retiree and you have a spouse who is legally married to you on the date you become eligible for retiree benefits, then your spouse is considered to be an eligible Dependent under the Plan and shall also be eligible for retiree benefits. No other persons, including any children, are entitled to retiree benefits under the Plan.

If you are a Retiree of Detroit Media Partnership, your spouse to whom you are legally married on the date upon which you become eligible for retiree benefits, as well as your Dependent children, are considered to be eligible Dependents under the Plan, and shall also be eligible for retiree benefits.

Continued Eligibility

In order to maintain your eligibility for retiree coverage for yourself and/or your Dependent you must make required contributions to the Fund in a timely manner, in an amount determined by the Trustees, and in compliance with any procedures determined by the Trustees.

Your eligibility to maintain retiree coverage for yourself and/or your Dependent is conditioned on your former Employer's continued participation in the Plan.

Termination of Retiree Eligibility

Except as set forth below with regard to Retirees of Detroit Media Partnership, your retiree coverage shall end on the earliest of the following:

(a) The date of termination of the plan;

(b) The first day of the month in which you reach age 65;

(c) The first day of the first month in which you become eligible for Medicare (unless your Employer has negotiated supplemental medical coverage);

(d) The date of your death;

(e) The date that your former Employer ceases to be a participating Employer in the Plan; or

(f) The last day of the last month for which you made required contributions to the Plan in a timely manner.

If you are a retiree of Detroit Media Partnership, your retiree coverage shall end on the earliest of the following:

(a) The date of termination of the plan;

(b) The date of your death;

(c) The date that your former Employer ceases to be a participating Employer in the Plan; or

(d) The last day of the last month for which you made required contributions to the Plan in a timely manner.

Continuation Coverage for Dependents of Retirees

If you are a Retiree (other than a Retiree of Detroit Media Partnership, in the event of your death, coverage under Medicare, or your attaining age 65, your spouse may continue retiree coverage until the earliest of: (i) the date on which your spouse reaches age 65, (ii) the date on which your spouse becomes eligible for Medicare, or (iii) five years after your death, coverage under Medicare, or attaining age 65.

III. For Dependents

Persons who qualify as your dependents under the terms of the Plan may also be entitled to receive benefits based on your eligibility for coverage. Consult your collective bargaining agreement or inquire with your Union or Employer to find out if the contributions being made to the Plan on your behalf under the terms of your collective bargaining agreement include coverage for your dependents, and whether there are any limitations on the number or types of dependents covered.

Definition of Dependent

The term "Dependent" is defined in the Plan Document, and includes:

(a) The wife or husband of an Employee, while not divorced or legally separated from the Employee.

(b) Each child of an Employee, until the date the child attains age 26, or as described further in this subparagraph below.

(i) child means the Employee's natural born child, stepchildren, children under court appointed guardianship, children placed for adoption, and legally adopted children are eligible for coverage as Dependents to the same extent as the Employee's natural children, and any child within the meaning of Section 152(f)(1) of the Internal Revenue Code..

(ii) A Dependent also means a child for whom there is a Qualified Medical Child Support Order which states that health care coverage must be maintained by an Employee.

(iii) A child who (a) otherwise qualifies as a Dependent, (b) would lose eligibility because of age, and (c) is incapable of self-sustaining employment by reason of mental or physical handicap, is a Dependent during the continuation of such incapacity, subject to the right of the Plan Administrator to require proof of incapacity when the claim is first made, and proof once each year thereafter of the continuation of said incapacity. A child eligible for coverage on the basis of incapacity must have become incapacitated while covered as a Dependent and is eligible for coverage only during the continuation of such incapacity.

(c) With respect to Retirees (except for Retirees of Detroit Media Partnership), the term Dependent means only the spouse of the Retiree from whom the Retiree is not legally separated.

Special Definition of Dependent for Employees living in the State of Florida

If you live in the State of Florida, your child(ren) may be entitled to coverage through the age of 30. In particular, if you live in the State of Florida, the term "Dependent" is expanded to include a child up until the end of the calendar year in which such child reaches the age of 30 if the child:

(a) Is unmarried and does not have a dependent of his or her own; and
(b) Is a resident of this state or a full-time or part-time student; and
(c) Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

If a child between the ages of 26 and 30 is enrolled for coverage on the basis of being a full or part time student, and the child goes on a "medically necessary leave of absence", as defined in 29 U.S.C. §1185c ("Michelle's Law"), and loses student status, the child's coverage will not be terminated before the date that is the earlier of 1) one year after the first day of the medically necessary leave of absence or 2) the date on which coverage would otherwise terminate under the terms of this Plan.

Domestic Partners as Dependents

The term "Dependent" may also include an Employee's domestic partner and the domestic partner's children if this benefit is provided for your group and certain conditions are met. Please consult the Plan Administrator to obtain information on your eligibility and requirements for the enrollment of domestic partners and their children as Dependents.

Effective Date of Eligibility for Dependents

Eligibility for your spouse and children as Dependents is generally effective on the first day that you become eligible for benefits, or upon the first day that a person becomes your Dependent, such as by birth or marriage. There may be different rules for domestic partners or retirees, so please seek additional information regarding the effective date of eligibility for such Dependents.

Termination of Dependent Eligibility

Except as described above relating to continuation coverage for Retirees and their Dependents, your Dependents' eligibility for benefits terminates (i) on the same date that your eligibility for

benefits terminates, or (ii) on the last day of the month during which your Dependent ceases to be your Dependent, whichever is earlier.

IV. Continuation Coverage under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Covered Employees and/or their Dependents may be entitled to temporarily extend their coverage under this Plan by electing COBRA continuation coverage after their eligibility for coverage under the Plan has terminated. Retirees and their Dependents are not eligible for COBRA coverage, except as specifically described herein in connection with an employer's bankruptcy.

The following sets forth important information about your right to COBRA continuation coverage. **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.**

What is COBRA Continuation Coverage?

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

If you 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, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Administrative Manager has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy by a participating employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Administrative Manager of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, a dependent child's losing eligibility for coverage as a dependent child, or the occurrence of an event that qualifies as a Second Qualifying Event that entitles you to an extension of your COBRA coverage), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Administrative Manager at

Automated Benefit Services, Inc.
8220 Irving Rd.
Sterling Heights, Michigan 48312
(586) 826-4300 or 1-800-447-1032

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 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 Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 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 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only

up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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 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.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, 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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under 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 EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

National Employees Health Plan
c/o Automated Benefit Services, Inc.
8220 Irving Rd.
Sterling Heights, Michigan 48312
(586) 693-4362 or 1-800-447-1032

V. Continuation Coverage under USERRA

The right to continuation coverage when you leave work to perform military service is provided under a federal law called the Uniformed Services Employment and Re-employment Rights Act of 1994

("USERRA"). If you leave your employment to perform services in the uniformed services you may elect to continue coverage under the Plan for yourself and your dependents up to a maximum period of time that is the lesser of:

(a) the 24-month period beginning on the date on which the absence for the purpose of performing military service begins; or

(b) the period beginning on the date upon which the absence for the purpose of performing military service begins, and ending on the day after the date on which you fail to apply for or return to a position of employment, as defined in USERRA.

If your service in the uniformed services continues for fewer than 31 days you will not be required to pay more than any regular employee share for continuing health plan coverage.

If your service in the uniformed services continues for more than 31 days and you elect continuation coverage you may be required to pay no more than 102 percent of the full premium under the Plan, representing the employer's share plus the employee's share plus 2% for administrative costs.

If you enter military service lasting more than 31 days; your eligibility is based on your reserve account; you elect continuation coverage; and you have a positive balance in your reserve account at the time you leave employment, you may either:

(a) use your reserve account balance instead of paying for continuation coverage, with the opportunity to continue coverage by paying no more than 102% of the full premium under the Plan if your reserve account balance is depleted; or

(b) pay for continuation coverage as provided above in order to maintain your reserve account balance intact as of the beginning date of your military service.

If you leave employment for military service without giving advance notice or with notice but without electing continuation coverage then your coverage may be terminated under the terms of the Plan. Depending on the circumstances you may be eligible for retroactive reinstatement of coverage. You may also lose coverage if you fail to make required payments.

If your coverage is terminated as a result of your service in the uniformed services your coverage under the Plan will be re-instated immediately upon re-employment after military service. You will not be subject to any exclusions or waiting periods if exclusions or waiting periods would not have been imposed if your coverage had not been terminated as a result of military service, unless you have an injury or illness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

If your eligibility for coverage is based on maintaining required numbers of hours or weeks in a reserve account your coverage will be re-instated immediately, even if you do not have sufficient hours or weeks in your reserve account to establish coverage. The Plan may require that you pay the cost of coverage until the time that your reserve account contains sufficient hours or weeks to sustain coverage.

VI. Special Enrollment Rights under HIPAA

"Special Enrollment" rights are sometimes allowed under Federal law (HIPAA) to allow employees or dependents to enroll outside of the open enrollment period or after initial eligibility. This section describes when you may have special enrollment rights.

New Dependents: If you enroll in the Plan at the time you are first eligible and you remain eligible for coverage you can enroll a new dependent as a result of marriage, birth, adoption, placement for adoption,

or legal guardianship by submitting a request for enrollment within 30 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

Limited "Special Enrollment" rights are also allowed under Federal law (HIPAA) if you decline or waive enrollment in the Plan and do not have other health insurance. Under these special enrollment rights you may request enrollment for yourself and/or your dependents outside of open enrollment if:

- You have a new dependent as a result of marriage, birth, adoption, placement for adoption, or legal guardianship and
- You request enrollment within 30 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

Loss of Other Coverage: If you decline or waive enrollment in the Plan because you have other health insurance coverage, you may be allowed "special enrollment" rights in the future if:

- You are covered under another group health plan or health insurance program at the time you waive coverage under the Plan;
- You lose eligibility for the health care coverage you had at the time of waiver, or the employer sponsoring the other coverage stops contributing towards such other coverage; and
- You make application for enrollment in the Plan within 30 days after your other coverage ends.

Loss of Medicaid or State Child Health Insurance Program: There are special rules for employees and dependents of employees who are eligible for Medicaid or a State Child Health Insurance Program. If an employee (or eligible dependent of such employee) experiences a loss of eligibility for Medicaid or a State Child Health Insurance Program, they have a Special Enrollment right to request enrollment in the Plan provided a request for enrollment is made within 60 days after the loss of eligibility.

Premium Assistance: If an employee (or eligible dependent of such employee) is determined to be eligible for premium assistance by Medicaid or a State Child Health Insurance Program (including under any waiver or demonstration project conducted under or in relation to such a program), such person has a Special Enrollment right to request enrollment in the Plan provided a request for enrollment is made within 60 days of the determination of assistance.

Employees who enroll in the Plan under these special circumstances will be offered the same benefit packages and payment options as those offered to similarly situated employees who enroll when first eligible.

VII. Qualified Medical Child Support Orders

Federal law requires employment-based group health plans to extend health care coverage to the children of a parent-employee who is divorced, separated, or never married when ordered to do so by state authorities. Generally, a State court or agency may require an ERISA-covered health plan to provide health benefits coverage to children by issuing a medical child support order. The group health plan must determine whether the medical child support order is "Qualified." Such an order is referred to as a Qualified Medical Child Support Order (QMCSO). Any judgment, decree, or order that is issued by a court of competent jurisdiction or an administrative agency authorized to issue child support orders under State law (such as a State child support enforcement agency) that provides for medical support of a child is a medical child support order. In addition, a State child support enforcement agency may obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified. A medical child support order must contain the following information in order to be Qualified:

- The name and last known mailing address of the participant and each alternate recipient. The order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined) ; and
- The period to which the order applies.

All requests for enrollment and/or claims for benefits pursuant to a medical child support order shall be submitted, in writing, to the Administrative Manager along with a copy of the medical child support order. The Administrative Manager can be reached at: Automated Benefit Services, Inc., 8220 Irving Rd., Sterling Heights, Michigan 48312, (586) 826-4300 or 1-800-447-1032.

Upon receipt of a medical child support order the Administrative Manager shall notify the Employee and each Alternate Recipient named in the order that the medical child support order was received and shall provide each with a written copy of the procedures for determining whether the order is Qualified. Notices shall be sent to the addresses shown in the medical child support order. Alternate Recipients may designate an attorney or other representative to receive copies of notices and communications sent to them relating to a medical child support order by submitting a written and signed authorization to the Plan Administrator.

The Board of Trustees shall consult with legal counsel and shall determine whether an order is a Qualified Medical Child Support Order no later than the date of the Board of Trustees' meeting that immediately follows the Plan's receipt of the medical child support order, unless it is submitted within 30 days preceding the date of such meeting. If a medical child support order is submitted less than 30 days before the next meeting, the Board of Trustees shall determine whether it is a QMCSO no later than the date of the second meeting following the Plan's receipt of the order. If special circumstances require a further extension of time, the Board of Trustees shall make the determination not later than the date of the third meeting following the Plan's receipt of the order.

The Trustees will provide notice of their decision to the Employee and to the Alternate Recipient as soon as possible, but not later than 5 days after the determination is made. The Trustees will notify the Employee and each Alternate Recipient of a denial of benefits based on a determination that a medical child support order is not qualified following the procedures established under this Plan for notification of benefit claim denials. The decision can be appealed by filing a notice of appeal within sixty (60) days after receipt of the Trustees' decision.

If the Administrative Manager receives an appropriately completed National Medical Support Notice that meets the requirements for a QMCSO set forth above, the Notice shall be deemed to be a QMCSO.

Pending a decision by the Board of Trustees as to whether a medical child support order is a QMCSO any amount which would be payable for benefits on behalf of such Alternate Recipient may be withheld.

BENEFITS AVAILABLE UNDER THE PLAN

Different Benefits, Different Groups: NEHP offers medical, prescription drug, vision, dental, short term disability, life, accidental death and dismemberment, and death benefits to eligible participants. All participants are not eligible, however, for all of the available benefits. Contributions are made to the Plan pursuant to the terms of collective bargaining agreements ("CBAs") between Employers and Unions, or the terms of Participation Agreements with the Board of Trustees. The CBAs or Participation Agreements establish the negotiated contribution rates and may describe required benefits. As each employer group

joins NEHP the Employer signs a Trust Acceptance Form, which describes the Schedule of Benefits offered to covered employees. Please check with your Employer or Union for additional information.

Definitions

Certain terms are used to describe the benefits available under the Plan, including terms that have specific definitions as used here. There are additional definitions in the Plan Document that may apply to certain types of benefits, and in the materials provided by the health care network providers and insurance companies through which benefits are provided under the Plan. The following definitions may be helpful in understanding your benefits.

Collective Bargaining Agreement: The term "Collective Bargaining Agreement" means an agreement between an Employer and a Union under which the Employer has agreed to make contributions to the Trust Fund on behalf of its Employees for health care benefits under the Plan.

Covered Employee: The terms "Covered Employee" or "eligible employee" mean an Employee who is eligible for benefits under this Plan.

Employee: The term "Employee" means each person who is employed by an Employer, and on whose behalf the Employer is required to make contributions to the Trust Fund. Employee shall also mean such other person who is eligible for coverage as agreed to by the Trustees and as set forth in a Participation Agreement.

Employer: The term "Employer" means:

(a) An employer who is bound by a Collective Bargaining Agreement with a Union or by a Participation Agreement with the Fund, to make contributions to the Trust Fund with respect to Employees covered by said Collective Bargaining Agreement or Participation Agreement.

(b) A Union required to contribute to the Trust Fund on behalf of its employees, as agreed to by the Trustees and as set forth in a Participation Agreement.

(c) The Trustees of the Trust Fund who contribute on behalf of Trust Fund employees, as set forth in a Participation Agreement.

(d) The trustees of any other trust fund established pursuant to a collective bargaining agreement who contribute on behalf of trust fund employees or trust fund participants, as agreed to by the Trustees and as set forth in a Participation Agreement.

Illness: With regard to benefits that the Board of Trustees pay directly from the assets of the fund (rather than through the purchase of insurance) the term "Illness" means only sickness or disease, including mental infirmity, which requires treatment by a Physician. For purposes of determining benefits payable, "Illness" shall include pregnancy, childbirth, or miscarriage, and complications thereof. All related Illnesses shall be considered one Illness. Concurrent Illnesses shall also be considered one Illness unless such Illnesses are clearly unrelated.

Injury: With regard to benefits that the Board of Trustees pay directly from the assets of the fund (rather than through the purchase of insurance) the term "Injury" means only bodily Injury sustained accidentally by external means, including such illness as results from an accident. All Injuries sustained by a Covered Person in connection with any accident shall be considered one Injury.

Network: The term "Network" means those Physicians and facilities which have contracted to participate in a preferred provider organization or other managed care network chosen by the Board of Trustees to facilitate providing benefits under the Plan. . In-Network shall refer to services received through a Network, while Out-of-Network shall refer to services received from providers who are not in a Network.

Participation Agreement: The term "Participation Agreement" means an agreement between an Employer, a Union or the trustees of a trust fund, and the Board of Trustees, under which the Employer, Union or the trustees of a trust fund have agreed to make contributions to the Trust Fund on behalf of bargaining and/or non-bargaining unit employees.

Physician: With regard to benefits that the Board of Trustees pay directly from the assets of the fund (rather than through the purchase of insurance), the term "Physician" means a medical doctor, doctor of osteopathy, doctor of podiatric medicine, doctor of dental surgery or doctor of medical dentistry who is legally licensed to practice.

Reasonable and Customary Charge: With regard to benefits that the Board of Trustees pay directly from the assets of the fund (rather than through the purchase of insurance), the term "Reasonable and Customary Charge" means the maximum allowable expense that the Plan will pay for a treatment, supply or service in a general area, based on charges made by persons or other entities regularly furnishing the type of treatment, services, or supplies in that area. The term "area" means a county or such greater area as is necessary to establish a representative cross section of persons or other entities regularly furnishing the type of treatment, services, or supplies for which the charge was made.

Schedule of Benefits: The term "Schedule of Benefits" means the Schedule that sets forth the levels of benefits and payment requirements, including Co-Payments, Co-Insurance, Deductible amounts and maximum benefit and payment limitations, for a group of Employees on whose behalf an Employer is making contributions to the Trust Fund. The Schedule of Benefits is identified in the Trust Acceptance.

Trust Acceptance: The term "Trust Acceptance" means an agreement signed by each Employer who is required to make contributions to the Trust Fund on behalf of its Employees under which the Employer agrees to be bound by the Agreement and Declaration of Trust of the Trust Fund and designates the Schedule of Benefits offered to its Employees.

Totally Disabled: The term "Totally Disabled" means that a Covered Employee is prevented, solely because of a non-occupational Injury or non-occupational Illness, from engaging in his regular or customary occupation and who is performing no work of any kind for compensation or profit.

Medical, Prescription Drug, Vision and Dental Benefits

Different Health Care Network Providers: This Summary Plan Description sets forth information that applies to all persons covered under the Plan, such as information about required benefits and eligibility rules. The Trustees have agreements with companies that create health care provider networks through which your health care benefits are delivered, such as health insurance companies that offer HMO and PPO benefit packages. Health, prescription drug and other benefits provided through NEHP's PPO program are self-funded, which means that the benefits are paid directly from monies in the Plan's trust fund. Health, prescription drug and other benefits provided through HMOs or insurance policies are fully insured, which means that the Trustees pay premiums using trust money and the insurance companies pay the claims.

Companies That Provide Health Care Benefit Services:

The following managed care companies will provide access to health care benefits for Plan participants through health care provider networks:

⇨ **Blue Cross Blue Shield of Michigan ("BCBSM")**: Provides access to a PPO network of health care providers who provide medical and prescription drug benefits for Employees covered under NEHP's self-funded PPO benefit package. BCBSM also administers claims for

medical and prescription drug benefits for the self-funded PPO programs. PPO Benefits are available through BCBSM and the Blue Cross Blue Shield system in all states.

Phone numbers for Customer Service are located on the back of your ID cards.
BCBSM Customer Service is available at 1-800-320-4950
To locate participating providers outside of Michigan: 1-800-810-2583
For Rx Prior Authorizations/Eligibility/Benefits: 1-800-437-3803

Information about your health care plan and benefits is also available by registering on the Secure Member portion of the BCBSM website at www.bcbsm.com. After registration on the website you will have access to information regarding the persons covered as your dependents, your Explanation of Benefits statements, and other important information.

BCBSM Addresses: Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 49226-2998
www.bcbsm.com

If you are covered under the self-funded PPO programs administered by BCBSM you have also been given a document titled Benefits at a Glance which was provided to you as a supplement to this Summary Plan Description. The Benefits at a Glance is important in understanding your benefits provided through the NEHP PPO program. It describes your benefits in summary fashion and sets forth your financial obligations towards the cost of your benefits, including your deductible, your co-pay obligations, and your co-insurance obligations. The Benefits at a Glance also describes any limitations on your benefits, such as limits on the number of treatments or provider visits for a specific benefit. You have also been given a document titled Your Benefit Guide which describes other features of the PPO program and other important information. Please keep copies of these important documents and refer to them as necessary.

Medical and Prescription Drug benefits under the Plan's PPO program are self-funded, which means that they are paid from monies held in the NEHP Trust. BCBSM administers the PPO program for NEHP under a contract and performs necessary services, including processing and paying claims and providing customer service. Medical and prescription drug benefits are provided under the terms established by BCBSM for BCBSM insured PPO programs using health care providers in BCBSM's provider networks.

For additional information regarding the benefits available to you under the self-funded PPO programs administered by BCBSM please contact BCBSM Customer Service at 1-800-320-4950.

BCBSM has issued to NEHP an insurance certificate modified by certain riders and other plan modifications that describes all of the benefits available to persons covered under the NEHP self-funded PPO program. Copies of the insurance certificate and any riders or other modifications to the certificate are available for review at the office of the Administrative Manager. Copies can also be provided upon request.

⇨ **Blue Care Network of Michigan ("BCN")**: Provides fully insured medical and prescription drug benefits through HMO products for Michigan residents. BCN also provides fully insured vision benefits through some HMO certificates. BCN is required by law to provide you with a copy of your certificate of insurance if you are covered under a BCN HMO program.

Information about your health care plan and benefits is also available by registering on the Secure Member portion of the BCBSM and BCN website at www.bcbsm.com.

Contact Information for BCN: Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 49226-2998
1-800-320-4950
www.bcbsm.com

⇨ **Coventry Health Plan:** Provides fully insured medical and prescription drug benefits through an HMO for Florida residents. Coventry is required by law to provide you with a copy of your certificate of insurance if you are covered under the Coventry HMO program.

Contact Information for Coventry: Coventry Health Care of Florida
1340 Concord Terrace
Sunrise, FL 33323
Toll Free: 1-866-847-8235
www.chcflorida.coventryhealthcare.com

⇨ **Health Alliance Plan of Michigan ("HAP")**: Provides fully insured medical and prescription drug benefits through an HMO for Michigan residents. HAP is required by law to provide you with a copy of your certificate of insurance if you are covered under the HAP HMO program.

Contact Information for HAP: Health Alliance Plan
2850 W. Grand Blvd.
Detroit, MI 48202
800-422-4641
www.hap.org

⇨ **United Health Care**: Provides fully insured medical and prescription drug benefits in Florida. United Health Care is required by law to provide you with a copy of your certificate of insurance if you are covered under their program.

Contact Information for United Health Care: United Health Care Neighborhood
Health Partnership
9900 Bren Road East
Minnetonka, MN 55343
800-633-2446
www.myuch.com

⇨ **EyeMed Vision Plan:** Provides access to a network of vision care providers and performs claims administration services. Vision benefits are paid from NEHP trust assets.

If you are covered for vision benefits provided through EyeMed you have been given a document describing vision benefits. This document is a supplement to this Summary Plan Description and is important in understanding your benefits provided through the EyeMed program. It describes your benefits; your financial obligations towards the cost of your benefits; exclusions; and any limitations on your benefits, such as limits on the number of treatments or provider visits for a specific benefit.

Vision benefits are self-funded, which means that they are paid from monies held in the NEHP Trust. EyeMed administers the vision benefit program for NEHP under a contract and performs necessary services, including processing and paying claims and providing customer service.

Contact Information for EyeMed: EyeMed Vision Plan
4000 Luxottica Place
Mason, OH 45040
888-362-7463
www.eyemedvisioncare.com

⇨ **Dentemax:** Provides access to a network of dental care providers through which self-funded dental benefits are provided.

If you are covered for dental benefits you have been given a document describing your dental benefits. This document is a supplement to this Summary Plan Description and is important in understanding your benefits provided through the Dentemax program. It describes your benefits; your financial obligations towards the cost of your benefits; exclusions; and any limitations on your benefits, such as limits on the number of treatments or provider visits for a specific benefit.

Dental benefits are self-funded, which means that they are paid from monies held in the NEHP Trust. Benefits are provided through the Dentemax network and are administered by either Automated Benefit Services or BCBSM, depending on your benefit program.

Contact Information for Dentemax: Dentemax
25925 Telegraph Road
Suite #400
Southfield, MI 48033
800-752-1547
www.dentemax.com

The complete description of your insured Plan benefits is set forth in materials provided by the managed care companies that coordinate your health care benefits. Each company's materials set forth:

(a) A description or summary of the benefits.

(b) A description of any cost-sharing provisions, including deductibles, co-insurance, and co-payment amounts for which participants will be responsible.

(c) Any annual or lifetime caps or other limits on benefits.

(d) The extent to which preventive services are covered.

(e) Whether, and under what circumstances, existing and new drugs are covered.

(f) Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures.

(g) Provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services.

(h) Any conditions or limits on the selection of primary care providers or providers of specialty medical care.

(i) Any conditions or limits applicable to obtaining emergency medical care.

(j) Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service.

(k) The listing of providers that are part of the provider network.

(l) Procedures for requesting and obtaining a Certificate of Creditable Coverage.

(m) Claims Procedures and procedures for appealing adverse benefit determinations.

(n) Rules and Procedures regarding the safeguarding, use and disclosure of Protected Health Information.

(o) Any circumstances under which benefits paid could be subject to offset, reduction or recovery, such as by exercise of subrogation or reimbursement rights.

If the health insurance companies selected by the Board of Trustees to provide health care benefits use provider networks, the health insurance companies may each provide a list of providers, which includes the names and contact information for all providers in the applicable network, as a separate document, automatically and free of charge.

The information provided by the health insurance companies and network providers selected by the Board of Trustees to provide health care benefits is an important part of this Summary Plan Description and is incorporated herein by reference.

Health Care Benefit Exclusions for All Benefit Options: Certain types of claims are excluded from coverage under all of the benefit options offered under the Plan. Benefits offered through fully insured policies may have additional exclusions. Benefits administered using a provider's claims review system may also have additional exclusions. You should check the materials provided by the company that manages your benefits in addition to this document in order to have a full list of all exclusions.

Payment will not be made for any expenses or services in connection with:

(a) Treatment or services that a Covered Person received at a veteran's administration hospital, public health service hospital or any facility contracted or operated by any governmental unit, unless the Covered Person is legally required to pay for them; or

(b) Treatment or services for an Illness or Injury received outside of the United States, its protectorates, Canada or Mexico except if the treatment is for a medical emergency or is related to an incident of domestic violence; or

(c) Treatment or services which are covered or provided by the Social Security Act; or

(d) Treatment or services for an Illness or Injury which is job-related or covered under workers' compensation; or

(e) Care received in the armed services of any country; or

(f) Treatment for Illness or Injury that is received while engaged in the commission of a violation of a state or federal statute; or

(g) Treatment or services which arise out of a war, whether declared or undeclared, or civil disturbance, including riots, demonstrations or marches; or

(h) Charges which are in excess of the Reasonable and Customary Charges; or

(i) State taxes or surcharges, or charges for completing claim forms; or

(j) Charges for services or supplies which are not medically necessary for the treatment of a diagnosed Illness or Injury; or

(k) Charges which are for experimental procedures or for the sole purpose of weight reduction.

Short Term Disability Benefits

Covered Employees are eligible for short term disability benefits if short term disability benefits are selected for a group as set forth in the Trust Acceptance establishing participation in the Plan. Retirees and their Dependents are not eligible for short term disability benefits.

When an Employee, while covered under this Plan, has become Totally Disabled due to a covered Illness or Injury, the Plan will pay the weekly income benefits stated in the applicable Schedule of Benefits. Benefits will commence as stated in the applicable Schedule of Benefits. To continue to receive short term disability benefits, the Covered Employee will be required to furnish proof of continued disability from his Physician, at least once per month or more often if the Plan Administrator deems it necessary.

An Employee shall be considered Totally Disabled when that person is prevented, solely because of a non-occupational Illness or Injury, from engaging in his regular or customary occupation, and who is performing no work of any kind for compensation or profit.

If an Employee becomes disabled as a result of an Injury requiring medical attention, short-term disability benefits will begin on the date the Employee first receives medical treatment for the Injury. This date will be determined by his Physician. If an Employee becomes disabled as a result of Illness requiring medical attention, short term disability benefits will begin eight (8) days after the date the Employee first receives medical treatment for the Illness. This date will be determined by his Physician. Short-term disability benefits for partial weeks will be computed on the basis of one seventh (1/7) of the weekly benefit per day.

In no event will any short-term disability benefits be paid for longer than the applicable maximum period as stated in the applicable Schedule of Benefits for any continuous period of disability, whether due to one or more causes or for all successive periods of disability due to the same or related cause or causes, unless separated by thirty (30) days of continuous regularly scheduled active work. If an eligible Employee returns to active work for a continuous period of at least thirty (30) days, any subsequent disability shall be deemed a new disability. A clearly unrelated Illness or Injury shall be considered a new disability provided such eligible Employee has returned to work for at least one (1) day.

Effective June 1, 2015, an Employee may qualify for short-term disability benefits under the Plan, if (i) the Employee became disabled under a short term disability plan sponsored by an International Brotherhood of Teamsters affiliate, (ii) the short term disability plan terminated and was unable to pay the short term disability benefits due to the Employee, and (iii) the Employee was employed by an Employer that commenced participation under this Plan immediately upon the termination date of the prior short term disability plan. If the Employee qualifies for short term disability benefits under this paragraph, the duration of the benefits will be limited to the maximum number of weeks set forth in the Schedule of Benefits less the number of weeks of short term disability benefits actually paid under the prior short-term disability plan.

Life, Accidental Death or Dismemberment Benefits

For Covered Employees: Covered Employees are eligible for life, accidental death or dismemberment benefits if such benefits are selected for a group as set forth in the Trust Acceptance establishing participation in the Plan. Benefits are provided in accordance with the applicable Schedule of Benefits.

All life, accidental death or dismemberment benefits are offered through one or more insurance contracts and are governed by the terms and conditions in the applicable insurance contract. All insurance contracts providing life, accidental death or dismemberment benefits under this Plan are incorporated herein by reference. The Plan Document shall govern in the event of any discrepancy between the provisions of any such insurance contract and specific provisions of the Plan Document or the Summary Plan Description.

The Plan has an insurance policy for life and accidental death or dismemberment benefits with:

Dearborn National

Contact Information:

Dearborn National
(formerly Fort Dearborn Life Insurance Co.)
1020 31st Street
Downers Grove, IL 60515
1-800-348-4512
www.dearbornnational.com

Life Benefits: In the event of a Covered Employee's death (other than death caused by an accident), benefits shall be payable on the life of the deceased Employee, in accordance with the applicable Schedule of Benefits.

Accidental Death or Dismemberment Benefits: In the event of a Covered Employee's death that is caused by an accident, both life benefits and accidental death benefits shall be payable on the life of the deceased Employee, in accordance with the applicable Schedule of Benefits.

In the event of the accidental loss of a Covered Employee's hands, feet or eyesight, accidental dismemberment benefits shall be payable to the eligible Employee, in accordance with the applicable Schedule of Benefits.

For Retirees: Retirees are not eligible for life, accidental death or dismemberment benefits. A Retiree who is eligible for and receives medical benefits under the Plan is eligible for **a death benefit**. In the event of an eligible Retiree's death, a death benefit of $1,000 shall be payable by the Plan to the eligible Retiree's beneficiary on the life of the deceased eligible Retiree.

For Dependents: Dependent life benefits are provided under the Plan to certain Covered Employees, in accordance with the applicable Schedule of Benefits. Dependents are not eligible for accidental death or dismemberment benefits.

In the event of the death of a covered Dependent who is entitled to Dependent life benefits, such benefits shall be paid to the Employee on the life of each deceased eligible Dependent, in accordance with the applicable Schedule of Benefits.

In the event of the death of a covered Dependent who is entitled to Dependent life insurance benefits and who is a Dependent to more than one eligible Employee, benefits are payable to only one eligible Employee, in accordance with the applicable Schedule of Benefits.

No Dependent life benefit shall be payable (a) on the death of an eligible dependent child occurring on or after the date the child attains 19 years of age, or (b) on the death of an eligible Employee.

Continuation of Life Insurance after Termination/Retirement: A Covered Employee may maintain, at his own cost, his life insurance on an individual basis upon termination of coverage under the Plan or upon retirement. The Employee must make a request for a conversion with the Insurer no later than 31 days following the termination of his coverage under this Plan, or his retirement, whichever is applicable.

CLAIMS PROCEDURES

The Plan is required by law to follow certain procedures in processing, reviewing and paying claims.

The following procedures apply for the filing and processing of benefit claims; the notification of benefit determinations; and the appeal of adverse benefit determinations. All insurance companies, PPOs, PBMs, or any other providers selected by the Trustees to facilitate delivery of benefits under this Plan are required to follow all applicable regulations and requirements for claims and appeals administration.

These rules incorporate and mirror the standards set forth in 29 CFR §2560.503-1 and 29 CFR §2590.715-2719. If there are any inconsistencies between these rules and applicable federal regulations then the applicable federal regulations apply. All modifications to the federal regulations are incorporated herein by reference.

I. Filing and Processing of Benefit Claims

The Plan offers several different types of benefits, and the procedures for filing benefit claims are different depending on the type of benefit. Please follow the appropriate procedure as described below.

A. Medical Benefits

All claims for Medical benefits shall be initially submitted to the Preferred Provider Organization(s) (PPO), Health Maintenance Organization (HMO) or other managed care network provider through which the medical benefits were provided, following procedures established by such provider for submitting claims. Such PPO, HMO or other managed care provider shall serve as the Claims Administrator and will make initial claims determinations.

Please note that the network providers through which benefits are provided under this Plan allow or require doctors, hospitals and other network health care providers to submit claims for benefits on your behalf. If, however, you need to submit a claim on your own behalf you must follow established procedures. If you receive benefits under a fully insured product issued by an insurance company, please follow the insurance company's procedures for submitting claims, which have been provided to you by the insurance company. If you receive benefits under the self-funded PPO benefit package administered by Blue Cross Blue Shield of Michigan ("BCBSM") then you must submit claims under procedures established by BCBSM, as described in the BCBSM Benefit Guide and on its website.

B. Prescription Drug Benefits

All claims for Prescription Drug benefits shall be initially submitted to the prescription drug program vendor or pharmacy benefit manager ("PBM") through which the Prescription Drug benefits were provided, following procedures established by such provider for submitting claims. Such prescription

drug program vendor or pharmacy benefit manager shall serve as the Claims Administrator and will make initial claims determinations.

Please note that claims for prescription drug benefits are almost always submitted on your behalf by the pharmacies at or near the time that the prescription is filled. If, however, you need to submit a claim on your own behalf you must follow established procedures. If you receive benefits under a fully insured product issued by an insurance company, please follow the insurance company's procedures for submitting claims, which have been provided to you by the insurance company. If you receive benefits under the self-funded PPO benefit package administered by Blue Cross Blue Shield of Michigan ("BCBSM") then you must submit claims under procedures established by BCBSM, as described in the BCBSM Benefit Guide and on its website.

C. Vision Benefits

All claims for Vision benefits shall be initially submitted to the managed care network provider through which the Vision benefits were provided, following procedures established by such provider for submitting claims. Such managed care network provider shall serve as the Claims Administrator and will make initial claims determinations.

Please note that claims for vision benefits are almost always submitted on your behalf by your network vision care providers at or near the time that the services are provided. If, however, you need to submit a claim on your own behalf you must follow established procedures.

Instructions for submitting claims other than through your provider are available on the EyeMed website at www.eyemed.com. Please be aware that vision benefits outside of the network may be limited or nonexistent; please consult your schedule of benefits before submitting claims directly to the Claims Administrator.

D. Dental Benefits

All claims for Dental benefits shall be initially submitted to the managed care network provider through which the dental benefits were provided, following procedures established by such provider for submitting claims. The claims will be sent by the network provider to the Plan Administrator or BCBSM, as appropriate, which will serve as the Claims Administrator and will make initial claims determinations.

Please note that claims for dental benefits are almost always submitted on your behalf by your network dentist at or near the time that the services are provided. If, however, you need to submit a claim on your own behalf you must follow established procedures.

The Administrative Manager, Automated Benefits Services, Inc., serves as the Claims Administrator for most dental benefits provided. Please contact Lisa Duncan at ABS, at (586) 693-4362 or 1-800-447-1032 or lduncan@ABS-TPA.com or by mail at 8220 Irving Rd., Sterling Heights, Michigan 48312, to obtain forms required to apply for dental benefits that are not submitted by your dentist. BCBSM serves as the Claims Administrator for some dental benefits. Please contact BCBSM following procedures described above in connection with medical and prescription drug benefits. Please be aware that dental benefits outside of the network may be limited or nonexistent; please consult your schedule of benefits before submitting claims directly to the Claims Administrator.

E. Short Term Disability Benefits

All claims for Short Term Disability benefits shall be initially submitted to the Plan Administrator, following procedures established by the Plan Administrator for submitting claims. The Plan Administrator will serve as the Claims Administrator and will make initial claims determination.

The Administrative Manager, Automated Benefits Services, Inc. ("ABS"), serves as the Claims Administrator for Short Term Disability benefits. Please contact Lisa Duncan at ABS, at (586) 693-4362 or 1-800-447-1032 or lduncan@ABS-TPA.com or by mail at 8220 Irving Rd., Sterling Heights, Michigan 48312, to obtain forms required to apply for Short Term Disability benefits.

F. Life, Accidental Death or Dismemberment Benefits

All claims for Life, Accidental Death or Dismemberment benefits shall be initially submitted to the Plan's life insurance carrier, following procedures established by such carrier for submitting claims. Such carrier shall serve as the Claims Administrator and will make initial claims determinations.

The Administrative Manager, Automated Benefits Services, Inc. ("ABS"), has forms required to apply for Life, Accidental Death or Dismemberment benefits. Please contact Lisa Duncan at ABS, at (586) 693-4362 or 1-800-447-1032 or lduncan@ABS-TPA.com or by mail at 8220 Irving Rd., Sterling Heights, Michigan 48312, to obtain necessary forms to apply for Life, Accidental Death or Dismemberment benefits.

G. Death Benefits

All claims for Death benefits shall be initially submitted to the Plan Administrator, following procedures established by the Plan Administrator for submitting claims. The Plan Administrator will serve as the Claims Administrator and will make initial claims determination.

The Administrative Manager, Automated Benefits Services, Inc. ("ABS"), serves as the Claims Administrator for Death benefits. Please contact Lisa Duncan at ABS, at (586) 693-4362 or 1-800-447-1032 or lduncan@ABS-TPA.com or by mail at 8220 Irving Rd., Sterling Heights, Michigan 48312, to obtain forms required to apply for Death benefits.

II. Time and Method for Filing Claims

Claims for benefits for which an insurance company, PPO, PBM or other managed care or network provider acts as Claims Administrator must be submitted following such Claims Administrator's rules and procedures, including time limits for filing claims.

Claims for benefits for which the Administrative Manager acts as Claims Administrator must be submitted within one year of the date a service was provided or the date of an event that forms the basis for a claim.

Claims for benefits may be submitted by a medical care service provider on behalf of a Covered Person at or near the time services were provided if allowed under the procedures established by the PPO, PBM, insurance company or other managed care network provider through which benefits are provided, or under procedures established by the applicable Claims Administrator.

Covered Persons may also submit claims for benefits to the Claims Administrator designated above for each type of benefit, following procedures established by the Claims Administrator.

III. Claims Determination Procedures

After a claim is filed the Claims Administrator follows set procedures to evaluate the claim and determine the benefits available under the terms of the Plan.

All benefit claim determinations will be made in accordance with governing plan documents and will be applied consistently with respect to similarly situated claimants.

All benefit claim determinations will be made within the time periods specified below under heading IV, Time Periods for Claims Determinations.

IV. Time Periods for Claims Determinations

All benefit claim determinations will be made within the time periods specified herein.

Except as otherwise stated under heading IV, Time Periods for Claims Determinations, if a claim is wholly or partially denied, the Claims Administrator shall notify you of the adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim.

If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 90 day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the benefit determination.

The time periods for benefit claim determinations are different depending on the type of claim, as described below.

The applicable time period begins at the time a claim is filed under the procedures provided, without regard to whether all the information necessary to make a benefit determination accompanies the filing. If a claimant fails to submit information necessary to decide a claim, and an applicable time period is extended as permitted herein, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

A. Time Periods for Determinations of Medical, Prescription Drug, Vision and Dental Claims

The Claims Administrator will process claims for Medical, Prescription Drug, Vision or Dental benefits upon receipt of each claim and will subsequently notify you of the benefit determination. Claims will be processed based on procedures and within the time period allowed for each type of claim, as follows:

1. *Urgent Care Claims*

An "Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—(A) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (B) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim is to be made by a person acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any claim that a physician with knowledge of the

claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim.

The Claims Administrator will notify you of the Plan's benefit determination on an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Participant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If you failed to provide sufficient information, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Following such notification, the Claims Administrator will notify you of the plan's benefit determination as soon as possible, but in no case later than 48 hours after (i) the Plan receives the specified information, or (ii) the end of the period afforded to provide the specified additional information, whichever is earlier.

Notification of any adverse benefit determinations made relating to urgent care claims will be made as provided herein.

2. *Concurrent Care Claims*

A Concurrent Care Claim is a claim for benefits for an approved ongoing course of treatment to be provided over a period of time or number of treatments.

It will be considered as an "adverse benefit determination" if, after approval of a course of treatment, there is a reduction or termination of the benefits (other than by plan amendment or termination) before the end of the approved time period or number of treatments. The Claims Administrator shall notify you of such a change in benefits at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

A request to extend an approved ongoing course of treatment beyond the approved time period or number of treatments that is also an urgent care Claim shall be decided as soon as possible, taking into account the medical exigencies, and, if such claim is made to the Claims Administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the Claims Administrator will notify you of the benefit determination within 24 hours after receipt of the claim.

Notification of any adverse benefit determinations made relating to Concurrent Care Claims will be made as provided herein.

3. *Pre-Service Claims*

A "Pre-Service Claim" is any claim for a benefit that requires, in whole or in part, approval of the benefit in advance of obtaining medical care.

If you submit a Pre-Service Claim, the Claims Administrator will notify you of the Plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan.

This period may be extended one time by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because you failed to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Notification of any adverse benefit determinations made relating to Pre-Service Claims will be made as provided herein.

If you or your authorized representative fail to follow the Plan's procedures for filing a Pre-Service Claim, you or your representative will be notified of the failure and of the proper procedures to be followed, provided that the failure to follow procedures is a communication as described in 29 C.F.R. §2560.503-1(c) (1)(ii). This notification shall be made as soon as possible, but no later than 24 hours following a failure to properly file a Pre-Service Claim involving urgent care, or 5 days following a failure to properly file any other type of Pre-Service Claim. Notification may be oral, unless you or your authorized representative request written notification.

4. ***Post-Service Claims***

A "Post-Service Claim" is a claim for a benefit that is filed after the services have been provided. The Claims Administrator shall notify you of an adverse benefit determination of a Post-Service Claim within a reasonable period of time, but not later than 30 days after receipt of the claim.

This period may be extended one time by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because you failed to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

This period may be extended one time by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because you failed to submit the information necessary to decide the claim, then the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

B. Time Period for Determinations of Short Term Disability Claims

Upon submission of a claim for Short Term Disability Benefits the Claims Administrator will process the claim and notify you of an adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan.

This period may be extended by the Claims Administrator, for up to 30 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision.

In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

Notification of any adverse benefit determinations made relating to Short Term Disability Claims will be made as provided herein.

C. Time Period for Determinations of Life, Accidental Death or Dismemberment and Death Claims

Upon submission of a claim for Accidental Death or Dismemberment or Death benefits the Claims Administrator will process the claim and notify the Participant of the benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. All claims for Death and Accidental Death or Dismemberment benefits will be processed using the general standards for notification of adverse benefit determinations, as set forth below.

V. Adverse Benefit Determinations

In the case of an Adverse Benefit Determination, the Claims Administrator will provide you notice of the Adverse Benefit Determination. Such notice will be provided within the time frames stated above under heading IV, Time Periods for Claims Determinations. The notice will comply with the requirements stated under this heading V, Adverse Benefit Determinations.

All PPOs, PBMs, insurance companies or other network or managed care providers acting as Claims Administrators must follow all federal requirements and guidelines for notification of adverse benefit determinations as applicable to the type of benefit adjudicated, including standards in 29 CFR §2560.503-1 and 29 CFR §2590.715-2719. If any such provider has rules or procedures that are different from those set forth here, such rules or procedures will apply, unless they are inconsistent with federal law requirements.

The term “adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. A rescission of coverage is also an ‘adverse benefit determination” for this purpose, whether or not there is an adverse effect on any particular benefit at the time of the rescission.

The term “adverse benefit determination” also means any rescission of short term disability coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at

that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

A. Manner and Content of Notification of Adverse Benefit Determinations

Except as otherwise described below, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination.

In the case of an adverse benefit determination on an Urgent Care Claim, notification may be given orally within the time frame described above, provided that a written or electronic notification is furnished not later than 3 days following the date of oral notification.

Except as otherwise provided herein, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv).

In the case of an adverse benefit determination on an urgent care claim, notification may be given orally within the time frame described above, provided that a written or electronic notification is furnished not later than 3 days following the date of oral notification.

The notification of an adverse benefit determination relating to any benefits offered under this Plan shall set forth, in a manner calculated to be understood by the claimant, the following information:

(a) The specific reason or reasons for the adverse determination;

(b) For Medical and Prescription Drug claims, information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis code, the treatment code and the meanings of any such codes.

(c) For Medical and Prescription Drug claims, the specific reason or reasons for the adverse determination, including the denial code and its meaning and a description of the standard that was used in denying the claim;

(d) Reference to the specific plan provisions on which the determination is based;

(e) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(f) A description of the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal;

(g) A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

(h) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request;

(i) In the case of an adverse benefit determination of Medical or Prescription Drug claims —

i. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or

other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request; or

ii. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(j) In the case of an adverse benefit determination concerning a claim involving urgent care—

i. A description of the expedited review process applicable to such claims.

ii. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to you're your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(k) In the case of an adverse benefit determination with respect to disability benefits—

i. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

I. The views of health care professionals treating you or of any vocational professionals who evaluated you that you presented to the Plan;

II. The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

III. Any disability determination by the Social Security Administration relating to you that you presented to the plan;

ii. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

iii. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

iv. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to the definition Relevant at item (h) of heading VI, Appeals of Adverse Benefit Determinations; and

v. The notification shall be provided in a culturally and linguistically appropriate manner.

(l) For Medical and Prescription Drug claims, contact information for any office of health insurance consumer assistance available to assist individuals with the internal claims and appeals process and applicable external review processes.

VI. Appeals of Adverse Benefit Determinations

You have a right to appeal an adverse benefit determination relating to any claim for benefits under this Plan to an appropriate named fiduciary of the Plan for a full and fair review of the claim and the adverse benefit determination. Appeals of adverse benefit determinations must be brought by you or by your authorized representative. The Plan will provide continued coverage pending the outcome of an appeal and will comply with required notice provisions before reducing or terminating an ongoing course of treatment.

Appeal procedures, including the time that you have to file an appeal, are different for each time of benefit, so please read the procedures below for the type of benefit to which your claim relates.

A. General Rules and Procedures for Appeals

The filing rules apply to all appeals:

(a) All PPOs, PBMs, insurance companies or other network or managed care providers acting as Claims Administrators must follow all federal requirements and guidelines for appeals of adverse benefit determinations as applicable to the type of benefit adjudicated, including standards in 29 CFR §2560.503-1 and 29 CFR §2590.715-2719. If any such provider has rules or procedures that are different from those set forth here, such rules or procedures will apply, unless they are inconsistent with federal law requirements.

(b) You will have an opportunity to appeal an adverse benefit determination relating to all claims for benefits under this Plan to an appropriate named fiduciary of the Plan for a full and fair review of the claim and the adverse benefit determination.

(c) Except as otherwise provided for specific types of benefits and claims, you will have at least 60 days following receipt of an adverse benefit determination to appeal the determination.

(d) Appeals of adverse benefit determinations must be brought by you or by your authorized representative.

(e) The Plan will provide you continued coverage pending the outcome of an appeal and will comply with required notice provisions before reducing or terminating an ongoing course of treatment.

(f) You will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.

(g) The Claims Administrator will provide you, free of charge and upon request, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

(h) A document, record, or other information shall be considered "relevant" to a claim for benefits if such document, record, or other information, (i) was relied upon in making the

benefit determination, (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination, (iii) demonstrates compliance with the administrative processes and safeguards required pursuant to this section in making the benefit determination, or (iv) in the case of disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(i) The review shall take into account all comments, documents, records, and other information that you submit during the review, without regard to whether such information was submitted or considered in the initial benefit determination.

(j) The Claims Administrator for each type of benefit may be authorized to administer and determine appeals. The Board of Trustees will determine appeals when the Administrative Manager acts as the initial Claims Administrator.

B. Additional Rules and Procedures for Appeals of Claims for Medical, Prescription Drug, Vision, Dental and Disability Benefits

The following additional rules apply to appeals for Medical, Prescription Drug, Vision, Dental and Disability benefits:

(a) Appeals of adverse benefit determinations of claims for Medical or Prescription Drug or Short Term Disability benefits must be submitted in writing within 180 days of a Participant's receipt of an adverse benefit determination.

(b) The Claims Administrator or the Board of Trustees, as applicable, will consider and decide all appeals of adverse benefit determinations for claims for Medical or Prescription Drug or Short Term Disability benefits taking into account all comments, documents, records and other information submitted by the claimant relating to the claims, without regard to whether such information was submitted or considered in the initial benefit determination.

(c) The Claims Administrator or the Board will not afford deference to the initial adverse benefit determination, and the review will be conducted by a fiduciary who did not make the initial adverse benefit determination and who is not a subordinate of the person who did.

(d) If an adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board of Trustees or Claims Administrator, as applicable, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The professional so consulted will not be a person who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and will not be a subordinate of any expert consulted in connection with the adverse determination under appeal.

(e) If medical or vocational experts were consulted on behalf of the Plan in connection with an adverse benefit determination, such experts will be identified, whether or not the advice obtained was relied upon in making the benefit determination.

(f) The Claims Administrator or Board of Trustees will also provide, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan or at the direction

of the Plan in connection with a claim. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided, so that you will have a reasonable opportunity to respond prior to that date.

(g) The Claims Administrator or Board of Trustees will not issue a final internal adverse benefit determination based on a new or additional rationale before first providing you the rationale, free of charge, as soon as possible, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided, so that you have a reasonable opportunity to respond prior to that date.

(h) The Trustees strive to ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly the Claims Administrator will not make any personnel decisions, including hiring, compensation, termination, promotion or other similar actions, based upon the likelihood that the persons involved in the claims review procedure will support the denial of benefits.

(i) Appeals of adverse benefit determinations of claims for Medical or Prescription Drug benefits involving urgent care will include an expedited review process. Under the expedited review process a request for an expedited appeal may be submitted by you orally or in writing, and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and you by telephone, facsimile, or other available similarly expeditious method.

C. Time for Determination and Notification of Decision after Appeal

All appeals of adverse benefit claim determinations will be made within the time periods described below:

(a) Generally

i. All appeals of adverse benefit claim determinations will be made within the time periods specified herein. The applicable time period begins at the time a request for an appeal is received by the Plan in accordance with the procedures for filing appeals, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing.

ii. If you fail to submit information necessary to decide a claim, and an applicable time period is extended as permitted herein, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which you respond to the request for additional information.

iii. Except as otherwise provided herein for certain types of health care claims, if the Board of Trustees is considering the appeal the Board shall make a benefit determination no later than the date of the Board of Trustees' meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. If a request for review is filed less than 30 days before the next meeting, the Board shall make a determination no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the date of the third meeting following the Plan's receipt of the request for review.

iv. If an extension of time for review is required because of special circumstances, the Plan Administrator shall provide you written notice of the extension, prior to the commencement of the extension, describing the special circumstances and the date as of which the benefit determination will be made.

v. The Plan Administrator shall notify you of a benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(b) Determination and Notification of Decision after Appeal of Certain Types of Health Care Claims

i. Urgent Care Claims: In the case of a claim involving urgent care, you will be notified of the Plan's determination after review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your appeal of the adverse benefit determination.

ii. Pre-Service Claims: In the case of a Pre-Service Claim, you will be notified of the Plan's determination after review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your appeal of the adverse benefit determination.

D. Manner and Content of Notification of Decision after Appeal

The Claims Administrator or Board of Trustees will provide you written or electronic notification of the decision after appeal and review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv).

In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant, the following information—

(a) Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code and the meanings of any such codes.

(b) The specific reason or reasons for the adverse determination, including the denial code and its meaning, a description of the standard that was used in denying the claim, and a discussion of the reasons supporting the decision;

(c) Reference to the specific plan provisions on which the benefit determination is based;

(d) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

(e) A description of the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal;

(f) A statement of your right to bring an action under section 502(a) of ERISA;

(g) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request;

(h) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical

judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request;

(i) In the case of an adverse benefit decision with respect to disability benefits—

i. Any applicable contractual limitations period that applies to your right to bring an action under section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim.

ii. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

I. The views of health care professionals treating you or of any vocational professionals who evaluated you that you presented to the plan;

II. The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

III. A disability determination by the Social Security Administration relating to you that you presented to the Plan;

iii. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of change upon request; and

iv. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

(j) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency"; and

(k) Contact information for any office of health insurance consumer assistance available to assist individuals with the internal claims and appeals process and applicable external review processes.

E. External Review Procedures

The following External Review Procedures rules apply to Medical and Prescription Drug claims only.

If you appealed an adverse benefit determination and your appeal was denied, you may request an external review of the Plan's decision by an Independent Review Organization ("IRO"). The following describes your rights and responsibilities in connection with an external review of the Plan's adverse benefit determination.

All PPOs, PBMs, insurance companies or other network or managed care providers acting as Claims Administrators must follow all federal requirements and guidelines for external reviews as applicable to the type of benefit adjudicated, including standards in 29 CFR §2560.503-1 and 29 CFR §2590.715-2719. If any such provider has rules or procedures that are different from those set forth here, such rules or procedures will apply, unless they are inconsistent with federal law requirements.

Depending on the circumstances you may request either a Standard external review or an Expedited external review. An Expedited external review is available when the time frame to complete a standard external review would seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or if the claim involves care related to emergency services received by the claimant and the claimant has not been discharged from a facility.

You must request an external review of a final adverse benefit determination under procedures established by the network provider through which your benefits were provided. If you receive benefits through a fully insured policy provided by an insurance company then you must request an external review under procedures established by the insurance company. Please consult the information provided to you by the insurance company to obtain information on how to file a request for an external review of your denied claim.

If you receive benefits through a self-funded benefit package administered through Blue Cross Blue Shield of Michigan ("BCBSM") then you must request an external review of an adverse benefit determination using BCBSM procedures. Please consult the BCBSM website or call the customer service number listed on your ID card.

External review procedures provided through each of the managed care network providers must comply with the same federal law guidelines described below.

Standard External Review

(a) ***Request for external review.*** You may file a request for an external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If that date falls on a weekend or holiday you have until the next business day.

(b) ***Preliminary review.*** Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

1. The claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care service was provided;

2. The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the eligibility requirements under the terms of the Plan;

3. The claimant has exhausted the plan's internal appeals process, unless the claimant is not required to do so under the applicable regulations; and

4. The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan must issue a written notification to the claimant. If the request is complete but not eligible for external review, such written notification must include the reasons the claim is ineligible and contact information for the DOL's Employee Benefits Security Administration. If the request is not complete, the written notification must describe the information needed to complete the request, and the claimant must be permitted to perfect the request within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

(c) ***Referral to Independent Review Organization (IRO).*** If the request for review is complete and is eligible for external review then the Plan will assign an Independent Review Organization (IRO) that is accredited under the appropriate regulations and federal guidance to conduct the

external review. In order to prevent against bias and ensure independence, the Plan or the network providers have established or will establish contracts with at least three (3) IROs for assignments and will rotate claims assignments among them (or will incorporate other independent, unbiased methods for selection of IROs, such as random selection). The IROs are prohibited from receiving any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(d) ***Procedures for IRO External Review:*** The assigned IRO will conduct the external review following applicable federal guidelines, as described in its contract, and using legal experts as necessary. The IRO assigned to review the claim will let the claimant know in writing that it will be conducting the external review and will give the claimant a notice stating that the claimant may submit, in writing, within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO may also consider information provided by the claimant after the 10 day window but is not required to do so. Upon receipt of any information from the claimant the IRO will promptly forward the information to the Plan within one business day, and the Plan may reconsider it decision to deny the claim. If the Plan were to reconsider its decision and allow the claim then the external review will be terminated upon receipt of notice of the Plan's decision.

The Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination within 5 business days after the date of assignment.

The IRO will review all of the information and documents timely received, and will review the claim without deferring to any decisions or conclusions reach during the plan's appeal process. The IRO may also consider, if the IRO thinks it is appropriate, the following:

1. The claimant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or the claimant's treating provider;
4. The terms of the plan to ensure that the IRO's decision is not contrary to them, as long as the terms are consistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards or associations;
6. Any applicable clinical review criteria developed and used by the Plan; and
7. The opinion of the IRO's clinical reviewer after considering the information described in the notice, as long as the documents are available and the clinical review considers them appropriate.

(e) ***Written notice:*** The assigned IRO will provide written notice of the final external review decision to the Plan and to the claimant within 45 days after the IRO receives the request for the external review. The IRO's decision notice will include the following:

1. A general description of the reason for the request for external review, the reason for the previous denial and information sufficient to identify the claim, the diagnosis code, treatment code, and explanations of the codes;
2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards considered in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standard that were relied on in making its decision;

5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to the claimant;
6. A statement that judicial review may be available to the claimant; and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the new federal health care reform law.

(f) ***Reversal of plan's decision.*** The IRO could determine after external review that the adverse benefit determination should be reversed. Upon receipt of a notice of a final external review decision that reverses the adverse benefit determination or final internal adverse benefit determination, the Plan is required to immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

(g) ***Records to be maintained:*** After a final external review decision the IRO must maintain record of all claims and notices associated with the external review process for six years. The IRO must make such records available for examination by the claimant, the Plan, or state or federal oversight agencies upon request, unless prohibited by law.

Expedited External Review

(a) ***Request for expedited external review.*** You may make a request for an expedited external review when you receive:

1. An adverse benefit determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or

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

(b) ***Preliminary Review.*** Upon receipt of a request for an expedited external review the Plan will immediately determine whether the request meets the standards described above for standard external review. The plan will send a notice regarding its preliminary review as soon as possible notifying the claimant of its eligibility determination.

(c) ***Referral to Independent Review Organization (IRO).*** Upon determination that a request is eligible for external review the Plan will assign an Independent Review Organization following the procedures described above for standard external reviews. The Plan will provide all necessary documents and information considered in making the adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO will consider the documents and information provided under the standards and procedures described above for standard external reviews. In reaching a decision the assigned IRO will review the claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(d) ***Notice of final external review decision.*** The IRO will provide notice of the final external review decision following the requirements and procedures described above for standard external review

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

BENEFITS AND RIGHTS REQUIRED UNDER FEDERAL LAW

Hospital Length of Stay after Childbirth

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 caesarean 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). The hospital length of stay begins at the time of delivery of the newborn if delivery occurs in the hospital or at the time of admission to the hospital if delivery occurs outside a hospital.

Reconstructive Surgery after Mastectomy

As required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) this Plan provides coverage to any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, for: (a) All stages of reconstruction of the breast on which the mastectomy was performed; (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) Prostheses; and (d) Treatment of physical complications of mastectomy, including lymphedema. Coverage will be provided in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and Co-Insurance provisions as set forth herein, and as are consistent with those established for other benefits provided hereunder.

Parity for Mental Health and Substance Use Disorder Benefits

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") requires that any group health plan that includes mental health and substance use disorder benefits along with standard medical and surgical coverage must treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review. Your Plan is designed to comply with the requirements of this federal law.

Benefits Required under the Affordable Care Act of 2010

Federal health care reform law passed in 2010 requires group health plans to comply with a number of requirements relating to the provision of benefits under group health care plans. Your Plan is designed to comply with all requirements under federal law, including all requirements under federal health care reform laws.

Selection of Primary Care Providers

Some of the health benefit packages offered through HMOs under NEHP may require or allow you to designate a primary care provider. You have the right to designate any primary care provider who participates in the appropriate network and who is available to accept you or your family members. For

children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in the appropriate network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, and for a list of the participating primary care providers, including a list of participating health care professionals who specialize in obstetrics or gynecology, contact the company through which your benefits are provided. Contact information is provided in this booklet in the section describing Benefits.

OTHER IMPORTANT INFORMATION ABOUT YOUR BENEFITS

I. Circumstances That Could Affect Your Receipt of Benefits

Fraud or Misrepresentation: The Plan shall have the right to recover whatever benefits are paid on behalf of any person when the basis of such claim is misrepresented or fraudulently presented to the Plan, whether by a Participant or by any medical service provider(s). If fraud or misrepresentation is established the Plan shall have the right to recover all benefits paid by either: (1) a direct recovery from the Participant and/or the medical service provider(s) responsible for the fraud or misrepresentation; or (2) by reducing or off-setting all subsequent benefits for such Participant and members of the Participant's family eligible for benefits until such time as the Plan has made full recovery of the misrepresented or fraudulent amounts. Such recovery may also include medical investigation charges, auditors' fees and attorney fees, as necessary.

Coordination of Benefits: If you or your Dependents have health care coverage under another group health plan, insurance program or government program, benefits shall be coordinated between the Plan and any such source of benefit payments. If this Plan is the primary plan it will pay full benefits, without regard to any other available coverage. If this Plan is the secondary plan it will provide payments toward the balance of the cost of covered services, up to the total allowed amount. Coordination of Benefits ("COB") ensures that the combined payments of all coverage will not exceed the actual cost approved for the medical services provided. The Preferred Provider Organization(s) (PPO), Health Maintenance Organization (HMO) or other managed care network provider through which the medical benefits were provided shall be responsible for COB and shall determine whether this Plan is the primary plan or secondary plan, following procedures established by such provider.

Reimbursement and Subrogation: If your illness or injuries are caused by a third party then in order to receive benefits under the Plan you must agree that the Plan has the right of subrogation against any third party tortfeasor or any insurance carrier, and that the Plan has a separate and independent right of reimbursement from you, to the extent of the benefits paid under the Plan. In other words if you receive benefits under the Plan and start legal proceedings or otherwise recover damages from another person who caused the injury or illness then the Plan has the right to be reimbursed for the benefits it paid to you or on your behalf in connection with the injury or illness. These provisions also apply to benefits paid to or on behalf of your Dependents.

If your illness or injuries are caused by a third party you must therefore execute a Reimbursement and Subrogation Agreement and any other required documents, as provided by the Plan Administrator, relating to the reimbursement and subrogation rights under this Plan. You are also required to notify the Plan Administrator of any claim or legal action asserted against any party or insurance carrier for such injuries or illness and to promptly provide the name and address of such party and any insurance carrier. You

must agree to take no action inconsistent with the requirements of this section, nor settle any claim without prior consent of the Trustees.

In order to protect the rights of the Plan as described in this section you agree that the Plan has a lien on any amounts recovered by you or on your behalf, whether or not designated as payment for medical expenses, including any recovery, settlement, or judgment obtained from or against any party at fault, or from any other source, relating to injuries or illness caused by a third party. The lien shall remain in effect until the Plan is repaid for all benefits paid under the Plan. The lien applies to any such amounts recovered, whether in your possession or in the possession of a third party, such as a trustee, guardian or conservator.

The Plan's reimbursement and subrogation rights shall not be subject to equitable distribution or to any reduction for costs or attorneys' fees incurred in pursuit of your claim against the third party or against any insurance carrier. In addition, the Plan shall be entitled to reimbursement from the first dollars paid to you by any party or insurance carrier and shall have the right to full recovery, which shall not be subject to reduction regardless of whether you recover the full value of your claim against the third party and/or any insurance carrier. If you fail to execute a Reimbursement and Subrogation Agreement, or otherwise fail to comply with the terms of this section, then such shall be considered a breach of this Plan and benefits may be denied by the Trustees.

Plan's Right to Recover Excess Payments: Whenever payments have been made by the Plan in excess of the maximum amount of payment allowed under the Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator shall determine: (a) any persons to whom, for whom or with respect to whom such payments were made or (b) any insurance companies, service plans or any other organizations to whom such payments were made.

II. Other Important Information

Assignment of Claims: Benefits which are not based on expenses incurred may not be assigned. Benefits payable for expenses incurred in connection with a specified period of disability, hospital care or surgical or medical treatment resulting from one injury or illness may be assigned only to the institution or individual furnishing the respective services or supplies for which such benefits are payable. The Plan assumes no responsibility for the validity of any assignment, nor will it be liable under assignment until and unless satisfactory proof of assignment is submitted to the Plan prior to payment of the assigned benefits.

Time Limitations for Legal Actions: Exhaustion of administrative remedies is required before a lawsuit may be brought in federal court. Any lawsuits must be initiated within two years of the date that a claim was denied.

Physician Review: A physician designated by the Plan shall have the right and opportunity to examine any person whose illness or injury is the basis of any claim when and as often as reasonably required and, in the event of such person's death, to make an autopsy unless prohibited by law.

Applicable Law: This Plan is created and accepted in the State of Michigan. All questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Michigan except as to matters governed by federal law.

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.

This Notice applies to benefits provided under the National Employees Health Plan (the "Plan"), a multiemployer health and welfare benefit plan. References to "we" and "us" throughout this Notice are references to the Plan. This Notice has been drafted to comply with the "HIPAA Privacy Rules", under federal law. Any terms that are not defined in this Notice have the meaning specified in the HIPAA Privacy Rules.

How We Protect Your Privacy: The Plan is required by law to protect the privacy of your "protected health information" and to provide you with this notice of privacy practices. Protected Health Information ("PHI") is defined in the HIPAA Privacy Rules, and federal law requires that PHI be handled under certain precautions. We will not disclose confidential information without your authorization unless it is necessary to provide your health benefits and administer the Plan, or as otherwise required or permitted by law. When we need to disclose individually identifiable information, we will follow the policies described in this Notice to protect your confidentiality. When the use or disclosure of PHI is permitted the minimum necessary amount of information will be provided to accomplish the intended purpose of the use or disclosure.

The Plan has agreements with different health care providers, such as HMOs, who provide health care services to you and who may hold your PHI. Such providers have obligations to safeguard your PHI and do so under their own procedures and obligations. To the extent that any confidential information is held by or under the control of the Plan we have procedures for accessing and storing confidential records. Internal access to your confidential information is limited to employees who need that information to administer the Plan.

How We May Use and Disclose Your Protected Health Information: The Plan may use your PHI for purposes of making or obtaining payment for your care and for administering the Plan. The following is a summary of permitted uses and disclosures of your PHI.

We will not use your confidential information or disclose it to others without your written authorization, except for the following purposes.

- **Treatment.** We may disclose your protected health information to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your protected health information to a health care provider when the provider needs that information to provide treatment to you. We may also disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

- **Payment.** We may use or disclose your protected health information to provide payment for the treatment you receive under the Plan. For example, we may use and disclose your protected health information to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may use and disclose your protected health information to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges. In addition, we may use and disclose your protected health information as necessary to

preauthorize services to you and review the services provided to you. We may also use and disclose your protected health information to obtain payment under a contract for reinsurance, including stop-loss insurance. We may use and disclose your protected health information to adjudicate your claims. Also, we may disclose your protected health information to other health care providers or entities who need your protected health information to obtain or provide payment for your treatment.

- **Health Care Operations.** We may use or disclose your protected health information for our health care operations. We may use or disclose your protected health information to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. We may use or disclose your protected health information to provide you with customer service activities or develop programs. We may also provide your protected health information to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your protected health information to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your protected health information to these entities if they have or have had a relationship with you and your protected health information pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

- **Disclosures to the Plan Sponsor**. The Board of Trustees is the sponsor of the Plan. The Plan sponsor is not permitted to use protected health information for any purpose other than the administration of the Plan. The Plan sponsor must certify, among other things, that it will only use and disclose your protected health information as permitted by the Plan, it will restrict access to your protected health information to those individuals whose job it is to administer the Plan and it will not use protected health information for any employment-related actions or decisions. The Plan may also disclose enrollment information to the Plan sponsor. The Plan may also disclose summary health information to the Plan sponsor for purposes of obtaining bids for health insurance or lending or modifying the Plan.

- **Disclosures to Business Associates**. We contract with individuals and entities (called "business associates") to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services our business associates will receive, create, maintain, use or disclose protected health information. We require the business associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, we may disclose your protected health information to a business associate to administer claims or provide service support, utilization management, subrogation or pharmacy benefit management.

- **Disclosures to Family Members or Others**. Unless you object, we may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose protected health information (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends.

- **Other Uses and Disclosures**. The law allows us to disclose protected health information without your prior authorization in the following circumstances:

    - **Required by law.** We may use and disclose your protected health information to comply with any federal, state or local law.

- **Public health activities.** We may disclose protected health information when we report to a public health authority for purposes such as public health surveillance, public health investigations or suspected child abuse.

- **Reports about victims of abuse, neglect or domestic violence.** We may disclose protected health information in these reports only if we are required or authorized by law to do so, or if you otherwise agree.

- **To health oversight agencies.** We may provide protected health information as requested to government agencies that have the authority to audit or investigate our operations.

- **Lawsuits and disputes.** As permitted or required by law, we may disclose your protected health information in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the protected health information requested.

  Law enforcement. As permitted or required by law, we may release protected health information if asked to do so by a law enforcement official in the following circumstances: (a) to respond to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) to assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) to investigate a death we believe may be due to criminal conduct; (e) to investigate criminal conduct; and (f) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).

- **Coroners, medical examiners and funeral directors.** We may disclose protected health information to facilitate the duties of these individuals.

- **Organ procurement.** We may disclose protected health information to facilitate organ donation and transplantation.

- **Medical research**. We may disclose protected health information for medical research projects, subject to strict legal restrictions.

- **Serious threat to health or safety.** We may disclose protected health information to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public.

- **Special government functions.** We may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State.

- **Workers' compensation or similar programs.** We may disclose protected health information when necessary to comply with worker's compensation laws.

Participant Rights: You have the following rights regarding PHI maintained by the Plan. :

Right to inspect and copy your protected health information. Except for limited circumstances, you may review and copy your protected health information. Your request must be addressed to the Privacy Officer. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information

you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

If you request copies of your protected health information, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your protected health information, upon your request if you agree to the rules and cost (if any) in advance.

Right to correct or update your protected health information. If you believe that the protected health information we have is incomplete or incorrect, you may ask us to amend it. Your request must be made in writing and must be addressed to the Privacy Officer. To process your request, you must use the form we provide and explain why you think the amendment is appropriate. We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify.

We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person who created the information is no longer available to make the amendment;
- Is not part of the protected health information we keep about you;
- Is not part of the protected health information that you would be allowed to see or copy; or
- Is determined by us to be accurate and complete.

If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement or complaint or request inclusion of your original amendment request in your protected health information.

Right to obtain a list of disclosures. You have the right to get a list of protected health information disclosures, which is also referred to as an accounting. You must make a written request to the Privacy Officer to obtain this information.

The list will not include any disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment and health care operations purposes (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include other disclosures, including incidental disclosures, disclosures we have made for national security purposes, disclosures to law enforcement personnel or disclosures made before April 14, 2003. The list we provide will include disclosures made within the last six years unless you specify a shorter period. Requests may be subject to a reasonable cost-based fee.

Right to choose how we communicate with you. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

Right to request additional restrictions on health information. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. However, we must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out of pocket.

Questions or Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201. To file a complaint with us, put your complaint in writing and address it to the Privacy Officer listed below. The Plan will not retaliate against you for filing a complaint. You may also contact the Privacy Officer if you have questions or comments about our privacy practices.

Future Changes to Practices under this Notice: We are required to follow the terms of the privacy notice currently in effect. However, we reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. We will send or provide a copy of the revised Notice. You may also obtain a copy of any revised Notice by contacting the Privacy Officer.

Contact Person: The Plan has designated Lisa Duncan, as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at Automated Benefit Services, Inc., 8220 Irving Rd., Sterling Heights, Michigan 48312, (586) 826-4300 or 1-800-447-1032.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan 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.

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 (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for benefits 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, 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. Information can also be obtained at the DOL's website, www.dol.gov.