MONROE PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 671
HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

(Dated JANUARY 1, 2005)

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SUMMARY PLAN DESCRIPTION

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Things That You Should Know About Your Health and Welfare Plan

The Trustees of the Monroe Plumbers and Pipefitters Local No. 671 Health and Welfare Fund are pleased to furnish you with this Summary Plan Description. This document summarizes the salient provisions of your benefits under the Health and Welfare Plan. Certain terms used in this Summary are capitalized, since they have specific meanings, as explained in the definition section of this Summary, see pages 57 and 58. This Summary does not contain all of the Plan's detailed provisions. Only by consulting the Plan document can you determine your rights and obligations. A copy of the Plan is on file at the administrator's office and may be read by you, your beneficiaries or your legal representatives during normal business hours. You can also obtain a copy of the Plan by submitting a written request to the administrator. If you have any questions regarding either the Plan, or this Summary Plan Description, you should ask the Plan administrator. In the event of any discrepancy between this Summary Plan Description and the actual provisions of the Plan, the Plan will govern.

I. How Do I Become Eligible?

Before you or your Dependents can receive benefits from the Health and Welfare Plan, you must first meet the initial eligibility requirements. Different rules apply to different groups of Participants. Please note that once you become eligible, you may still have to satisfy certain co-pays and deductibles that may apply to a particular benefit.

1.1. **Active (Bargaining Unit) Employees**. As a bargaining unit Employee working in covered employment, you are considered an active "bargaining unit" Participant and can become eligible in either of these two ways:

a. Normal Eligibility Option

A bargaining unit Employee can establish initial eligibility for coverage on the first day of the third month following completion of 300 Contribution Hours in any twelve consecutive calendar months, provided the Employee is working for a contributing Employer when coverage would otherwise begin. Additionally, at least 145 Contribution Hours per month must also be made by your Employer during the two-month interval after satisfying the initial 300 Contribution Hours requirement. If during this two-month interval, less than 145 Contribution Hours per month are received from your Employer, your eligibility period will start over on the first day of the third month following your earning the initial 300 Contribution Hours. Please note that Contribution Hours used for initial eligibility cannot be banked. Also, the 290 Contribution Hour requirement (two months at 145 hours) can be satisfied through self payment, while the 300 Contribution Hours cannot.

b. Quick Eligibility Option

A bargaining unit Employee may establish initial eligibility utilizing a quick-eligibility option by filing out a form at the Fund office or union hall, before he/she works in Covered Employment. If you choose the quick-eligibility option, your eligibility date will be the Monday following the week in which you accrue at least 300 Contribution Hours, as long as you are still working for an Employer when coverage would otherwise begin. Under this option, you start out with a negative 320 Contribution Hours in your hour bank. Subsequently, Contribution Hours that you accrue, in excess of the 145 per month needed to maintain ongoing eligibility, will be applied to erase the 320 hour deficit in your hour bank, before you become eligible for all benefits offered by the Fund.

Keep in mind that if you elect the quick-eligibility option, you will **not** be eligible for the dental, vision and hearing benefit as long as you have a negative balance in your hour bank nor is the reduced self pay rate available. Your election to use the quick eligibility rule is final and cannot be revoked.

Please note that actual contributions must be received from your Employer for your work hours to count towards the Plan's eligibility requirements. You must also complete the necessary forms at the Fund's office or the union hall to commence coverage.

1.2. **Non-Bargaining Unit Employees**. Full time non-bargaining unit employees of contributing Employers, i.e., those who do not work in Covered Employment, are eligible to participate in the Plan, with the advance approval of the trustees, provided **all** such Employees are participating. Initial eligibility for non-bargaining unit employees will commence on the first day of the month following six consecutive months of contributions by the Employer, at a contribution rate set by Trustees. Once eligible non-bargaining unit employees are eligible for coverage as long as their Employer makes contributions for them for that month. All non-bargaining unit employees of the Employer must participate in the Plan and such Employer must be current in its fringe benefit contributions.

1.3. **Working Owners.** A working owner (an Employee with an ownership interest in the contributing Employer) can establish initial eligibility for benefits in two ways, similar to the bargaining unit Employee.

a. Normal Eligibility Option. A working owner can establish eligibility on the first day of the third month, following receipt of 300 Contribution Hours during a consecutive 12-month period, provided the working owner is still working for his company when coverage would otherwise begin. A working owner will cease participating as of the last day of the month preceding the month in which fewer than 145 Contribution Hours are received, unless the working owner has returned to the bargaining unit, or elected COBRA continuation coverage. Once eligibility of a working owner ceases, you must again meet the initial eligibility requirements to requalify. Working owners must be common law employees of a corporation, or limited liability company, i.e., they cannot be self-employed.

b. Quick Eligibility Option. Working owners may elect the quick eligibility option by filing a form at the Fund office or at the union hall before performing Covered Work. With this option, the eligibility date will be the Monday that follows the week in which the Fund receives at least 300 Contribution Hours (based on an assumed work week of 40 hours), as long as you are still working for your company when coverage would otherwise begin. However, you will also have a 320 hour bank deficit, effective on the first day of the month following the date of initial eligibility. This deficit will be reduced by 15 hours per month, based on a minimum contribution requirement of 160 Contribution Hours per month until your hour bank deficit is eliminated. As a working owner, you are not eligible for the dental, vision, and hearing benefit until this deficit has been eliminated. The election to use the quick-eligibility rule is final and cannot be revoked.

1.4. **Retirees**.

a. Normal Retirees (Age 65 or Older). To qualify for initial eligibility under the Plan's normal retiree program, a Participant must meet all of the following requirements:

i. Participate in the Plan for the five-consecutive year period just before retirement at or after age 65 (continuous coverage had to be maintained during this five-year period); and

ii. attain the age of 65.

b. Early Retirees (Under Age 65). To be eligible for the early retirement program, you must meet all of the following requirements:

i. have at least 15 continuous years of participation (15 continuous years of contributions for office workers);

ii. the sum of your age and years of service at retirement must equal at least 65; and

iii. you must have maintained continuous coverage in the Plan during this 15-year period .

Early retirees who qualify must apply for coverage at the union hall or at the Fund office immediately after leaving covered employment. If early retiree coverage is lost (because you fail to make timely self-payments or cease to be retired), the only way coverage can be renewed is by meeting the eligibility rules for normal retirees. The Fund may adopt rules to determine what constitutes retirement, for purposes of this coverage.

You must notify the Fund office that you want to maintain eligibility through the retiree program within 60 days of the last day of the last month in which you are covered under the active Employee program. Otherwise, you will not be eligible for the coverage. Retirees eligible for Medicare will be treated as if they elected both parts A&B and coverage from this Plan will be provided accordingly. Be sure that you elect the right Medicare options, so that you do not end up with gaps in your coverage. You will be notified by the Fund office of the monthly amount due to maintain your coverage. Self-payments must be made from the date active coverage was lost, and are due the first day of each calendar month. If you fail to make a timely self-payment, you will lose your coverage and it cannot be reinstated**.** Keep in mind that retiree coverage is not "vested" in any way and can be changed, or eliminated at any time.

1.5. **Disabled Participants**. If you are a Participant, who becomes totally and permanently disabled, you will be eligible for coverage, if you participated in the Plan for at least 10 years immediately prior to your disability. You will first be required to use up your hour bank to continue your coverage during the disability. Active bargaining unit Participants are then eligible for up to six months free coverage, without the requirement to self pay for coverage. All other Participants (and active bargaining unit Participants following the six-month free coverage period) can self pay to continue coverage at the appropriate rate established for disabled Participants.

As a disabled employee, you must notify the Fund office in writing that you want to maintain your eligibility through self-payments within 60 days of the later of the month in which you were last covered under the Active Participant program or the month in which you receive a Social Security disability award. Otherwise, coverage will be forever lost.

1.6. **Eligibility for Dependents**. When you become eligible under the Plan, your legal spouse and each unmarried or adopted child under the age of 22 will become eligible for coverage under the Plan, provided such child is dependent on the Participant for support, which entitles the Participant to an income tax exemption for such child. In case of divorce, proof of the Participant's obligation to provide coverage for a child is required, such as a judgment of divorce, qualified medical child support order, or such other order of a court of competent jurisdiction. Illegitimate children will be included within this definition, so long as the Participant provides the Fund administrator with proof of paternity, by presenting a registered birth certificate, naming the Participant as the parent, order of filiation or adoption order. Handicapped children will be covered if the incapacity commenced prior to the date the child's coverage would otherwise have terminated under the Plan, and the Participant's coverage remains in force. In case of a court-mandated child support order, a so-called "qualified medial child support order ("QMCSO") which applies to your Dependents, the Plan will provide coverage as described in the Plan to your Dependent and as required in such order, or applicable law. New spouses or children will become eligible on the date they become eligible Dependents.

1.7. **Surviving Spouse**. The surviving spouse of a deceased active Participant or retiree is eligible for continued coverage under the Plan on herself and any eligible Dependents, provided both the deceased Participant or retiree and the surviving spouse were covered under the Plan at the time of the death of the Participant or retiree. Coverage of a surviving spouse will commence on the first day of the month following the month in which the Participant or retiree dies and continue so long as the hour bank of the deceased Participant or retiree is not exhausted. Thereafter, the surviving spouse must self pay to maintain eligibility, at the appropriate rates established by the Fund. Continuity of coverage must be maintained, since it cannot be reinstated, once interrupted.

1.8. **Special Classification.** The Fund may create limited or special classifications for newly organized Employers, in order to encourage participation in the Plan. In doing so, the Fund may establish such different eligibility and coverage criteria, as deemed appropriate.

II. How Do I Maintain My Eligibility?

Once you become eligible, you must satisfy the Plan's ongoing eligibility requirements that apply to your participation class, in order to maintain coverage under the Plan.

2.1. **Continued Eligibility Through Work**. To maintain your eligibility, you must meet the requirements applicable to your participant class, or group. Please note that actual contributions must be received for your work hours to count towards eligibility:

a. **Active Participants**. After you establish initial eligibility for benefits as an active Participant, i.e., one working in the bargaining unit, you will maintain eligibility so long as the Fund receives at least 145 Contribution Hours each month on your behalf. If insufficient Contribution Hours are received to maintain eligibility, you can continue coverage under the Plan by drawing from your banked hours, or by making self-payments, at rates established from time to time by the Trustees, as explained later. Once your participation ends, you will not be eligible to participate again until you meet the initial eligibility requirements as explained in Section 1.1.

b. **Non-Bargaining Unit Employees**. Upon establishing initial eligibility for benefits, a non-bargaining unit employee will maintain eligibility so long as your Employer makes contributions for you for the month in which coverage is provided. Contributions are required at the rate periodically set by the Fund. No self payment, (other than COBRA), or hour bank option is available to non-bargaining unit employees. Coverage terminates at the end of the last month for which Employer contributions are paid (disregarding the initial six-month qualification period). Please note that all of your Employer's non-bargaining unit employees must participate, for you to continue your participation.

c. **Working Owners.** Upon establishing initial eligibility for benefits, a working owner will maintain eligibility so long as the Fund receives at least 145 Contribution Hours each calendar month on such individual's behalf. No self payment (other than COBRA), or hour bank option, is available to working owners.

2.2. **Self-Pay Eligibility**. When there are insufficient hours in your hour bank (for those who can maintain an hour bank), an eligible active Participant must timely self pay the appropriate monthly premium in order to maintain coverage under the Plan. The Trustees will establish the amount of the self payment premium from time to time and reserve the right to modify the terms of and the amount of any self pay coverage requirements. For example, a lower self pay rate is charged during the first 12 months of your eligibility for coverage through self pay, after you exhaust your hour bank. If you have a negative hour bank under the quick eligibility option, you will not be eligible for the reduced self pay option until you establish a positive hour bank. This option may not be applicable to certain groups of Participants. Please note that at least 435 Contribution Hours must be made by your Employer during the six month interval after you have had 12 months of reduced self-payments in any 18 consecutive month period, in order to again be eligible for the reduced self-pay rate. If you do not make a self-payment on time each month, your participation will end as of the last day of the month in which you last had coverage. No self-pay option is available to non-bargaining unit employees or working owners.

2.3 **Hour Bank Eligibility**. Only active Participants(working in the bargaining unit) are eligible to bank excess Contribution Hours in an hour bank. Contribution Hours made on such Participant's behalf which are greater than those required to maintain continuing coverage (i.e., 145 hours per month) are credited to the Participant's hour bank. The maximum number of hours that may be banked is 870. In the event you have not worked sufficient hours to maintain coverage, you may draw upon the hours in your hour bank to continue eligibility, or to offset the cost of self-pay coverage. No hour bank can be maintained by any other group of Participants, except active

(bargaining unit) Participants and surviving spouses, who have the option of using up the balance of a deceased active Participant's hour bank.

> **EXAMPLE**: You have built up an hour bank of 500 hours. You work only 80 hours in July (65 short for eligibility); those 65 hours can then be taken from your hour bank to make you eligible for coverage in July (80 + 65 = 145 hours), leaving a balance of 435 hours in your hour bank (500 – 65 = 435). In August, you work a total of 150 hours. The first 145 hours are used to keep you eligible for August and the 5 extra hours will be put back into your hour bank, increasing your balance to 440 hours in the hour bank (435 + 5 = 440 hours).

If your initial eligibility was obtained by the quick or "negative hour bank" method, that leaves you with a deficit of hours in your hour bank, then you must make up this negative hour bank balance before you can accrue additional hours in your bank.

2.4. **Eligibility for Veterans**. If you perform military service covered by the United States Employment and Reemployment Rights Act of 1994 ("USERRA") and you comply with the notice, reemployment, and documentation requirements of the Act, you will not have to re-qualify for the initial eligibility under the Plan upon your return to Covered Employment and will have any hours in your hour bank "frozen" during the period of such service. Additionally, you may be entitled to extended coverage during the terms of the military service. If you are planning on entering the military, you must first notify the Plan's administrator so that the appropriate steps can be taken to protect your coverage.

2.5. **COBRA Eligibility**. Federal law, commonly known as COBRA, extends coverage for you and/or your Dependents for a limited period in certain circumstances, known as "qualifying events," but only if you timely pay the COBRA premiums established by the trustees.

a. ***Events***.

QUALIFYING EVENT	MAXIMUM COVERAGE
Reduction in hours worked or termination of employment (other than for gross misconduct)	up to 18 months
Loss of dependency status, *i.e.*, death of employee, divorce or legal separation, eligibility for Medicare	up to 36 months
Employer bankruptcy (retired employees and dependents only)	up to 36 months
Total and permanent disability	up to 29 months
Second qualifying event	18 month extension, up to 36 months total

b. ***Premium***. The amount of the premium is established by the trustees, annually.

c. ***Notice***. If your coverage terminates due to divorce/separation or loss of dependency status, you, or your affected dependent, must notify the Plan's administrator within 60 days of the qualifying event. Your failure to provide the required notice may affect your COBRA coverage.

d. ***Exceptions***. COBRA extended coverage is a limited right. Additionally, COBRA rights terminate if your Employer no longer participates in this Plan, you fail to pay your COBRA premium, you become covered by another group health plan or you become eligible for Medicare. In order to be sure that you are protected, you should immediately contact the Plan administrator if you think you or your Dependents have incurred a "qualifying event" or if you think you may be eligible for COBRA extended coverage.

2.6. **Continuation of Coverage Under the Family and Medical Leave Act (FMLA).** Your Employer, as a "covered employer" (as that term is defined by the FMLA law), in order to provide or continue your coverage, must notify the Fund when an "eligible employee" has been granted family or medical leave. Such leave is normally granted to care for family members, such as newborns, or other family members with serious health conditions. Both your Employer and you must provide the notices, information, and documentation required by the Plan and by law. The Fund will continue coverage (other than weekly disability) during the period of approved leave for which you are eligible under the provisions of the FMLA, without charge to you, provided your Employer and you fully comply with all requirements established by the Plan and the law.

2.7. **Pre-Existing Conditions**. If you or your Dependents have been treated for a pre-existing condition within six months before your coverage Effective Date, no coverage will be provided for such sickness, injury or medical condition (unless otherwise required by law), until the earlier of:

a. there has been no examination or treatment for the condition for 180 days; or

b. the affected individual has been in the Plan for at least 365 days.

2.8. **Portability of Coverage (HIPAA)**. Under a law commonly called "HIPAA," you are entitled to a limited waiver of certain waiting periods associated with preexisting conditions. To qualify for such waiver, you need to obtain a "certificate of coverage" from the plan that you are leaving to join this Plan, or from this Plan if you are going to be covered by a new plan. To document your previous coverage, you must obtain the certificate of coverage from your prior plan and provide it to the Plan administrator. Likewise, if you are switching to a new plan, you can obtain your certificate of coverage from the Plan administrator by requesting it in writing.

2.9. **Termination of Eligibility**. Your eligibility for benefits will terminate on the last day of the month immediately prior to the month in which you have failed to meet the requirement for continuing eligibility, unless you make self-payments, when permitted, in accordance with the provisions of the Plan. Other events may result in the termination of coverage, such as when your Dependents lose that status under the Plan, or in case of death, service in armed forces and other events described in the Plan.

2.10. **Eligibility Through Reciprocity**. The Fund may enter into a reciprocity agreement with other insurance programs sponsored by the Union, as well as reciprocity agreements with other health and welfare funds covering plumbers or related crafts throughout the country. Contributions made on your behalf may then be transferred from one fund to another, upon your request and authorization, or in some cases automatically. Please note that the actual hours worked for which contributions are transferred will be credited by this Fund, regardless of whether the contribution rate is higher or lower in the other insurance fund's area.

2.11. **Eligibility - Miscellaneous**. Eligibility for coverage does not automatically make you eligible for *all* benefits offered by the Plan. Some benefits require you, in addition to satisfying the eligibility requirements, to also meet certain deductible, co-pay and/or other requirements before you can receive those particular benefits. Please consult the schedule of benefits or the Plan itself, for any specific requirements that may apply.

III. __What Benefits Are Available To Me__?

This Plan provides coverage to you and your eligible Dependents for various benefits which are summarized here and in more detail in the schedule of benefits. For some benefits, you must also pay a portion of the expense, known as a co-pay, while others may require you to first pay a deductible, before coverage is provided. For a summary schedule of the benefits afforded by the Plan, see Appendix A, or consult the Plan for a more detailed explanation. Please note that the schedule of benefits may be modified from time to time, and is not "vested" i.e., there are no guaranteed rights to any benefits under the Plan. The following is a summary of the types of benefits covered by the Plan.

3.1. **Medical, Hospital, and Surgical Benefits.**

a. **Coverage**. The Fund has contracted with various providers (so-called preferred provider organizations – PPO), to furnish medical, hospital and surgical benefits to eligible Participants, retirees and their Dependents at a discount. The coverage levels, as well as the benefits covered, can be found in the summary schedule of benefits, which is attached as Appendix A. Some of these benefits may be provided directly by the Fund, without the use of outside entities. The level of coverage depends on whether it is provided in the PPO network or out of such network. The Plan provides a higher level of coverage within the PPO network to encourage you to use those network providers who have agreed to discount their charges to the Fund and minimize, or eliminate, any charges to you. Of course, out-of-network providers are more expensive to both the Fund and you – resulting in a reduced coverage level so that you will be encouraged to use the in-network providers.

b. **Second Opinions and Pre-Certification.** To control costs, all hospital stays (inpatient), some out-patient surgeries, confinements in a convalescent facility or any home health care or hospice case **MUST** be pre-certified. That is, such services must be approved ahead of time or they will NOT be covered. The Plan uses the services of Direct Medical Management an independent utilization review group, to review all inpatient admissions for "medical necessity" and length of stay. You or your provider must contact **Direct Medical Management (1-800-345-6700)**, at least one week before a scheduled admission to a hospital or convalescent facility, or within 48 hours of an emergency admission. You or your provider must also contact Direct Medical Management at least one week before using home health care or hospice care benefits and for scheduled surgical procedures. Further, if Direct Medical Management does not approve the admission, no coverage will be provided. This reduction will not count toward any deductibles or out-of-pocket maximums.

c. **Summary of Covered Medical Benefits**. The following medical benefits are provided under the Plan, at the levels described in the schedule of benefits - Appendix A. The coverage levels apply to reasonable and customary charges, so-called "R&C" levels, rather than the actual amount billed by the provider.

1. **Hospital, Surgical, Medical, Nurse and Ambulance Expense Benefits**.

i. **Coverage**. When accidental bodily injury or sickness requires an eligible Participant or Dependent (other than one covered by Medicare) to be confined in a hospital as a resident patient, and such confinement is recommended by a legally qualified Physician or surgeon and commences while this coverage is in force as to such person, the Fund will pay a percentage of the approved expense (R&C) actually incurred, for the medically necessary eligible expenses described here, as the result of any one injury or any one period of sickness. If an eligible Participant or Dependent is confined to a hospital within six months after a previous confinement, such confinements will be considered as one period of sickness unless:

1. The second confinement is due to entirely different causes from those which caused the first confinement; or

2. After the first confinement, the attending physician had certified that the Participant was available to return to work; or

3. The Participant did, in fact, return to Covered Employment with a contributing Employer for at least five consecutive working days.

ii. **Eligible Expenses**. Eligible expenses under this Benefit are as follows:

1. Hospital room and board. Allowances for room and board are limited to expenses for a semi-private room.

2. Miscellaneous necessary services and supplies furnished by the hospital.

3. Surgery and other medical care and treatment by a legally qualified Physician or surgeon. The Fund will not pay for post-surgical, in-hospital medical visits unless required for causes other than that which required surgery.

4. Anesthesia and its administration.

5. Local surface ambulance service to the nearest hospital with equipment required to provide treatment for the sickness or injury. Air ambulance service will be covered only in life-threatening situations.

6. Outpatient or office charges for chemotherapy treatments will be payable as an extension of the in-hospital comprehensive confinement benefit following hospitalization for treatment of cancer.

2. **Diagnostic Laboratory and X-Ray Benefit**. When accidental bodily injury or sickness causes an eligible Participant or Dependent (other than one for whom Medicare is the primary payer) to incur expense for laboratory or x-ray examinations for diagnosis of such injury or sickness and the eligible Participant or Dependent is not confined within a hospital as a resident patient charged for room and board during the time such expense is incurred. This benefit is not payable if the service is required as a result of an occupational injury or sickness or as a result of an automobile or vehicular accident.

3. **Maternity Benefits**. Maternity benefits normally are paid for only an eligible Participant or the legal spouse of an eligible Participant. However, payment of maternity benefits will be available to the unmarried daughter of an eligible Participant, **(not the newborn baby)** provided the Participant meets the eligibility requirements and the unmarried daughter is still an eligible Dependent.

4. **Emergency Medical Care**. When non occupational illness causes an eligible Participant (other than one for whom Medicare is the primary payer) to require emergency first-aid treatment in a hospital, while not confined as a resident patient in such hospital, the Fund will pay the hospital and physician's reasonable expenses actually incurred but not to exceed in the aggregate the applicable amount as set forth in the schedule of benefits. Such expenses may include local ambulance service to the hospital.

5. **Surgical Benefits**. The Fund will pay a percentage of the approved expense actually incurred for medically necessary surgical expenses, as provided here. Procedures, which are primarily cosmetic in nature, not medically necessary, or not generally recognized by the medical profession, are not covered at all by the Fund.

6. **Office Calls**. The Fund will pay the amount described in the schedule for each Physician's office visit for each eligible Participant or Dependent. Routine Physician office visits and approved injections, not otherwise covered by Medicare, for Retirees will be covered at the applicable amounts as set forth in the schedule of benefits.

7. **Mental Health**. The Fund will pay a percentage of the Reasonable and Customary expense actually incurred for necessary mental health expenses, as provided in the benefit schedules.

8. **Preventative and Other Services**. The Fund will pay the approved amount or a percentage of the approved expense actually incurred for certain preventative services, mammography screening, allergy testing and other like benefits described in the level of benefit schedules.

9. **Prescription Drugs.**
   Prescription drug coverage is described in Section 3.2.

3.2. **Prescription Drug Coverage.** The Fund provides certain prescription drug coverage, which is subject to co-pays and deductibles, as described in Appendix A. This coverage may be offered through one or more prescription drug programs, or directly from the Fund and may differ for different groups of participants. The prescription drug program does not cover the following:

a. Drugs or medicines delivered or administered by the individual who prescribed them.

b. Ointments or creams in excess of 4 ounces per prescription.

c. Non-legend, patent, proprietary, or non-prescriptions drugs and over-the-counter medication.

d. Contraceptives, contraceptive devices and infertility medication.

e. Hypodermic syringes or needles.

f. Vaccines to prevent diseases.

g. Non-prescription vitamins.

h. Injectable drugs or medicines (except insulin).

i. Viagra and Viagra-type medication (sexual dysfunction), effective January 1, 1999.

j. Charges for any refill more than one year after the date of the original prescription.

k. Drugs that cost less than the deductible amount.

l. Drugs consumed at the time and place of order.

m. Appetite suppressants, even if Medically Necessary for attention deficit disorder, narcolepsy or other condition.

n. Compounded prescription medications with ingredients not requiring a Physician's authorization by state or Federal law.

o. Medications for cosmetic purposes only (for example, Retin-A for aging or Rogaine for hair loss; however, Retin-A and similar products available for acne up to age 26).

p. Medications for treatment relating to smoking cessation (such as, but not limited to, nicotine gum, patches and inhalers).

q. Medications that are experimental or are used for experimental indications and/or dosage regimens determined to be experimental (experimental medications are defined as non-FDA approved).

r. Medications with no approved FDA indications.

s. Devices or equipment of any kind.

3.3. **Life Insurance/Death Benefit.** The Fund will provide life insurance coverage to eligible bargaining unit Participants, non-bargaining unit employees and retirees only. The amount of the benefit is specified in the summary schedule of benefits – see Appendix A. The Fund may purchase this coverage from a life insurance company, which may impose additional requirements for such coverage. If you terminate your coverage under the Plan, you have a limited right to convert the life insurance policy that is provided by the Plan into an individual policy, without providing evidence of insurability. You must file a written application within 31 days of the loss of coverage in order to preserve this individual policy conversion right. The insurance policy also contains a waiver of premium provision that applies to you if you become totally disabled before age 60. Please contact the Fund administrator, or consult the Plan for additional information. It is important that you keep your life insurance beneficiary information updated.

3.4. **Accidental Death, Dismemberment, and Loss of Sight Benefit.** If you are an eligible bargaining unit Participant or such Participant's beneficiary, the Fund will provide a benefit to compensate you for an accidental death, dismemberment or loss of sight if this occurs within ninety (90) days of an accident either at or away from work. The levels of coverage are described in the summary schedule of benefits, in Appendix A. The "principal sum" is the maximum amount that is payable for injuries to any one eligible person resulting from any one accident. Multiple injuries resulting from the same accident are payable from only one principal sum, which will not be duplicated.

3.5. **Weekly Disability Benefits**. When an eligible bargaining unit Participant is prevented from engaging in Covered Employment because of accidental bodily injury, sickness (or pregnancy) and requires the regular care and attendance of a legally qualified Physician or surgeon, the Fund will pay to such Participant benefits for a period of time not to exceed 13 weeks, provided the active Participant was an eligible Participant at the time such injury, sickness or pregnancy occurred, the disabling condition did not arise out of, or occur in the course of any occupation or employment for wage or profit, the eligible Participant is not entitled to benefits for such disability under any Workers' Compensation or Occupational Disease Law, and did not result from an automobile or other vehicular accident for which other coverage is available. The weekly loss of time benefit will begin on the (a) first day of disability due to an accident, or (b) the eighth day of disability due to disease or sickness. Successive periods of disability separated by less than two weeks full-time active work with a contributing Employer will be considered one period of disability unless the subsequent disability is due to a different cause and commences after the eligible Participant has returned to covered employment with a contributing Employer. Non-bargaining unit Employees, Working Owners and retirees are not eligible for this benefit.

Benefits will not be paid for any disability during which you are not under the professional care and regular attendance of a Physician. Weekly loss of time benefits will also not be paid:

a. for hospitalization or medical treatment paid by the U.S. Government or any of its instrumentalities.
b. for losses caused by an act of war or by service in the armed forces.
c. for disability caused by or resulting from a condition which is not covered by the Plan.
d. for disability caused by or resulting from drug or alcohol dependency or a mental health condition.
e. for any day for which you work for compensation or profit or for which you continue to receive compensation through an Employer, including unemployment benefits.

3.6. **Dental, Vision and Hearing Benefit**. The dental, vision and hearing benefit reimburses up to the amount set out in the schedule of benefits (Appendix A), per calendar year per family for dental services (such as

dental examinations, fillings and orthodontic treatment), and vision services (such as vision examinations, purchases of lenses, frames and contacts), and hearing-related services (such as hearing aids, hearing tests and treatment for hearing impairments). This coverage cannot be used to reimburse deductibles or co-payments. If you elected the quick eligibility option, you are not eligible for the dental, vision and hearing benefit as long as you have a negative hour bank.

3.7. **Other Benefits**. The Trustees may, from time to time, adopt such other benefits, or modify existing ones, as they deem appropriate. No benefits offered by the plan can in any way be considered "vested" since same can be modified or eliminated at any time.

IV. What Restrictions Apply To My Coverage?

4.1. **Exclusions.** Even though you are eligible for coverage, certain benefits may be excluded from such coverage, as explained later. Each exclusion described below applies to all benefits under this Plan, except life insurance, which has its own exclusion provisions, whether or not the exclusion is repeated in a provision of this Plan describing those benefits. This Plan **will not provide** benefits, as follows:

a. for loss or expense from sickness, or disease, or as a result of any accidental bodily injury which arises out of or in the course of employment, which entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law.

b. Anything that is not medically necessary

c. Confinement and treatment in any facility pursuant to the suggestion, recommendation or order of any court or agency.

d. Confinement and treatment as a ward of the state (or any governmental agency), ward of the court or in a group home.

e. Any injury for which you are reimbursed or entitled to be reimbursed by any third party for which such third party is liable.

f. Injury caused by or related to self-destruction or self-inflicted injury while sane or insane.

g. Telephone, television, patient care kits, personal convenience items or services, barbers and beauty aids.

h. Injury or sickness a contributing cause of which was the commission (or attempt to commit) a felony, or a contributing cause of which was the engagement in an illegal occupation.

i. Injuries incurred while under the influence of any illegal drug.

j. Injuries while operating a motorized vehicle with a blood alcohol level at or above .08.

k. Abuse or misuse of hallucinogenic agents, airplane glue or similar compounds, poison or fumes.

l. Dental services or devices of any type, such as the extraction of teeth, treatment of cavities, care of gums (including cutting on the gums or scraping the bone), care of bones supporting the teeth, treatment of periodontal tumors or cysts, removal of impacted teeth, root canal therapy, dental x-rays, preparation of the mouth for dentures, and dentures. (See Section 3.6)

m. Tests, supplies, treatment or services not required or not related to the diagnosis or treatment of illness or injury, or not recommended or approved by a Physician.

n. Reversal of sterilization and tubal ligation procedures.

o. Cosmetic or beautifying services, including diet control.

p. Injury or sickness incurred while engaged in or resulting from military service.

q. Injury or sickness caused by war or act of war, whether declared or undeclared.

r. Experimental services, treatments or supplies.

s. Temporomandibular joint (TMJ) disorders.

t. Services or treatment provided by an immediate relative.

u. Special requirement physical examinations, such as (but not limited to) pre-marital, pre-employment, sports and school participation examination.

v. Social workers, education and job retraining, and learning disabilities.

w. Acupuncture, acupressure and related expenses.

x. Treatment of a mental health condition after determination that a condition will not respond to treatment.

y. Eyeglasses, contact lenses, seeing eye dogs, and Braille materials. (See Section 3.6)

z. Hearing aids and related devices or services. (See Section 3.6)

aa. Sex-change operations or other treatment of gender dysphasia.

bb. Routine foot care, including care of weak, unstable or flat feet, corns, calluses, bunions, unless an open cutting operation is performed, or toenails, unless part of the nail root is removed.

cc. Shoe buildups or corrective shoes; or arch supports and foot care to improve comfort or appearance such as subluxation (except capsular or bone surgery).

dd. Hypnotism or goal-oriented behavioral modification therapy such as to quit smoking or lose weight, including (but not limited to) treatment of nicotine addiction and non-legend medications for smoking cessation.

ee. Removal of excess fat or skin after weight loss or pregnancy.

ff. Exogenous obesity, a condition usually caused by overeating, unless the patient is 60 percent over normal body weight and treatment is otherwise medically necessary.

gg. Alternative health therapies.

hh. Contraceptives or contraceptive devices.

ii. Infertility treatment, including artificial insemination or in-vitro and in-vivo fertilization, services of a surrogate mother, or genetic counseling or testing.

jj. Abortion (unless the life of the mother would be endangered by delivery).

kk. Dental, vision and hearing examinations. (See Section 3.6)

ll. Services of more than one physician rendering treatment for the same condition.

mm. Transcutaneous electrical nerve stimulation (TENS) unit.

nn. Services, devices, medication or treatment relating to smoking cessation, such as (but not limited to) inhalers, patches and gum.

oo. Organ or cell transplants and related treatment, including anti-rejection drugs.

pp. Services, devices, medication or treatment relating to addictions (such as, but not limited to, gambling or sex).

qq. Sleep disorders or sleep apnea studies.

rr. Hair removal (including electrolysis) and hair transplants.

ss. Missed appointments.

tt. Services provided before coverage begins or after it ends.

uu. Custodial, rest home or nursing home care.

vv. Treatment for sexual dysfunction.

ww. Items or services of general use or application, such as beds, blankets, baby-sitting, wigs, club memberships, transportation vehicles or home improvements.

xx. Funeral expenses.

yy. Lead-based paint removal.

A more detailed description of the Plan's exclusions and limitations is contained in the Plan itself. Additional exclusions may be applied by any insurance carrier used by the Fund. The Trustees reserve the right to modify these exclusions as they, in their sole discretion, deem appropriate. If you have any questions about covered services, consult the Plan document, or contact the Plan administrator prior to incurring the expense.

4.2. **Modifications**. The benefits offered by the Plan and the eligibility requirements can be modified or eliminated at any time by the Trustees, as the Trustees deem appropriate. No retroactive claim to benefits will be recognized in case of such modification or elimination of coverage.

4.3. **Coordination of Benefits.** Coordination of benefits sets out rules for the order of payment of covered charges when two or more plans cover the same individual. When a person, spouse or dependent is covered by this Plan and another plan, this Plan will coordinate benefits when a claim is received. The plan that pays first (primary) according to the rules will pay as if there were no other plans involved. The other plans (secondary) will pay the balance due up to 100% of the total allowable expenses. The following is a brief description of the coordination rules. Consult the Plan document for the complete rules on coordination of benefits:

COVERAGE	PRIMARY	SECONDARY
No coordination	Plan without coordination provision	Plan with coordination provision
Employee	Plan covering patient as employee	Plan covering patient as spouse/dependent
Child	Plan covering parent whose birthday is earlier in the year	Plan covering parent whose birthday is later in the year
Divorce	Plan covering parent with custody. If both parents have custody, plan covering parent whose birthday is earlier in the year.	Plan covering parent without custody. If both parents have custody, plan covering parent whose birthday is later in the year

a. **Coordination of Benefits - Medicare.** Coverage will be coordinated as if the Participant and Spouse both elected Medicare parts A and B (at age 65 or upon eligibility after a Social Security disability award), regardless of whether they actually did so. You are generally eligible for Medicare if you are at least 65, or you have been receiving Social Security disability benefits for at least 24 months. You may also be eligible for Medicare at any age if you are eligible for Social Security and you receive maintenance dialysis or a kidney transplant. Medicare has two parts – hospital insurance (sometimes called part A) and medical insurance (sometimes called Part B). Part A helps pay for care in a hospital (or for care in a skilled nursing facility following a hospital stay), certain home health care benefits, and hospice care. You pay no medicare premium for Part A. The other part of Medicare (Part B) helps pay for doctors' bills, charges for X-rays and laboratory tests, and outpatient hospital services. You must pay a monthly Medicare premium for Part B coverage if you want it. It is not automatically provided to you. The Plan is secondary to Medicare coverage wherever possible. You or the provider must submit the Explanation of Medicare Benefits (EOMB) to the Fund office along with the claim before any Medicare related payment can be made by the Plan.

When you become eligible for Medicare because of attained age, the Plan generally will continue to offset Employer contributions against retiree self-payments. However, if you receive sufficient Employer contributions to establish eligibility as an active Employee (145 hours/month employer contributions), you will be treated as an active Participant. The Plan will become primary payor for your claims, and Medicare will be the secondary payor. When Employer contributions and hour bank credits become inadequate for

maintenance of your eligibility, you will be automatically re-enrolled in the retiree program and Medicare again will become your primary payor.

b. **Coordination of Benefits – Motor Vehicle Coverage.** The COB rules described here are also applicable to any medical claims resulting from, or related to, a motor vehicle accident. This Plan will provide only secondary, or "excess" coverage, when coordinated with any motor vehicle insurance, or uninsured motorist pool, up to 50% of remaining medical expenses, subject to the Plan's limits, exclusions, deductibles and copayments. This Plan expressly disavows coverage for any claim for which the claimant had any no-fault, third-party, or any other insurance coverage (including uninsured motorist coverage) applicable to such motor vehicle related claim, up to the amount of coverage available from all such policy(ies). Coverage under this Plan is always subordinate, or secondary, to any motor vehicle insurance coverage, as defined here.

4.4. **Subrogation Rights**. When benefits are paid to you under the Plan for injuries which may have been caused by the act or omission of another person, against whom you may have a legal claim, then this Plan will be automatically subrogated (entitled to your legal rights) against the person who caused the injuries. By accepting coverage by this Plan you are automatically agreeing to:

a. assign to the Plan your rights of recovery when this subrogation provision applies;

b. repay to the Plan the amount paid on your behalf or on the behalf of your covered dependent out of the recovery made from the other person or the other person's insurer; and

c. execute and deliver all required documents needed to secure the right of subrogation.

This subrogation right applies to all recoveries from other insurance plans, such as a homeowner's plan or a general liability policy. Only the amount recovered for medical expenses will be subject to subrogation, up to the amount paid by the Plan on your behalf.

The Plan's right of recovery will be a first priority lien against any proceeds recovered by the covered person, which right shall not be reduced or compromised by the application of any so-called "Make-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the Plan's priority recovery rights by allocating the proceeds exclusively to non-medical expense damages.

A Participant or Dependant may not incur any expenses or costs on behalf of the Plan, attributable to any rights of the Plan under this coordination of benefits provision; specifically, neither court costs nor attorney's fees shall be deducted from the Plan's recovery without the prior written consent of the Plan, such costs and expenses being the sole responsibility of the Participant or Dependant. Any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine" or other equitable remedy shall not defeat the Plan's right to unconditional full reimbursement granted hereunder.

4.5. **Fraud Against the Plan**. Any fraud committed against the Plan – for example, submitting claims for individuals who are not eligible for benefits – will result in cancellation of any hour bank credits and immediate and permanent termination of coverage under the Plan. In addition, fraud may result in civil or criminal prosecution, or both.

4.6. **Claims Incurred Outside the Unites States**. Due to increasing mobility of covered persons, claims may be paid that arise from medical treatment received outside the United States, provided that certain conditions are first met:

a. If there has been an emergency medical care, the covered person, upon returning to the United States, must submit the bills that have been paid for the emergency treatment in order to be reimbursed according to the provisions and limitations of the Plan.

b. If there will be elective medical care, the covered person must first submit to the Fund office or utilization review group a request stating the intended medical procedures to be undergone. The covered person will receive a determination from the trustees about whether or not it is in accordance with accepted medical procedures within the United States and whether it is a benefit or service covered by the Plan. Until such a determination is received, the covered person cannot be assured that elective medical treatment will be covered under the Plan.

c. Payment will be made in accordance with the foreign exchange rate as of the date of the medical care. Foreign currency will be converted to United States values as of that date.

4.7. **Recovery of Overpayment**. If the board of trustees ascertains that a covered person has received an erroneous overpayment of a benefit, the Fund office will immediately notify the covered person in writing, explaining the nature of the erroneous overpayment and requesting return of the amount of such overpayment. If the initial request for restitution is not successful, the Fund office will renew the demand in writing upon the covered person, and may take other reasonable actions to obtain reimbursement of the erroneous overpayment. If taking reasonable steps to obtain repayment of the overpayment has been unsuccessful, the board of trustees may treat the overpayment of benefits as an advance payment of benefits due the covered person and offset the amount of such overpayment against and Plan benefits due or which may become due to the covered person until the full amount of the overpayment has been repaid to the Plan.

V. How Do I File A Claim?

Claims are **ONLY** paid if they are for a covered expense and medically necessary. All approved claims are further subject to the Reasonable and Customary limit, as well as the co-pays, deductibles, and exclusions described here and in the Plan. Benefits are paid either directly to the service provider (with your written authorization) who has agreed to accept payment from the Plan, or as a reimbursement to you after you incur a covered expense.

5.1. **Claims Filing Procedures**. A written request for a Plan benefit is a claim and can be made by an individual who is or may be eligible, his Dependent or beneficiary; the person making such claim is a claimant. Each claim shall be presented to the Fund office within 90 days of the date charges for the service were incurred. Claims filed later than that date may be declined/reduced unless:

a. it was not reasonably possible to submit the claim within the time period; and

b. the claim is submitted within one year from the date incurred, which limitation will not apply if the individual is legally incapable of submitting the claim.

i. **Medical Claims**. General hospital, medical, surgical and major medical claims are filed with the Fund administrator's office, directly by providers. Medical claims and loss of time claims submitted by an eligible participant are to be filed with the Fund administrator: Meyer & Associates, P.O. Box 986, Monroe, Michigan, 48161, 1-888-242-6544. The claim is considered filed when received. Original copies of all bills for services rendered must be submitted to the Fund administrator along with such other information as is required by the trustees from time to time. Pre-service authorizations are filed with the Plan's utilization review group Direct Medical Management, 1-800-345-6700.

iii. **Prescription Drug Claims**.
Prescription drug claims are filed with the Pharmacy Benefits Manager (PBM), utilized by the Fund. The claim is considered filed when received. Original copies of all bills for services rendered must be submitted to the Fund administrator along with such other information as is required by the trustees from time to time.

iii. **Dental, Vision and Hearing Claims**. Claims for dental benefits are filed with the Plan's administrator: Meyer & Associates, P.O. Box 986, Monroe, Michigan, 48161, 1-888-242-6544. The

claim is considered filed when received. Original copies of all bills for services rendered must be submitted to the Fund administrator along with such other information as is required by the trustees from time to time. Dental, vision and hearing benefits are reimbursed after you submit proof of payment. You must provide a paid itemized statement from the provider. An invoice showing a balance due is not sufficient. These claims are paid semi-monthly. Proper claims submitted to the Fund Office for payment by the 10th and 25th of the month are generally paid by the 15th and 30th of the month, respectively. However, no reimbursement check will be issued for less than $25, except for the last payment of the year.

iv. **Weekly Disability Claims, Life Insurance and AD&D Claims**. Claims for weekly disability benefits, life insurance and AD&D are filed with the Fund's administrator: Meyer & Associates, P.O. Box 986, Monroe, Michigan, 48161, 1-888-242-6544. The claim is considered filed when received.

In-network providers are responsible for submitting claims to the Fund directly. If a covered person is billed by an in-network provider for eligible expenses, the eligible person should contact the Fund office. For health services received from out-of-network providers, claims for reimbursement must be submitted to the Fund office on appropriate forms. Prescription drug benefits will be submitted by the pharmacy to the pharmacy benefit manager.

All claims must be submitted to the Fund office within one year of the date the service was performed. Otherwise, no payment will be made.

5.2. **Claims Processing**. Your claims are processed by the Fund, based on the type of claim submitted. Because your rights are affected by how certain claims are handled, the following information will help you understand your legal rights:

a. **Initial Claim Filing**

i. When additional information is needed to process a claim. If the Fund, upon receipt of a Pre-Service claim for benefits, needs additional information or the claim does not follow the Fund's procedures, the Fund will notify the claimant within twenty-four (24) hours (for an Urgent Care benefit claim) or five days (for a Non-Urgent Care benefit claim), of receipt of the claim that such information is necessary. The Fund shall allow the claimant a minimum period of forty-eight (48) hours (for Urgent Care benefit claims) or forty-five (45) days (for Non-Urgent Care benefit claims) to furnish such information. For those claims where additional information is requested by the claims department, any partial or total denial of the claim shall be made by the Fund, within forty-eight (48) hours (for an Urgent Care benefit claim), fifteen (15) days (for a Non-Urgent Care Pre-Service benefit claim) from the date the Fund receives the information requested from the claimant, thirty (30) days (for a Non-Urgent Post-Service benefit claim), or 45 days (for a Disability claim). In the case of a Non-Urgent Care benefit claim, the period for a benefit determination to be made may be extended for fifteen (15) days (45 days for Disability benefit claims) if it is due to circumstances beyond the Fund's control. However, the claimant will be given notice of such extension prior to the original deadline for a determination.

ii. Determination of Claim. For those claims where additional information is not necessary, the claims department shall make any determination regarding the validity of the claim and, upon any partial or total denial of the claim for benefits, the Fund shall notify the claimant within seventy-two (72) hours (for an urgent Care benefit claim), fifteen (15) days (for a Non-Urgent Care Pre-Service claim) from the date the Fund receives information from the claimant, thirty (30) days (for a Non-Urgent Post-Service benefit claim), or 45 days (for a Disability, life insurance, accidental death and dismemberment or waiver of premium claim). In the case of a Non-Urgent Care benefit claim, the period for a benefit determination to be made may be extended for fifteen (15) days (or 30 days for Disability, life insurance, accidental death and dismemberment or waiver of premium claims) if it is due to circumstances beyond the Fund's control. However, the claimant will be given notice of such extension prior to the original deadline for a determination.

An adverse determination regarding a Concurrent Care Claim is any reduction or termination by the Plan of the course of treatment before the end of the period of time or the full number of treatments, unless the reduction or termination occurs as the result of a Plan amendment or termination of the Plan. The Plan will notify the claimant of the adverse benefit determination regarding a Concurrent Care Claim at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Additionally, any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care shall be decided (A) as soon as possible, taking into account the medical exigencies, and (B) the Plan shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, if the claim was submitted to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

iii. Claim Denial Notice.
Information Included in a Claim Denial Notice. The notice of claim denial shall contain:

1. The specific reason(s) for denying the claim;

2. Specific reference(s) to pertinent Plan provisions on which the denial is based;

3. A description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such information is necessary.

4. A description of the Plan's review procedures, including the time limits under the procedures, and a statement regarding the claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal;

5. If applicable, a copy of the internal rule, guideline or protocol that was relied upon, and a statement that such rule will be provided free of charge to the claimant upon request;

6. If the adverse determination is based on the issues of medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge to the claimant upon request; and

7. A description of the expedited review process applicable to "Urgent Care" claims.

SUMMARY OF DEADLINES FOR NOTIFYING CLAIMANTS OF BENEFIT DECISIONS				
CLAIMS PROCEDURES	URGENT	PRE-SERVICE	POST-SERVICE	DISABILITY*
Initial Benefit Determination	72 hours	15 days	30 days	45 days
Plan Notifies Claimant if Additional Information is Necessary	24 hours	5 days	5 days	5 days
Maximum Time For Claimant to Furnish Information After Information is Requested by Plan	48 hours	45 days	45 days	45 days
Determination Required (after Claimant Submits)	48 hours	15 days plus potential 15 day extension	30 days plus potential 15 day extension	45 days plus potential 30 day extension

* Also includes life insurance, accidental death and dismemberment or waiver of premium claims.

5.3. **Appeals Procedures**.

a. Step 1 Appeal. If you disagree with the action taken on your claim by the Plan, then you may submit a written request for review. You may either submit the claim personally, or may have the claim submitted by your duly authorized representative. The Fund administrator will review the claim in accordance with the following rules:

i. A request for review of the Plan's action must be submitted in writing to the Administrator within 180 days after mailing of the notice of the adverse benefit determination.

ii. You may have an opportunity to review necessary and pertinent documents on which the denial in whole or in part is based and may submit written comments, documents, records, and other information relating to the claim for benefits.

iii. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. A document is considered relevant to the claim if the document (A) was relied upon in making the benefit determination, (B) was submitted, considered or generated in the course of making the benefit decision, or (C) demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the Plan and be consistent when applied to similarly situated claimants.

iv. The Fund shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination by the Plan.

v. The Fund shall not afford deference to the initial adverse benefit determination.

vi. The review will not be con- ducted by the individual who made the initial adverse determination, nor by the subordinate of such individual.

vii. If the appeal is from an adverse benefit determination that was 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, then the Fund shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for the purposes of a consultation under this section shall be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the review, nor the subordinate of any such individual. You will be informed of the identity of each medical or vocational expert 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.

viii. If the request for review involves an Urgent Care claim, then you will be offered an expedited review process pursuant to which (A) the request for appeal of an adverse benefit determination may be submitted orally or in writing by you, and (B) all necessary information, including the Fund's benefit determination on review, shall be transmitted between the Fund and you by telephone, facsimile, or other available similarly expeditious method.

ix. The Fund administrator shall consider an appeal of an Urgent Care benefit claim within seventy-two (72) hours, a Non-Urgent Pre-Service benefit claim within fifteen (15) days and a Non-Urgent Care Post-Service benefit claim or Disability claim within thirty (30) days of receipt of the appeal. Mutual of Omaha will consider a life insurance, accidental death and dismemberment or waiver of premium within 45 days of receipt of the appeal.

x. If the determination is adverse, the notice shall include the following information:

1. The specific reason(s) for the adverse determination;

2. Reference(s) to the specific Plan provisions on which the determination is based;

3. A statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim. A document is considered relevant to the claim if the document (A) was relied upon in making the benefit determination, (B) was submitted, considered or generated in the course of making the benefit decision, or (C) demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the Plan and be consistent when applied to similarly situated claimants.

4. If applicable, a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination, or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to you upon request.

5. If the adverse determination is based on 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 the your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

6. A statement regarding your right to bring a civil action under ERISA section 502(a) following the adverse benefit determination on appeal.

7. 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."

b. Step 2 Appeal.

i. You or your authorized representative may appeal the final decision by the Fund Administrator, by written notice received by the Board of Trustees within one hundred (180) days of the mailing of the notice of an adverse benefit determination. The written notice only needs to state the claimant's name, address, and the fact that the claimant is appealing from the decision of the Fund Administrator, giving the date of the decision appealed from.

ii. The Board of Trustees shall review the claim and advise the claimant of any adverse benefit determination in accordance with the notice content and timing requirements set forth in Step 1 of the Appeals Procedure, section a, (i) through (x), above.

Decision of the Trustees Is Final. Under the Trust, the Board of Trustees has discretionary authority (a) to make any determination with respect to an individual's eligibility for participation and/or eligibility for benefits under the Plan, and (b) to construe the provisions of the Plan, and its policies, procedures, resolutions, and directives adopted by the Trustees, as amended from time to time. This discretionary authority includes, but is not limited to, the power to construe any disputed or doubtful terms of the Plan and its policies, procedures, resolutions or directives. Any decision rendered by the Trustees after compliance with the foregoing procedures shall be final and binding upon the claimant, his/her beneficiaries, heirs, legatees, and personal representatives. No further appeals shall be available under the Plan.

SUMMARY OF NOTIFICATION OF RESULT OF APPEAL TO THE FUND ADMINISTRATOR AND BOARD OF TRUSTEES (STEPS 1 AND 2)				
APPEALS PROCEDURES	URGENT	PRE-SERVICE	POST-SERVICE	DISABILITY*
INITIAL REVIEW	72 hours	15 days	30 days	45 days

* The disability timing provisions also apply to a first level of appeal to Mutual of Omaha regarding a life insurance, accidental death and dismemberment or waiver of premium appeal. Mutual of Omaha creates its own rules regarding further appeals.

VI. __What Are My Rights and Responsibilities__?

6.1. **__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, also called ERISA. ERISA provides that all Plan Participants are entitled to:

a. Examine, without charge, all Plan documents, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description and insurance contracts and any documents filed by the Plan with the U.S. Department of Labor, such as detailed financial reports, etc. This examination may take place at the Plan administrator's office and at other specified locations such as the work site or the union hall.

b. Obtain, upon written request to the Plan administrator, copies of documents governing 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.

c. Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each Participant with a copy of this summary annual report.

d. Obtain a statement telling you what rights you have with respect to benefits offered by the Plan. THIS STATEMENT MUST BE REQUESTED IN WRITING AND IS NOT REQUIRED TO BE GIVEN MORE THAN ONCE A YEAR. The Plan must provide the statement free of charge.

e. 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.

f. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

g. Reduction or elimination of exclusionary periods of coverage for preexisting conditions creditable under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, or if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people (trustees) 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 Plan benefit or exercising your rights under ERISA.

a. If your claim for a benefit is denied 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, within certain time schedules.

b. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 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 Plan administrator.

c. 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.

d. If it should happen that the Plan's 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 if, for example, it finds your claim is frivolous.

e. 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 concerning a QDRO or Medical Child Support Order, you may file suit in Federal Court. If the Plan's 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 if, for example, it finds your claim is frivolous.

If you have any questions about this statement, or about your rights under ERISA, you should first contact your Plan administrator, and then contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor, listed in your telephone directory or the Division of Technical Assistance & Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

6.2. **HIPAA Privacy Rights.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the benefits manager.

This Plan and the trustees will not use or disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you have questions about the privacy of your health information please contact the Fund's legal counsel, set forth in Section 8.5. If you wish to file a complaint under HIPAA, please contact the Fund administrator.

6.3. **Duty to Notify the Fund of Changes.** The Fund office must be notified of any changes regarding the following:

a. **Marriage -** To add a spouse to coverage, the marriage must be reported within thirty (30) days. A copy of the certificate of marriage must be filed in the fund office. The spouse will then be covered from the moment of marriage.

b. **Dependent Children** - who marry and children who no longer qualify under Section 1.6 must be removed within thirty (30) days and will not be eligible for benefits from the date they lose dependency status, except as provided by COBRA.

c. **New Babies -** To add a participant's child to coverage, the birth must be reported within thirty (30) days. A copy of the birth certificate must be filed in the fund office. The child will be covered from the moment of birth, as provided herein.

d. **Adoptions -** Adoption or placement of a child must be reported within thirty (30) days to add the child as an eligible dependent and a copy of the legal adoption papers or court order for placement must be filed in the fund office.

e. **Change of Address -** Any change of address must be reported immediately.

f. **Name Change** - Any name change must be reported immediately.

g. **Deaths -** Deaths should be reported immediately. A certified copy of the death certificate is required.

h. **Divorce -** Divorce must be reported immediately and a copy of the judgment of divorce must be filed in the fund office. A former spouse is not eligible for benefits commencing on the date of the divorce, except as provided under the Continuation of Coverage (COBRA) Provisions outlined herein. Eligible dependent children will continue to be covered if they continue to be legal dependents.

6.4. **Child Medical Support Orders**. Where a court has issued a child medical support order, the Plan is required to honor this order if the order meets the requirements of federal law. For a copy of the written procedures for seeking a determination from the Plan as to whether an order is "qualified," contact the Plan administrator.

VII. What Happens When Circumstances Change?

7.1. **Amendment.** The trustees have the discretionary authority to prospectively or retroactively amend or adjust the eligibility requirements, the schedule of benefits or any other provision of the Plan. Although the trustees have the right to amend the Plan at any time, these amendments cannot:

a. authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of participants or their beneficiaries; or

b. cause any part of your Plan assets to revert to the contributing employers.

7.2. **Termination.** The Plan may be terminated, in whole or in part, merged, combined or otherwise modified by the trustees. It may also be terminated by the trustees when a collective bargaining agreement requiring contributions no longer exists. Any claim for benefits pending at the time of such termination will be considered a priority claim against the remaining assets of the Plan, to the extent permitted by law.

VIII. What Should I Know About the Employee Benefits Fund?

8.1. **General Plan Information**. The following is important information about your Plan:

a. The name of your Fund is the *Monroe Plumbers and Pipefitters Local Union No. 671 Health and Welfare Fund*.

b. The Fund's tax identification number is 38-1753045, Plan No. 002.

d. Your Fund's records are maintained on a 12-month period of time. This is known as the "Plan Year." The Plan Year begins on May 1 and ends on April 30.

e. The Fund's operations are governed by the applicable federal laws, as well as the laws of the State of Michigan in some limited circumstances.

8.2. **Definitions**. There are certain terms that will be used in this Summary Plan Description, which have a specific legal meaning and are capitalized in this document for purposes of clarity, such as:

a. **Contribution Hours** - means those hours worked in Covered Employment, for which actual contributions have been received from your Employer.

b. **Covered Employment** - means employment in the trade for which your Employer is required to contribute to this Health and Welfare Fund.

c. **Dependent** - means your eligible legal spouse, and/or child. An eligible dependent child includes the participant's unmarried child or adopted child under the age of 22, if such child is dependent upon the participant for support, as evidenced by an income tax exemption claimed by the participant for such child.

d. **Effective Date -** means the effective date of this Plan, the effective date of a specific benefit, or the date an Employee or Dependent becomes eligible for benefits. The Effective Date of this Summary Plan Description is January 1, 2005.

e. **Employee** - means any person working in Covered Employment for which your Employer is obligated to contribute to this Fund. The Union will be treated as the Employer of its Employees for whom it contributes to this Fund.

f. **Employer** - means any entity that is required to make contributions on your behalf to this fund.

g. **Participant -** you become a Participant when you have met the requirements to be eligible for benefits under the Plan.

h. **Physician** - means a doctor that is legally qualified and licensed to practice medicine when the services are performed.

j. **Reasonable and Customary or "R&C"** - means the level of covered charges approved for payment under the Plan. Such level is generally a percentage of the Medicare approved amount, or such similar guidelines, subject to any co-pays or deductibles.

8.3. **Role of Insurance Carrier**. This Fund provides benefits through both insurance contracts purchased from various insurance carriers, as well as on a self-funded basis. The trustees reserve the right to modify which part of the benefits schedule is insured through an insurance carrier and which part, if any, will be self funded.

8.4. **Trustee Information**.

The names of the current Fund Trustees are:

Union Trustees	Employer Trustees
Ronald Sweat	Joseph G. Connors
Paul Padot	William Schoch
Stanley Emerick	Mike Binder
Thomas Sieb (alternate)	Dale Thompson, Jr. (alternate)

The Trustees' principal place of business is:

Monroe Plumbers and Pipefitters Local No. 671 Health and Welfare Fund
c/o Meyer & Associates
P.O. Box 986
1255 S. Telegraph Rd.
Monroe, MI 48161
(888) 242-6544 (Toll Free)
E-mail address: **local671@meyergroup.com**
Website: **www.meyergroup.com**

Trustees are known as the "named fiduciaries" and, as such, oversee the Fund's administration, including the resolution of any claim appeals.

8.5. **Legal Counsel**. The Fund has retained the following legal counsel:

Novara, Tesija & McGuire, P.L.L.C.
2000 Town Center, Ste. 2370
Southfield, MI 48075-1314
Tel: (248) 354-0380
Fax: (248) 354-0393
E-mail address: ntm@novaratesija.com

The Fund's attorneys are responsible for all legal matters involving the Fund.

8.6. **Service of Legal Process**. Legal process is to be served on the above named legal counsel or on the Fund's administrator:

Monroe Plumbers and Pipefitters Local No. 671 Health and Welfare Fund
c/o Meyer & Associates
P.O. Box 986
1255 S. Telegraph Rd.
Monroe, MI 48161

8.7. **Administrator Information**. The Fund is administered by the trustees, who have retained the following administrative service organization:

Meyer & Associates, P.C.
P.O. Box 986
1255 S. Telegraph Rd.
Monroe, MI 48161
Tel: (734) 241-6180 OR (888) 242-6544
Fax: (734) 242-0215

The administrator keeps the records of the Fund and is responsible for its day-to-day operations. The administrator will also answer any questions that you may have about your Plan or this Summary Plan Description.

8.8. **Government Approval**. The trustees will submit the Plan to the Internal Revenue Service, which will issue a "determination letter," approving the Plan as a "qualified" program if the Plan meets specific legal requirements. This Summary Plan Description is a brief description of the Plan and your rights, obligations and benefits under it. Some of the statements made in this Summary Plan Description are dependent upon the Plan being "qualified" under the provisions of the Internal Revenue Code. This Summary Plan Description is not meant to interpret, extend or change the provisions of the Plan in any way. The provisions of the Plan may only be determined accurately by reading the actual Plan document(s). In case of conflict between the terms of the Plan and this Summary Plan Description, the Plan will control.

NOTE: This summary plan description contains only a summary of the Plan's provisions. Due to the complexity and length of the Plan document, the trustees have provided you with this summary, as required by law. You can obtain a copy of any plan or other relevant document by requesting same, in writing, from the Plan Administrator. (See Section 8.7 for administrator information.) IN CASE OF ANY CONFLICT BETWEEN THE TERMS OF THIS SUMMARY PLAN DESCRIPTION AND THE PLAN DOCUMENT, THE TERMS OF THE PLAN DOCUMENT SHALL CONTROL.

Trustees of the Monroe Plumbers and Pipefitters Local No. 671 Health and Welfare Fund

APPENDIX A

SUMMARY SCHEDULE OF BENEFITS

MONROE PLUMBERS AND PIPEFITTERS LOCAL NO. 671 HEALTH AND WELFARE PLAN

This Plan offers coverage for various benefits, some of which require the satisfaction of applicable deductibles, co-pays, limitations, exclusions or separate eligibility requirements. Keep in mind that coverage levels differ between "in-network" and "out-of-network" providers. All coverage levels are based on approved charges. For in-network services, the approved amount is generally the amount billed by the PPO provider, less any contracted discounts. For out-of-network services, the approved amounts are generally based on Reasonable and Customary (R&C) levels for the services rendered, not necessarily the amount billed by your provider. The Reasonable & Customary level is based on a percentage of certain published reimbursement levels, such as those used by Medicare. The following benefit levels currently apply. Please note that these benefit levels, or any other Plan features, can be modified or eliminated by the trustees at any time.

1. **Deductibles, Co-Pays and Maximums**. Before you can receive coverage for benefits, you will have to satisfy the following applicable deductibles and co-pays. Your coverage is also subject to the Plan's maximums:

Annual Deductible	$400 per year, per family	
Deductible – Mental Health and Substance Abuse	$800 per person, per year	
Co-pays - Medical	In-Network : 20% co-pay based on PPO approved charges Out-of-Network: based on coverage level set as the allowable percentage of reasonable and customary (R&C) charges, then reduced by the 20% co-pay i.e., you pay the balance between the billed amount and the reduced amount paid by the Fund Emergency room co-pay of $75.00/visit – if admitted, not applicable	
Co-pays – Mental Health, Substance Abuse	25% for mental health care and substance abuse care	
Co-Pays - Prescriptions	**Retail (34 day supply)**	**Mail Order (90-day supply)**
	Brand Name Drugs $20.00 co-pay	$20.00 co-pay
	Generic Drugs $5.00 co-pay	$5.00 co-pay
Out of Pocket Maximums	$1,500 per family per year (consisting of $400 deductible and $1,100 total in co-pays), except for mental health and substance abuse	
Dental, Vision and Hearing	$1,000 maximum per family, per year	
Lifetime Dollar Maximums	$1 Million lifetime, per covered individual	

NOTE: After you meet the annual deductible, coverage begins, with the appropriate co-pay applied. Of course, once you satisfy the applicable co-pay, benefits are paid at 100% in network, or at the approved amount of the R&C reimbursement level, for out-of-network charges, subject to the lifetime maximum.

2. **Network Providers**. ***Note: If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge***. You are encouraged to use in-network providers whenever possible to receive the maximum coverage offered by the Plan. Two are available to you in the Michigan and Ohio area**:**

Direct Care America, Inc. (DCA)
4301 Darrow Road
Stow, OH 44224

FrontPath Coalition
Maumee, OH 43457

Outside of the Michigan and Ohio area:

CCN
4301 Darrow Road
Stow, OH 44244

You must present your benefit card whenever you receive services.

3. **Medical Benefit Levels**: The following benefit levels currently apply to approved medical services:

	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
PREVENTATIVE SERVICES		
Health Maintenance Exam	Covered - 80% of PPO approved charges	Covered – 80% of the R&C level
Annual Gynecological Exam	Covered - 80% of PPO approved charges	Covered – 80% of the approved R&C level
Pap Smear Screening - laboratory services	Covered - 80% of PPO approved charges	Covered – 80% of the R&C level
Well-Baby and Child Care	Covered - 80% of PPO approved charges	Covered – 80% of the R&C level
Fecal Occult Blood Screening	Covered - 80% of PPO approved charges	Covered – 80% of the approved R&C level
Flexible Sigmoidoscopy Exam	Covered - 80% of PPO approved charges	Covered – 80% of the approved R&C level
Prostate Specific Antigen (PSA) Screening	Covered - 80% of PPO approved charges	Covered – 80% of the approved R&C level
MAMMOGRAPHY		
Mammography Screening	Covered - 80% of PPO approved charges - one per calendar year, no age restrictions	Covered – 80% of the approved R&C level - one per calendar year, no age restrictions
PHYSICIAN OFFICE SERVICES		
Office Visits	Covered – 80% of PPO approved charges	Covered – 80% of the approved R&C level
Outpatient and	Covered – 80% of	Covered – 80% of the approved

Home Visits	PPO approved charges	R&C level
Office Consultations	Covered –80% of PPO approved charges	Covered – 80% of the approved R&C level
Urgent Care Visits	Covered – 80% of PPO approved charges	Covered – 80% of the approved R&C level
EMERGENCY MEDICAL CARE		
Hospital Emergency Room -approved diagnosis	Covered – 80% of PPO approved charges after $75 co-pay if applicable	Covered – 80% of the approved R&C level after $75 co-pay if applicable
Physician's Office - approved diagnosis	Covered - 80% of PPO approved charges	Covered – 80% of the approved R&C level
Ambulance Services-medically necessary	Covered – 80% of PPO approved charges	Covered – 80% of the approved R&C level
DIAGNOSTIC SERVICES		
Laboratory and Pathology Tests	Covered - 80% of PPO approved charges	Covered – 80% of the approved R&C level
Diagnostic Tests and X-Rays	Covered – 80% of PPO approved charges	Covered – 80% of the approved R&C level
MATERNITY SERVICES		
Pre-Natal and Post-Natal Care	Covered – 80% of PPO approved charges	Covered – 80% of the approved R&C level
Delivery and Nursery Care – Maximum 48 hours for normal and 96 hours of stay for cesarean delivery	Covered – 80% of PPO approved charges	Covered – 80% of the approved R&C level
HOSPITAL CARE – INPATIENT ADMISSIONS REQUIRES PRE-CERTIFICATION-CALL 1-800-345-6700		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 80% of PPO approved charges, 365 days of confinement	Covered – 80% of the approved R&C level, 365 days of confinement
Inpatient Consultations	Covered - 80% of PPO approved charges	Covered – 80% of the R&C level
Chemotherapy	Covered – 80% of PPO approved charges	Covered – 80% of the approved R&C level
Pre Admission Testing	Covered – 80% of PPO approved charges, within seven days of admission	Covered – 80% of the approved R&C level, within seven days of admission
ALTERNATIVES TO HOSPITAL CARE – REQUIRED PRE-CERTIFICATION – CALL 1-800-345-6700		
Skilled Nursing Care	Covered - 80% of PPO approved charges, up to 120 Days per calendar year, up to 4 hours each	Covered – 80% of the approved R&C level, up to 120 per calendar year, up to 4 hours

		each
Hospice Care	Covered - 80% of PPO approved charges, limited to the lifetime dollar maximum.	Covered – 80% of the approved R&C level. Limited to the lifetime dollar maximum.
Home Health Care	Covered – 80% of PPO approved charges, up to 120 visits per year, up to 4 hours each	Covered – 80% of the approved R&C level, up to 120 visits per year, up to 4 hours each
SURGICAL SERVICES		
Surgery, including all related surgical services, anesthesia and surgical assistance	Covered – 80% of PPO approved charges	Covered – 80% of the approved R&C level
Voluntary Sterilization	Covered – 80% of PPO approved charges	Covered – 80% of the R&C level
MENTAL HEALTH – FOR REVIEW		
Outpatient Mental Health Care Facility and Clinic Physician's Office Outpatient Substance Abuse Care	Covered 75% of PPO approved charges - 30 visits per calendar year, 60 visits per lifetime	Covered – 75% of the approved R&C level -30 visits per calendar year, 60 visits per lifetime
Inpatient Mental Health Care Including Substance Abuse Care	Covered 75% of PPO approved charges - 30 inpatient days per calendar year, 60 inpatient days per lifetime	Covered – 75% of the approved R&C level - 30 inpatient days per calendar year, 60 inpatient days per lifetime
OTHER BENEFITS		
Allergy Testing and Therapy	Covered – 80% of PPO approved charges	Covered – 80% of the approved R&C level
Chiropractic Spinal Manipulation and X-Rays	Covered - 80% of PPO approved charges, up to $500 maximum per calendar year	Covered – 80% of the approved R&C level, up to $500 maximum per calendar year
Outpatient Physical, Speech and Occupational Therapy	Covered - 80% of PPO approved charges, up to 60 visits per calendar year	Covered – 80% of the approved f R&C level, up to 60 visits per calendar year
Durable Medical Equipment	Covered – 80% of PPO approved charges	Covered – 80% of the approved R&C level
Prosthetic and Orthotic Appliances	Covered – 80% of PPO approved charges	Covered – 80% of the R&C level

Note: If you receive care from a nonparticipating provider, even when referred by a network provider, you may be billed for the difference between our approved amount and the provider's charge.

4. **Prescription Drug Benefits**. Coverage for prescription drugs is available under the Plan, although certain groups of Participants may be required to pay an additional premium for this coverage. Coverage is limited to a 34-day supply or a 100-unit dose (90-day supply for mail order drugs) of any prescription, with refills limited to the number of times ordered by the physician. Prescription drug coverage does not extend to experimental drugs, allergens, infertility medicine, contraceptives or any other drugs excluded by the program through which the coverage is provided – see benefits section for more details. The following levels of coverage apply:

Retail Prescription Drugs	**Limited to a 34 day supply** $5.00 co-pay for generic drugs $20.00 co-pay for name brand drugs
Mail Order Prescriptions Drugs	**Limited to 90-day supply with single co-pay of:** $5.00 co-pay for generic drugs $20.00 co-pay for name brand drugs

5. **Dental, Vision and Hearing Benefits**. Dental, vision and hearing benefits are offered by the Plan on a reimbursement basis, which reimburses up to $1,000.00 per calendar year. This coverage includes: dental services (such as dental examinations, fillings, and orthodontic treatment), and vision services (such as vision examinations, purchase of lenses, frames and contacts), and hearing-related services (such as hearing aids, hearing tests and treatment for hearing impairments). This coverage level cannot be used to reimburse deductibles or co-pays. If you elected the quick-eligibility option as a bargaining unit Employee, or as a working owner, you are not eligible for the dental and vision benefit as long as you have a negative hour bank.

Dental, Vision and Hearing Benefits	$1,000.00 per calendar year, per covered family.

6. **Weekly Disability Benefits**. When an active (bargaining unit) Participant is prevented by a disability from engaging in Covered Employment, the following amount will be paid:

BENEFIT AMOUNT	$350.00/week
MAXIMUM PERIOD OF PAYMENT	13 weeks
WAITING PERIODS: For disability due to disease or illness For disability due to accident or injury	 7 days none
RETURN TO WORK	Two full weeks of continuous Covered Employment are required between periods for which weekly disability is payable; one day is required if the disability is unrelated to the prior accident or sickness.

7. Death and Accident Benefits.

Provided through:

United of Omaha Life Insurance Company
No. 30 Oak Hollow, Ste. 265
Southfield, MI 48034
Tel: 248 350-0040

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (Eligible Active (Bargaining Unit) Participants and Retirees Only)	
Life Insurance (Principal Amount)	$15,000.00
Accidental Death and Dismemberment (within 13 weeks of accident) Principal Amount (in addition to the life insurance)	$15,000.00
Death, loss of both hands, both feet, both eyes, one hand and one foot, one hand and one eye, or one foot and one eye	$15,000.00
Loss of one hand, one foot, or either eye	$7,500.00
Loss of thumb and index finger of either hand	$3,750.00

8. **Limitations and Exclusions**. All limitations, restrictions or exclusions included in the Plan apply to all benefits offered. Some benefits have additional exclusions or limitations, such as prescription drugs and life insurance. No benefits will be paid if excluded by the Plan, even if the individual is otherwise eligible for same.

The Trustees reserve the right to modify or eliminate the level of benefits provided herein, either prospectively, or retroactively, as they, in their sole discretion, deem appropriate.