FLINT PLUMBING AND PIPEFITTING FRINGE BENEFIT FUNDS

Flint Plumbing & Pipefitting Industry Health Care Fund
Flint Plumbing & Pipefitting Industry Pension Fund
Flint Plumbing & Pipefitting Industry Defined Contribution Plan
Supplemental Unemployment & Disability Plan of Local Union 370

Managed for the Trustees by:
TIC International Corporation

July 2023

IMPORTANT INFORMATION FOR PARTICIPANTS OF THE FLINT PLUMBING & PIPEFITTING INDUSTRY HEALTH CARE FUND REGARDING SUMMARY OF BENEFITS AND COVERAGE

Dear Participant:

The Federal health care reform law – the Patient Protection and Affordable Care Act – requires that all group health plans, such as the Fund, provide participants and beneficiaries with a Summary of Benefits and Coverage ("SBC").

Please share the SBC and this letter with your family members who are eligible for coverage under the Plan.

The SBC is a document designed to provide a general description of some of the benefits provided by the Fund. The Federal government has issued a strict form template and detailed rules on the format and contents of the SBC. For this reason, the SBC does not cover all of the benefits provided by the Fund and it does not contain any information regarding eligibility. We recommend that you refer to the Fund's Summary Plan Description ("SPD") and the Summary of Material Modifications ("SMM") for a more complete description of the benefits provided by the Fund, as well as the eligibility rules. The SPD and SMM can also be found on the Fund's website listed below, or you may contact the Fund Office to request a copy.

If you have any questions regarding the SBC or your benefits, please contact the Fund Office at (888) 797-5862 for assistance.

Sincerely,

Board of Trustees
Flint Plumbing & Pipefitting Industry Health Care Fund

6525 Centurion Drive • Lansing, MI 48917-9275
(517) 321-7502• FAX (517) 321-7508
Toll Free (888) 797-5862
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FLINT PLUMBING
AND
PIPEFITTING INDUSTRY
HEALTH CARE FUND

SUMMARY PLAN DESCRIPTION
2021

PREFACE

The Board of Trustees of the Flint Plumbing and Pipefitting Industry Health Care Fund (the Trustees) describe the benefits provided by the Flint Plumbing and Pipefitting Industry Health Care Fund (the Fund) by a plan document titled "Flint Plumbing and Pipefitting Industry Health Care Fund Plan" (Plan). It is intended that the Plan shall conform to the requirements found in the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time. If any portion of the Plan does now, or in the future, conflict with ERISA or applicable federal regulations, ERISA and/or such regulations will govern.

Although the Trustees expect to continue the Fund indefinitely, they reserve the right to change or terminate the Fund at any time and for any reason, for any group or class of Participants or Dependents, as well as for all such groups. Correspondingly, the Trustees may change the level of benefits provided, or eliminate an entire category of benefits, at any time and/or for any reason. There are no vested benefits under the Plan for Active Employees or Retirees.

The Fund is subject to all terms, provisions and limitations stated in the Plan which are described in this summary plan description ("SPD"). **If there is any conflict between the terms of this SPD and the Plan, the Plan controls.**

Contents

ARTICLE 1 – DEFINITIONS

Active Employee means a Journeyman, Apprentice, Serviceman, Union Employee, Apprenticeship Fund Employee, or other person on whose account an Employer makes Contributions to the Fund based upon current employment.

Apprentice means a person learning the trade and designated as an Apprentice under the Collective Bargaining Agreement.

Apprenticeship Fund Employee means an instructor or other employee of the Local 370 Apprentice and Journeymen Training Fund (Apprenticeship Fund) on whose behalf the Apprenticeship Fund makes Contributions to the Fund.

Association means Flint Association of Plumbing & Mechanical Contractors, Inc.

Children or Child means:

(a) Any person up until the first of the month following the month in which he/she turns age 26 and either:

(1) is a Participant's natural child or adopted child; or
(2) has been placed with a Participant for adoption; or
(3) is a Participant's stepchild, which means he/she is the child of his/her Spouse; or

(b) A person who would qualify as a "child" under paragraph (a) but for the age limitations, who by reason of mental or physical handicap is incapable of sustaining employment and the Participant has submitted proof of such acceptable to the Trustees to the Fund Office within 31 days of the date upon which he/she attains 26 years of age; or

(c) An alternate recipient under a Qualified Medical Child Support Order of a Participant.

Collective Bargaining Agreement means any contract entered into between the Union and the Association or any Employer under which the Employer has agreed to contribute to the Fund.

Contributions or Employer Contributions mean contributions received by the Fund by an Employer as required under a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act. Contributions become vested plan assets at the time they become due and owing.

Covered Employment is employment covered by the Collective Bargaining Agreement, or employment for which Contributions have been or are required to be made to the Fund on behalf of a Participant.

Covered Person means the Participant or Dependent who is eligible for a particular benefit.

Dependent means a Participant's Spouse or Child.

Employer means:

(a) a member of the Association who is bound by the terms of a Collective Bargaining Agreement between the Union and the Association to make Contributions to the Fund;
(b) any other employer engaged in work coming within the jurisdiction of the Union who is obliged, by a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act, to make Contributions to the Fund;

(c) the Union to the extent, and solely to the extent, that it acts in the capacity of an employer of its business representatives or other employees on whose behalf it makes Contributions to the Fund; and
(d) the Apprenticeship Fund, to the extent and solely to the extent that it acts in the capacity of an employer of employees on whose behalf Contributions are made to the Fund.

Fund means the Flint Plumbing & Pipefitting Industry Health Care Fund.

Fund Office or Plan Office means Flint Plumbing & Pipefitting Industry Health Care Fund, 6525 Centurion Drive, Lansing, MI 48917, (517) 321-7502 or (888) 797-5862.

Illness means a bodily disorder, disease, physical sickness, or mental disorder, including pregnancy, childbirth, miscarriage, or complications of pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Participant means an Active Employee, Retiree, or Surviving Spouse.

Plan means this document, i.e. the Flint Plumbing and Pipefitting Industry Health Care Fund Plan.

Plan Year means the fiscal year August 1 through July 31 of the following year.

Retiree means an individual who:

1. Has at least 8,700 hours in Contributions remitted to the Plan in the 10 years immediately preceding his retirement; and
2. Is eligible in this Plan at the time of his retirement as an Active Employee and immediately upon retirement elects to continue coverage as a Retiree;
3. Is receiving an Early, Normal or Disability Pension Benefit from the Flint Plumbing & Pipefitting Industry Pension Fund; and
4. Is and remains a member in good standing with the Union.

Short Term Disability means a Participant is unable to perform Covered Employment.

Spouse means the Active Employee's or Retiree's legal spouse.

Surviving Spouse means the person who was married to an Active Employee or Retiree on the date of the Participant's death.

Totally Disabled means a Covered Person has a current Social Security Disability Award.

Trustees mean the Trustees of the Fund as appointed by the Flint Plumbing & Pipefitting Industry Health Care Fund Trust Agreement.

Union means UA Local 370 Plumbers, Pipefitters and Service Trades.

ARTICLE 2 – ELIGIBILITY RULES

2.1 Active Employees

(a) Initial Eligibility

The Participant will become initially eligible on the first of the second month following the month in which the participant has been credited with at least $3,850 of employer contributions within a 12-month period, as set forth below:

If credited with at least $3,850 (in a 12-month period) as of:	Then will establish initial eligibility as of:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

Amounts received on behalf of a Participant from the Funded Market Recovery Program (FMRP) shall be treated the same as employer contributions. for the purpose of establishing eligibility only. Amounts paid by the FMRP represent an interest free loan to the Fund made from time to time to establish eligibility for a Participant. When and if FMRP contributions will be contributed is determined in the sole and exclusive discretion of the FMRP.

(b) Continuing Eligibility/Dollar Bank. Any Employer Contributions received in excess of the initial eligibility requirement are added to the Active Employee's Dollar Bank. Each month, a monthly dollar requirement necessary to remain eligible (Monthly Requirement) is deducted from the Active Employee's Dollar Bank to maintain eligibility. The Monthly Requirement is set from time to time in the sole discretion of the Trustees. As of August 1, 2017, the Monthly Requirement is $1,040 per month.

An Active Employee can bank a maximum of $16,000 in his/her Dollar Bank. (If Participants had $16,200 in their Banks as of 3/1/14, their Banks can remain at $16,200, but no further credit will be given until such Banks fall below $16,000 and thereafter may not exceed $16,000.)

Notwithstanding anything in this section to the contrary, where a Participant's initial eligibility has been paid via contributions from the Funded Market Recovery Program, any employer contributions received each month on behalf of such Participant in in excess of the Monthly Requirement shall be remitted to the FMRP until it has been reimbursed the amount expended to provide such initial eligibility.

Employer Contributions are credited to an Active Employee's Dollar Bank as follows:

Work Month:	Contributions Received for This Work Month Credited to Dollar Bank in the Following Month:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

The above schedule allows for one bookkeeping month. Notwithstanding, if an Active Employee submits proof that he/she has other comprehensive medical coverage that will be cancelled once eligibility in the Fund is established, the bookkeeping month will be waived and coverage may commence the first of the month following the month in which he has met Initial or Continuing Eligibility requirements.

A Participant's Dollar Bank is forfeited if he/she works for a noncontributing employer in the plumbing and pipefitting industry in the jurisdiction of the Union.

(c) **Self-Payments.** If an Active Employee's Dollar Bank has less than the Monthly Requirement, he/she can continue to be eligible by paying the difference between the amount in his/her Dollar Bank and the Monthly Requirement. This is the "self-pay rate." The self-pay rate can change at any time in the sole discretion of the Trustees.

In the event an Active Employee has less than one month's reserve in his/her Dollar Bank and elects not to self-pay to continue coverage, such balance will be frozen and used in the event he/she re-establishes eligibility within 18 months.

The Fund Office will send monthly self-pay notices and payment is due to the Fund Office within 10 days of the date of this self-pay notice. Once an Active Employee fails to timely make a self-payment, he/she will be offered COBRA coverage.

To be entitled to self-pay, an Active Employee must be available for work for a contributing Employer, on the Union's out of work list, and not working for a noncontributing employer in the plumbing and pipefitting industry in the jurisdiction of the Union. Where there is no balance in the dollar bank, an employee must pay the entire Monthly Requirement, known as a "full self-payment." No individual can make full self-payments for longer than 18 consecutive months, unless they can provide proof, acceptable in the sole discretion of the trustees, that they have met these requirements for such 18 months and continue to do so.

An Active Employee who is not eligible for self-pay will be offered COBRA coverage and all months for which self-payments were previously made will be counted towards his/her maximum allowable time on COBRA.

(d) **Reinstatement of Eligibility for Active.** An Active Employee whose eligibility has terminated will be reinstated when sufficient funds are credited to his/her Dollar Bank to meet the Monthly Requirement. Notwithstanding, if an individual has been ineligible for more than 18 months, he/she must again satisfy the initial eligibility requirements of section 2.1(a) to be reinstated.

(e) **Supplemental Benefit.** Funds in the Dollar Bank can be used for the Supplemental Benefit, as set forth in Article 6.

(f) **Work for Noncontributing Employer.** Notwithstanding any term of this Plan to the contrary, all coverage will terminate for an Active Employee who works for a noncontributing employer in the plumbing and pipefitting industry in the jurisdiction of the Union and he/she will be offered COBRA coverage.

2.2 Short Term Disability Coverage for Active Employees

When an Active Employee has a Short-Term Disability, continued eligibility is provided via his/her Dollar Bank as set forth in this section.

An Active Employee's Dollar Bank will be credited each weekday he/she has a Short-Term Disability in an amount equal to the Monthly Requirement divided by 20, but not to exceed the Monthly Requirement per month. This is referred to as the "Short Term Disability Credit." If necessary to maintain eligibility, an Active Employee may self-pay the difference in Short Term Disability Credit and the Monthly Requirement. Short Term Disability Credit begins the date of injury or one week following the onset of Illness.

Short Term Disability Credit is only available if an Active Employee:

(1) submits proof sufficient, in the sole discretion of the Trustees, that he/she is unable to perform Covered Employment, and

(2) either:

(A) he/she is eligible for payment of Weekly Disability (Loss of Time) Benefits under the Plan, or

(B) is eligible for weekly worker's compensation benefits as a result of a disability incurred while working in Covered Employment within the jurisdiction of Local Union 370.

To be eligible for Short Term Disability Credit, an Active Employee and his physician must complete and submit a form provided by the Fund, and the information provided must be acceptable, in the sole discretion

of the Trustees, to establish a Short-Term Disability. The Trustees have the right to have an Active Employee medically examined by a physician chosen by the Trustees, at the Fund's expense, to assist in their determination as to whether an Active Employee has a Short-Term Disability.

Short Term Disability Credit is provided for a maximum of 26 weeks for any single period of disability. All Short-Term Disability absences will be considered a single period of disability, regardless of whether the disabilities are related, until a Participant returns to Covered Employment and the number of hours worked upon such return multiplied by the applicable contribution rate equals the Monthly Requirement.

Once eligibility is exhausted under this section, an Active Employee may continue coverage via the remaining credit in his/her Dollar Bank or by self-payments.

2.3 Active Employee Absence Due to Military Service

- Coverage for an Active Employee or Dependent under the Plan will terminate upon entry into military service. Military service means that service covered under the Uniformed Services Employment and Reemployment Act, 38 USC §4303.
- If coverage under the Plan is terminating due to military service, a Covered Person may elect to continue the health coverage under the Plan for up to 24 months after the absence begins, or for the period of military service, if shorter. The Covered Person must notify the Plan Office as soon as he volunteers for or is called to active duty. The maximum premium that will be charged is 102% of the full premium for the coverage. However, if the military service is for 30 or fewer days, the maximum premium will be the self-payment amount.
- Upon termination for military duty, a Participant's eligibility shall be frozen, with reinstatement under that same status upon his/her discharge from the military. Exclusions and waiting periods will not be imposed upon re-employment provided coverage would have been afforded had the person not been absent for military service, unless there are disabilities that the Veterans Administration determines to be service related. For these benefits to apply, however, the period of service must be less than five years and a Participant must return to Covered Employment within 90 days after completion of the service.

2.4 Retiree Coverage

(a) **General**. Upon meeting the definition of Retiree, a Retiree and his/her Dependents become eligible for Retiree coverage. If an otherwise eligible individual does not elect to continue coverage as a Retiree immediately upon retirement, he/she will not be allowed to participate at a later date.

(b) **Required Medicare Enrollment.** All Medicare eligible Retirees and Dependents are required to enroll in Medicare Parts A and B (but not Part D Prescription Drug coverage) as soon as he/she becomes eligible for Medicare coverage and must immediately forward a copy of his/her Medicare card to the Fund Office. Failure to do so will result in the individual becoming responsible for the costs of medical expenses that otherwise would have been covered by Medicare.

(c) **Self-Payments.** Retirees are required to make monthly self-payments to maintain coverage. The self-payment amount is established from time to time in the sole discretion of the Trustees. Failure to timely make a self-payment will result in the loss of coverage which cannot be reinstated. Notwithstanding, if the Trustees determine, in their sole discretion, that an former Participant who never had Retiree coverage and who is receiving a disability pension from the Flint Plumbing & Pipefitting Industry Pension Fund, had a lapse in coverage because he/she was incapacitated from making self-payments on his/her own behalf, then on a one time only basis this former Participant may

be allowed to retroactively elect Retiree coverage to the date coverage lapsed, not to exceed one year retroactive reinstatement, upon payment of any and all missed self-payments. The Fund Office will send monthly self-pay notices and payment is due to the Fund Office within 10 days of the date of this self-pay notice.

The extent to which Retiree self-payments do not cover the full cost of coverage is the Retiree Subsidy. The Retiree Subsidy for pre-Medicare Retirees is the difference between the Active Monthly Requirement (see section 2.1(b)) and the pre-Medicare Retiree self-payment rate established by the Trustees. The Retiree Subsidy for Medicare Retirees is the difference between the premium for coverage under the Medicare Policy (see section 5.2) and the Medicare Retiree self-payment rate established by the Trustees. The amount of the Retiree Subsidy is determined in the sole discretion of the Trustees and can be changed or eliminated at any time.

(d) **Return to Work.** A Retiree who returns to work will be covered as a Retiree until sufficient funds are credited to his/her Dollar Bank to meet the Monthly Requirement as an Active Employee. Notwithstanding, if an individual has not been an Active Employee for more than 18 months, he/she must again satisfy the initial eligibility requirements of section 2.1(a) to be reinstated as an Active Employee.

A Retiree who engages in non-bargaining unit work in the plumbing and pipefitting industry (for example, sales, estimating, project manager, and safety) will not receive the Retiree Subsidy as set forth in Section 2.4(c) and must pay the full cost of coverage as determined in the sole discretion of the Trustees. A Retiree has an obligation to notify the Fund Office before he returns to work, or if that is not feasible as soon as possible. Such an individual will be eligible for the Retiree Subsidy again the first month following written notice to the Fund Office that he is no longer working, provided there has been no lapse in his Retiree coverage under the Fund (in which case coverage would permanently terminate).

2.5 Termination of Coverage for an Active Employee or Retiree

Notwithstanding any term of this Plan to the contrary, coverage for an Active Employee or Retiree terminates the earliest of the following:

(1) Failure to meet the requirements for continuing eligibility, including a failure to make any self-payment in a timely manner; or
(2) Plan amendment which results in the termination of coverage; or
(3) Termination of the Plan.

2.6 Dependents

(a) **In General.** Dependents are eligible for coverage under this Plan when the Participant upon whom they are dependent is eligible. Notwithstanding any term of the Plan to the contrary, Dependent coverage terminates when such individual no longer meets the definition of Dependent.

A new Dependent should be enrolled within 30 days of marriage, birth, adoption, or placement for adoption and if so enrolled a Spouse will become eligible for coverage as of first day of the first month following the date of marriage and a Child's coverage will be effective the date of birth, adoption, or placement for adoption. If a Dependent is enrolled after these 30 days, retroactive coverage cannot be guaranteed, and any retroactive coverage will be limited to that allowed by BCBSM policies and procedures.

(b) **Dependent Coverage upon Death of the Participant.** Notwithstanding the above, if an Active Employee or Retired Participant dies, his/her surviving Dependents will continue coverage, without self-payment, so long as they continue to meet the definition of Dependent and until the later of:

(1) The normal eligibility termination date based on the Participant's Dollar Bank as if death had not occurred; or
(2) The last day of the third calendar month following the month in which the Participant died.

Thereafter, coverage may continue so long as self-payments, established from time to time in the sole discretion of the Trustees, are timely made for individuals who continue to meet the definition of Dependent.

(c) **Termination of Dependent Coverage.** Notwithstanding any term of the Plan of the Plan to the contrary, Dependent coverage terminates upon the first of the following:

(1) Failure to make timely self-payments;
(2) Failure to meet requirements for continuing coverage, including failure to meet the definition of Dependent;
(3) Remarriage of Dependent Spouse;
(4) Termination of coverage of the Participant upon whom coverage is based; or
(5) Termination of the Plan.

2.7 Opt Out.

(a) **Opting Out of Full Plan Coverage.** One time per year upon receipt by the Fund Office of a written request acceptable to the Trustees, an Active Employee may opt out of the benefits provided by the Fund if:

(1) He/she is actually enrolled in a group health plan that does not consist solely of excepted benefits (e.g., can be a spouse's plan) (Other Coverage); and
(2) The Other Coverage meets the Affordable Care Act minimum value standard.

Medicare is not "Other Coverage" for purposes of this provision.

(b) **Freezing of Dollar Bank.** Upon opting out, an Active Employee's Dollar Bank will be frozen. "Freezing" the Dollar Bank means:

(1) Eligibility for the Active Employee and his/her Dependents will terminate the first of the month following the receipt of the request to opt out, except the Active Employee will remain eligible for life insurance and the Supplemental Benefit provided under Article 4;
(2) The Active Employee's Dollar Bank will continue to be credited with ½ of the Employer Contributions received while the Dollar Bank is frozen less the cost of life insurance, up to the maximum Dollar Bank limit set forth in Section 2.1(b); and
(3) Active Employee's will maintain their "frozen" bank until there have been no contributions made on the Active Employee's behalf for 18 months. After there have been no contributions for 18 months, the remaining balance in the Active Employee's dollar bank will be forfeited, and there will be no further eligibility under (a) or credit given under (b), above.

If any contributions are received on behalf of the Active Employee thereafter, eligibility must be re-established per the Initial Eligibility Provisions of the Plan.

(c) Reinstatement of Full Coverage

(1) One Year After Effective Date of Opt Out. An Active Employee may reinstate full coverage no sooner than one year after the effective date of his/her opt out by forwarding a written request for reinstatement to the Fund Office acceptable to the Trustees.

(2) Within One Year of Effective Date of Opt Out. An Active Employee may reinstate full coverage within one year of the effective date of opting out only under the following conditions:

(A) Acquisition of a new Dependent as a result of marriage, birth, adoption, or placement for adoption, if a request to re-enroll for full coverage is made within 30 days of such event. An election change for marriage shall be effective the first day of the first month following the requested change. An election change for birth, adoption, or placement for adoption shall be effective the date of birth, adoption, or placement for adoption.

(B) If each of the following conditions are met:

(i) The Active Employee was covered under a group health plan or had health insurance coverage ("Other Coverage") at the time he made his election to opt out;
(ii) The Participant executed an Acknowledgment at the time of his election for Opt Out coverage verifying he/she had Other Coverage;
(iii) The Participant's Other Coverage:
(a) was COBRA coverage and which has been exhausted; or
(b) was non-COBRA coverage which has been terminated as a result of:
(I) loss of eligibility due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of the plan for similarly situated individuals, or cessation of Dependent status; or
(II) employer contributions toward such coverage were terminated; and
(iv) The Participant requests re-enrollment in full coverage within 30 days of the termination of the Other Coverage.

An election change for the reasons set forth above shall be effective the first day of the first month following the requested change.

(C) An Active Employee taking leave under the Family Medical Leave Act may change his election for the period of time he/she is on such leave.

(D) The Active Employee loses eligibility for Medicaid or State Children's Health Insurance Program ("CHIP") coverage, or becomes eligible to participate in a premium assistance program under Medicaid or CHIP. In both instances, the employee must request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

(3) **Dollar Bank Upon Reinstatement.** Upon reinstatement, the Active Employee's Dollar Bank will be "unfrozen" and coverage reinstated the first day of the month following the request to re-enroll, provided the Active Employee has returned to Covered Employment in the jurisdiction of the Union and the amount in the Dollar Bank is sufficient to cover the Monthly Requirement in effect as of the date of the request for reinstatement.

2.8 Reciprocity

The Trustees have entered into reciprocal agreements with the Trustees of similar UA health and welfare funds. Under these agreements, contributions for hours worked in the jurisdiction of another UA local may be transferred to this Fund for use in continuing eligibility.

The amounts to be transferred and the way those transfers are credited to Participants are governed by the Reciprocity Agreements and by the administrative procedures adopted by the Trustees, in their sole discretion, from time to time.

2.9 Trustee Discretion

The Trustees, in their discretion, have the authority to change any term or condition of this Plan at any time, including but not limited to the provisions regarding eligibility.

2.10 Notification to Fund Office

Each Participant and adult Dependent has an obligation to keep the Fund Office informed of changes in address, marital status, beneficiary, and dependents.

2.11 Nonbargaining Unit (NBU) Participation

The Trustees may enter into participation agreements to allow coverage under the Fund for NBU participants under the following conditions:

(1) The Employer must sign a participation agreement provided by the Trustees.
(2) The Employer must:

- (a) Have an office in the jurisdiction of Local 370;
- (b) Have a current CBA with Local 370;
- (c) Currently employ, and continue to employ as a condition of participation, bargaining unit employees; and
- (d) Be current in contributions to all Local 370 funds for bargaining unit employees, and current in contributions to this Fund for NBU participants.

Failure to meet these conditions will be considered a fraud on the Fund, in which event the Employer shall be liable to reimburse the Fund for the costs of all claims incurred for the period of time for which any such condition was not met.

(3) NBU participants must be employees of the Employer.
(4) NBU participants have no Bank (and thus no Supplemental Benefit).
(5) Contributions for each NBU participant must be made at the journeyman rate under the Local 370 CBA for 40 hours per week, 52 weeks per year. No self-payments are allowed to maintain coverage if contributions are not timely received. Eligibility will be terminated where contributions are not timely received and will not be reinstated. No COBRA coverage will be offered if eligibility is terminated due to the Employer's failure to timely pay contributions. Contributions are due for each NBU participant 15 days prior to the month of coverage.

(6) NBU participants and their Dependents are eligible for medical, prescription drugs, and dental coverage under Article 5. Life insurance coverage will be available only if such coverage is approved by the life insurance carrier.

(7) NBU participants are not entitled to Weekly Disability Benefits, nor extended eligibility for disability.

(8) No Dependent coverage is available upon the death of the NBU participant. Dependents will be offered COBRA.

(9) No retiree coverage is available for NBU participants.

(10) The Employer is responsible for determining which of its employees will participate. The Employer agrees it is the Employer's responsibility to ensure the benefits it provides to its employees are provided on a nondiscriminatory basis and agrees to indemnify and hold harmless the Fund for any costs or expenses incurred if the Employer fails to do so.

(11) The Fund will not accept any NBU participation if the total number of NBU participants reaches the 10% limitation applicable to VEBAs under IRC §501(c)(9).

(12) The Trustees retain the right to change or eliminate the benefits or participation of NBU participants. An election to participate can only be made once per year by an Employer, and if elected the Employer is bound to make contributions for entire year for each of its NBU participants. If the employment of any such NBU participant with the Employer terminates, he/she will be offered COBRA pursuant to the terms of Article 8.

This section 2.11 does not apply to the Union or Apprenticeship Fund.

ARTICLE 3 – WEEKLY DISABILITY BENEFITS (LOSS OF TIME) – ACTIVE EMPLOYEES ONLY

An Active Employee who as the result of a non-occupational accidental bodily Injury or Illness is unable to perform Covered Employment is eligible for a Weekly Disability Benefit in the amount of $200 per week. An Active Employee must complete an application, supported by a physician statement, on a form provided by the Fund Office. If requested, the applicant must submit to an independent medical examination with a physician selected by the Fund. No benefits are payable under this benefit provision for any period or day of disability for which the Employee is not under the regular care and attendance of a physician. A Chiropractor is not considered a physician for the purposes of disability benefits.

Weekly Disability Benefits are provided for a maximum of 26 weeks for any single period of disability. All disabilities will be considered a single period of disability, regardless of whether the disabilities are related, until a Participant returns to Covered Employment and the number of hours worked upon such return multiplied by the applicable contribution rate equals the Monthly Requirement.

Weekly Disability Benefits begin the date of Injury or one week following the onset of Illness. No Weekly Disability Benefits are payable on or after the date an Employee retires. Weekly Disability Benefits are not assignable.
Weekly Accident Disability Benefits are also subject to all General Plan Exclusions and Limitations.

ARTICLE 4 – LIFE INSURANCE

4.1 Insured Basic Life and Accidental Death and Dismemberment Benefits – Active Employees

Active Employees are eligible for coverage under a fully insured life insurance policy purchased by the Fund. The amount of coverage is $30,000 basic life and $10,000 accidental death and dismemberment. Further information, including limitations and exclusions to coverage, are set forth in the life insurance policy. **If there is any conflict between the terms of the Plan, this SPD or the terms of the life insurance policy, the terms of the life insurance policy control.**

4.2 Retirees

Retirees are eligible for $9,000 basic life coverage. A Retiree may continue life insurance even if he/she ceases all other coverage under the Fund if he/she continuously makes a monthly self-payment for this coverage. The amount of such self-payment shall be determined from time to time in the sole discretion of the Trustees.

4.3 Beneficiary Designation

You must file a written designation of Beneficiary with the Fund Office on a properly completed form. If you have not made an irrevocable designation of Beneficiary, you may name a new Beneficiary without your prior Beneficiary's consent, by filing a new form with the Fund Office. The change of Beneficiary will be effective on the date received by the Fund Office and prior to your death, regardless of the date you sign the form. If you do not designate a Beneficiary or if your Beneficiary does not outlive you, then Beneficiary shall mean the following who survive you in the following order: (1) Spouse; (2) Children, including legally adopted children; (3) Parents; (4) Brothers and sisters; or (5) Estate. If two or more persons are entitled to the benefit as Beneficiaries, they will share equally.

4.4 Claims and Appeals/Conflicts

All claims and appeals regarding insured life insurance benefits shall be determined by the procedures set forth in the applicable life insurance policies and not pursuant to Article 7. **In the event of any conflict between the provisions of this Plan and the insurance policy, including the proper determination of the beneficiary, the terms of the insurance policy and the determination by the insurance company controls.**

ARTICLE 5 – MEDICAL/PRESCRIPTION DRUG/DENTAL BENEFITS

5.1 Medical/Prescription Drug Benefits – Non-Medicare Eligible Covered Persons

Self-insured medical and prescription drug benefits for non-Medicare eligible Participants and Dependents are administered by Blue Cross Blue Shield of Michigan (BCBSM). Please refer to the applicable BCBSM Benefits Guide for a description of the benefits available under each plan, available at www.bcbsm.com. The coverage provided under each respective BCBSM program is subject to the exclusions and restrictions set forth in the BCBSM Benefits Guides and in this document.

5.2 Medical/Prescription Drug Benefits – Medicare Eligible Covered Persons

Medicare eligible Participants and Dependents are provided medical and prescription drug coverage via a fully insured Medicare coordinated policy. The terms and conditions of such coverage are set forth in the Medicare Policy. Non-Medicare eligible dependents of Medicare eligible Participants are covered under the Fund's self-insured medical and prescription drug plan.

Coverage under the Medicare Policy may be limited if such person has not timely applied for and obtained Medicare. It is the Participant's or Dependent's responsibility to timely obtain Medicare coverage (i.e. as soon as eligible to do so). This obligation applies whether Medicare eligibility is based on age, disability, or end stage renal disease. If a Participant or Dependent does not timely obtain Medicare coverage, he/she is directly responsible for the medical and prescription drug costs that otherwise would have been covered by Medicare or the Medicare Policy.

All Medicare eligible Participants and Dependents will automatically be enrolled in the Medicare Policy at the earliest enrollment opportunity after Medicare eligibility is obtained.

If a Participant has other coverage under a Spouse's plan or any other type of medical plan (Other Coverage), he/she must contact the Fund Office so benefits can be properly coordinated. If he/she does not do so, he/she

may be responsible for the costs of medical expenses that otherwise would have been paid by the Other Coverage.

5.3 Dental Benefits

Self-insured dental benefits for eligible Active Employees, Retirees, and their Dependents are administered by Blue Cross Blue Shield of Michigan (BCBSM). Please refer to the applicable BCBSM Benefits Guide for a description of the benefits available under each plan, available at www.bcbsm.com. The coverage provided under each respective BCBSM program is subject to the exclusions and restrictions set forth in the BCBSM Benefits Guides and in this document.

5.4 Coordination of Benefits

(a) Application

This provision shall apply in determining the benefits for an allowable expense if the sum of:

(1) the benefits that would be payable under the Plan in the absence of this provision; and
(2) the benefits that would be payable under any other plan in the absence of a coordination of benefits provision, would exceed the allowable expense payable under this Plan.

Benefits payable under another plan include the benefits that would have been payable had the claim been duly filed under that plan.

Notwithstanding anything in this section to the contrary, a Participant or Dependent will never receive less if covered by two or more plans than he would receive if covered by this Plan alone; provided, however, that this Plan will pay no more than an amount which would bring total coverage up to the amount which would have been provided under this Plan.

(b) Coordination

Plan rules regarding coordination:

(1) Another plan without a coordinating provision shall always be deemed to be the primary Plan.

(2) If another plan has a provision that makes this Plan primary, then:

(A) The plan covering the patient directly rather than as a dependent is primary and the other is secondary.
(B) If a child is covered under both parents' plans, the plan that covers the parent whose birthday occurs earlier in the calendar year shall be considered the primary plan.

(C) If neither (A) nor (B) applies, the plan covering the patient longest is primary.

(3) With respect to dependents of divorced parents, the following rule applies:

(A) if there is a court decree, the plan that covers the dependent of the parent with responsibility to do so pursuant to such decree shall be primary;
(B) if (A) does not apply:

(i) the plan covering the parent with custody of the dependent shall be considered the primary plan;

(ii) the plan covering the spouse, if any, of the parent with custody of the dependent will be secondarily liable; then
(iii) the plan covering the parent without custody shall be liable; then
(iv) the plan covering the spouse, if any, of the parent without custody of the dependent will be liable last;

(C) if neither (A) nor (B) apply, the "Birthday Rule" will be used to determine liability in the order set forth in (B)(i)-(iv).

(4) Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) Rules when applicable.

The following addresses specific situations where MSP Rules are applicable:

(A) **Coordination with Coverage by Virtue of Current Employment Status**: In the event a Medicare-eligible Covered Person is eligible under one plan as a dependent (for example, a dependent of an actively employed spouse) and another plan other than as a dependent (for example, a Retiree under this Plan), and as a result of the Medicare Secondary Payer Rules, Medicare is
(i) Secondary to the plan covering the Covered Person as a dependent; and
(ii) Primary to the plan covering the Covered Person other than as a dependent.

Then benefits of the plan covering the Covered Person as a dependent are primary to those of the plan covering the Covered Person other than as a dependent. For example, if a Pensioner is covered as a dependent under a plan covering his/her Spouse as an active employee, then the benefits of the Spouse's plan are primary to the benefits provided by this Plan.

(B) **End Stage Renal Disease**: After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Participant or Dependent receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e., will provide benefits) only to the extent required by Medicare's Secondary Payer rules.

(5) With respect to a Participant or Dependent on COBRA Continuation of Coverage from any other plan, this Plan will be secondary.

(6) This Plan is primary when Medicaid is involved as the other carrier.

5.5 Benchmark

The Plan adopts the Michigan benchmark plan for purposes of defining essential health benefits.

ARTICLE 6 – SUPPLEMENTAL BENEFIT

6.1 Supplemental Benefit

Amounts in an Active Participant's Dollar Bank can be used for a Supplemental Benefit (SB), subject to the terms and conditions of this Article. The SB, like all other Fund benefits, it is not a vested benefit. The Trustees may eliminate the SB at any time.

6.2 Eligible Expenses

The following expenses, not otherwise covered by this Fund or any other health care plan or insurance, are eligible for reimbursement as a SB:

- Reimbursement of self-payments made to maintain coverage in the Fund,
- hearing aids,
- vision care expenses, including laser eye surgery,
- dental benefits, including orthodontics, and
- deductibles and co-insurance on BCBSM administered benefits.

Participants receive a "Benny" debit card that can also be used to access the medical reimbursement portion of the Supplemental Benefit.
Unless auto substantiated, a Participant must submit file an itemized claim and upload substantiation documentation via the Consumer Portal provided by Wex Health at: https://tici.lh1ondemand.com/Login.aspx

All receipts or documentation must include the following information: bill from the provider that reflects name and address of the provider, detailed description of the service, the date of service, patient's name, amount charged, and amount paid by the Participant.

6.3 Annual Benefit Amount/Minimum Balance

The maximum SB allowed per calendar year is $5,000 for claims incurred on or after 8/1/13. However, when the balance equals or is less than the Monthly Requirement, the remaining amount can only be used for Fund self-payments.

6.4 Supplemental Benefit After Retirement

An eligible Retiree may continue to utilize the balance in his/her Dollar Bank upon retirement for the SB. If prior to retirement the Retiree had frozen his/her Dollar Bank under Section 2.7(b), such Dollar Bank shall be reactivated upon his/her retirement. When an eligible Retiree's Dollar Bank balance equals or is less than the Monthly Requirement, the remaining amount can only be used for Fund self-payments.

ARTICLE 7 – CLAIMS REVIEW AND APPEAL PROCEDURES

For benefits provided under the fully insured policies, and the Medicare Policy referenced in section 5.2, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits, and not by the provisions of Article 7 and 7A.

The Plan will disregard the period from March 1, 2020, until the earlier of: (1) 1 year from the date a Participant or Beneficiary becomes eligible for an extended deadline or (2): 60 days after the announced end of the National Emergency or such other date announced by the applicable federal agency (the "Outbreak Period") for all participants and dependents in determining the following periods and dates:

(1) Relating to election periods under Section 2.7:
The 30-day period (or 60-day period, if applicable) to request special enrollment.

(2) Relating to COBRA Coverage under Article 8:

a. The 60-day election period for COBRA continuation coverage,
b. The date for making COBRA premium payments,
c. The date for individuals to notify the plan of a qualifying event or determination of disability, and
d. The date for the Plan to provide a COBRA election notice.

(3) Relating to submission of claims under Section 7.2 and claims and appeal procedures under Articles 7 and 7A:

a. The date within which individuals may file a benefit claim,
b. The date within which claimants may file an appeal of an adverse benefit determination,
c. The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination, and
d. The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

7.1 Types of Claims Covered

For purposes of the procedures set forth below, the following terms are used to define health claims:

- **Urgent Health Claims**: claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;
- **Pre-Service Health Claims**: for example, pre-certification of a hospital stay or predetermination of dental coverage;
- **Post-Service Health Claims**: for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician; and
- **Concurrent Claims**: claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by Plan amendment or Plan termination.
- **Rescission of Coverage**: retroactive cancellation of coverage.
- **Disability Claims**: initial claims for disability benefits or any rescission of coverage of a disability benefit.

7.2 Initial Submission of Claims

Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, medical, dental, and prescription drug claims should be submitted to Blue Cross Blue Shield of Michigan, and all other claims for benefits (including eligibility claims) should be submitted to the Fund Office.

7.3 Notice That Additional Information is Needed to Claim

After the claim is submitted, the Fund deadline to provide notice to Claimant that the claim is incomplete (with explanation of additional information is necessary to process claim) is:

- For Urgent Health Claims – 24 hours after receiving improper claim.
- For Pre-Service health claims – 5 days after receiving improper claim.

After receipt of notice from the Fund that the claim is incomplete, the Claimant's deadline to supply the Fund the information requested to complete claim is:

- For Urgent Health Claims – 48 hours after receiving notice.
- For Pre-Service Health Claims – 45 days after receiving notice.

- For Post-Service Health Claims – 45 days after receiving notice.
- For Disability Claims – 45 days after receiving notice.

7.4 Avoiding Conflicts of Interest

The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

7.5 Initial Decision on A Claim

(a) Additional Evidence

(1) The Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), below, to give the Claimant a reasonable opportunity to respond prior to that date; and

(2) Before the Fund can issue an initial benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), to give the claimant a reasonable opportunity to respond prior to that date.

(b) The Fund deadline for making an initial decision on a claim is:

- For Urgent Health Claims – As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim; or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier.
- For Pre-Service Health Claims – 15 days after receiving the initial claim. A 15-day extension is permitted if the Plan needs more information and it has provided notice of same to the Claimant during the initial 15 day period. Fund deadline for responding is tolled while awaiting requested information from the Claimant.
- For Post-Service Health Claims – 30 days after receiving the initial claim. A 15-day extension is permitted if the Plan needs more information and has provided notice of same to the Claimant during the initial 30-day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.
- For Disability Claims – 45 days after receiving the initial claim. A 30-day extension is permitted if the Plan needs more information and has provided proper notice of same to the Claimant. An additional 30-day extension is permitted if the Plan needs more information and has provided notice of same to the Claimant during the first 30-day extension. Fund deadline for responding is tolled while awaiting additional information from Claimant.

7.6 Adverse Benefit Determination

Notice of an adverse benefit determination will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rule or similar guideline does not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of available internal appeal process and how to initiate the external review process for an adverse benefit determination which involves a medical condition of the claimant for which the timeframe for completion of the internal appeal would jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function;
- if applicable, a statement of the Claimant's right to bring a civil action after further denial on appeal or external appeal; and
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272, or the Michigan Office of Financial and Insurance Regulation, MiCHAP, P.O. Box 30220, Lansing, Michigan 48909, (877) 999-6442.

With respect to an adverse benefit determination involving disability benefits, the adverse benefit determination must also include the following:

- An explanation of the basis for disagreeing with any of the following:
  - The health care professionals that treated the Claimant;
  - The advice of the health professional obtained by the Plan; or
  - A disability determination from the Social Security Administration.
- A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.
- The adverse benefit determination must be in a culturally and linguistically appropriate manner.

7.7 Internal Appeals

(a) Adverse Benefit Determinations

A Claimant may appeal any Adverse Benefit Determination received under Section 7.6. An Adverse Benefit Determination means any of the following:

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan;
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
- failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate;
- rescission of coverage; or

- A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a disability benefit or any rescission of coverage of a disability benefit.

(b) Submission of Internal Appeals

An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the Claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal appeal.

The Plan will continue to provide coverage for an ongoing course of treatment pending the outcome of an internal appeal.

The review on appeal 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. Appeals should be submitted as follows:

Appeals Regarding Benefits Administered by Blue Cross Blue Shield of Michigan:

- For those claims administered by BCBSM, submit an initial appeal of a benefit denial to the address set forth on the BCBSM denial. If BCBSM denies this appeal, you may submit a second appeal to the Plan Office.

Appeals Regarding Benefits Not Administered by Blue Cross Blue Shield of Michigan:

- For those claims not administered by BCBSM, submit appeals to the Plan Office.

(c) Time for Submitting Internal Appeals

A Claimant must appeal a benefit denial within the following time limits:

- For Urgent Health Claims – 180 days after receiving denial.

- For Pre-Service Health Claims – 180 days after receiving denial.
- For Post-Service Health Claims – 180 days after receiving denial. In addition, for those claims administered by BCBSM, the second appeal to Trustees must be made within 30 days of the BCBSM appeal denial.
- For Concurrent Claims – Claimant must be given enough time to appeal decision before termination effective.
- For Disability Claims – 180 days after receiving denial.

ALL APPEALS MUST BE TIMELY SUBMITTED. A CLAIMANT WHO DOES NOT TIMELY SUBMIT AN APPEAL WAIVES HIS/HER RIGHT TO HAVE THE BENEFIT CLAIM SUBSEQUENTLY REVIEWED ON INTERNAL APPEAL, ON EXTERNAL REVIEW, OR IN A COURT OF LAW.

(d) Notice of Decision on Internal Appeal

The notice of a decision on appeal will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rules or guidelines do not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of the external review process, including information regarding how to initiate the external review process;
- a statement of the Claimant's right to bring a civil action under ERISA §502(a);
- A statement describing any contractual limitation period that applies to the Claimant's right to bring an action under ERISA §502(a) and the calendar date on which such contractual limitation expires;
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272, or the Michigan Office of Financial and Insurance Regulation, MiCHAP, P.O. Box 30220, Lansing, Michigan 48909, (877) 999-6442; and
- 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."

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Fund can a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

In addition to the above, a notice of decision on appeal pertaining to a claim for disability benefits will include the following:

- An explanation of the basis for disagreeing with any of the following:
  - The health care professionals that treated the Claimant;
  - The advice of the health professional obtained by the Plan; or
  - A disability determination from the Social Security Administration.

- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.
- The benefit denial must be in a culturally and linguistically appropriate manner.

The Fund deadline for deciding an appeal of a benefit denial and notifying the Claimant of its decision is:

- For Urgent Health Claims – 72 hours after receiving appeal.
- For Pre-Service Health Claims:
  - Benefits administered by BCBSM – BCBSM shall decide the initial appeal and inform the Claimant of its decision 15 days after receiving appeal. A second appeal to the Trustees must be filed within 30 days of receipt of the BCBSM appeal denial. The Trustees shall decide this appeal within 15 days.
  - Benefits not administered by BCBSM – The Trustees shall decide the appeal 30 days after receiving the appeal.
- For Post-Service Health Claims:
  - Benefits administered by BCBSM – BCBSM shall decide the initial appeal and inform the Claimant of its decision 30 days after receiving appeal. A second appeal to the Trustees must be filed within 30 days of receipt of the BCBSM appeal denial. The Trustees shall decide this appeal at a Board Meeting. *
  - Benefits not administered by BCBSM – The Trustees shall decide the appeal at a Board Meeting. *
- For Concurrent Claims – Prior to termination of previously approved course of treatment.
- For Disability Claims – The Trustees shall decide the appeal at a Board Meeting. *

*Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third Board Meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees decision on appeal no later than five days after the decision is made.

7.8 Deemed Exhaustion of Internal Claims and Appeals Processes

If the Plan fails to adhere to all the requirements in this Article 7 with respect to any claim for benefits, the Claimant is deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Article 7A.
The Claimant is also entitled to pursue any available remedies under Section 502(a) of ERISA, or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

In addition to the above, if the Plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the Claimant chooses to pursue available remedies under ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees.

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

7.9 Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

7.10 Limitations of Actions

For adverse benefit denials not subject to external review, no action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal. For adverse benefit denials subject to external review, a request for external review must be made within the time limitations provided in Section 7A.2. In the event a Claimant does not abide by these time limitations, he/she waives his/her right to any further review of an adverse determination, including waiving his/her right to have the determination reviewed in a court of law.

7.11 Avoiding Conflicts of Interest

The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

ARTICLE 7A – EXTERNAL REVIEW PROCESS

7A.1 Eligibility for External Review

The external review process applies to any final internal adverse benefit determination that involves: (1) medical judgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or legal interpretation without any use of medical judgment), or (2) a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time). Weekly disability benefits are not subject to external review.

A denial, reduction, or termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

7A.2 Request for External Review

A Claimant must file a request for an external review with the Fund within four months after receipt of a notice of the final internal appeal. If he/she fails to do so, he/she waives the right to an external review or review in a court of law.

The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an external review.

7A.3 Preliminary Review

Within five business days following the receipt of the external review request, the Fund must complete a preliminary review of the request to determine whether:

(a) The Claimant is or was covered under the Plan at the time the health care item or service was requested or provided;
(b) The final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;
(c) The Claimant has exhausted the Plan's internal appeal process; and
(d) The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Fund must issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-ESBS (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete and the Fund must allow a Claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

7A.4 Referral to Independent Review Organization

(a) The Fund must assign an independent review organization (IRO) to conduct the external review.

(b) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the IRO within ten business days additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Fund. Upon receipt of such information, the Fund may reconsider its final internal decision on appeal, but such reconsideration will not delay the external review. If the Fund decides to provide coverage, within one business day after such decision the Fund must provide written notice of same to the Claimant and the IRO and the IRO must then terminate the external review.

(c) Within five business days after the date of assignment, the Fund will provide to the IRO documents and any information considered in making the final decision on internal appeal, but failure to do so

will not delay the conduct of the external review. If the Fund fails to timely provide this information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination and notice of such decision will be provided by the IRO to the Claimant and Fund within one business day.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

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

(e) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and deliver its decision to the Claimant and the Fund.

(f) The IRO's decision notice will contain:

1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
2) the date the IRO received the assignment and the date of the IRO decision;
3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
6) A statement that judicial review may be available to the Claimant; and
7) Current contact information, including phone number, for any applicable state office of health insurance consumer assistance or ombudsman established under PHS Act §2793.

(g) The external reviewer's decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law. The Plan must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(h) The IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, Fund, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

7A.5 Expedited External Review

A Claimant can make a request for an expedited external review at the time the Claimant receives

(a) An adverse benefit determination which involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

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

Immediately upon receipt of the request for expedited external review, the Fund must take the steps for Preliminary Review outlined above under the standard external review procedures and immediately send the notification of such review to the claimant.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO as outlined in Section 7.3A, above. The Plan must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

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

7A.6 Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret Plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

7A.7 Limitations of Actions

No action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on External Review. In the event a Claimant does not bring an action within such 180 days, he/she waives his/her right to any further review of an adverse determination in a court of law.

ARTICLE 8 – COBRA CONTINUATION COVERAGE

8.1 Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to participants and their dependents when they would otherwise lose group health coverage.

8.2 Nature of COBRA Continuation Coverage

(a) COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A Participant, his Spouse, and dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

(b) A Participant will become a qualified beneficiary if coverage is lost under the Plan because either one of the following qualifying events happens:

(1) Hours of employment are reduced such that hours are insufficient to maintain eligibility, Or
(2) Employment ends for any reason other than gross misconduct.

(c) The Spouse of a Participant will become a qualified beneficiary if coverage is lost under the Plan because any of the following qualifying events happens:

(1) Death of spouse;
(2) Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;
(3) Spouse's employment ends for any reason other than his or her gross misconduct;
(4) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(5) Divorce or legal separation from the participant.

(d) Dependent Children become qualified beneficiaries if coverage is lost under the Plan because any of the following qualifying events happens:

(1) The parent-Participant dies;
(2) The parent-Participant's hours of employment are reduced such that hours in the hour bank are insufficient to maintain eligibility;
(3) The parent-Participant's employment ends for any reason other than his or her gross misconduct;
(4) The parent-Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The Child stops being eligible for coverage under the plan as a "Dependent Child."

8.3 When COBRA Coverage Is Available

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the Participant, the Employer must notify the Plan Administrator of this qualifying event within 30 days of the death. The Plan Administrator will monitor whether a qualifying event has occurred due to reduction in hours, termination of employment, or Medicare eligibility.

8.4 Participant/Spouse Obligation to Give Notice to Plan of Certain Qualifying Events

In the event of divorce, legal separation, or a dependent Child loses eligibility for coverage as a dependent Child or if after COBRA coverage is elected a qualified beneficiary becomes covered under another group health plan, the Participant and his Spouse both have an obligation to notify the Plan Administrator of such event within 60 after this qualifying event occurs.This notice must include: the name of the Participant, the social security number of the Participant, the name of the qualified beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the qualifying event (for example, the date of a divorce), and the date on which the qualifying event occurred. If timely notice is not provided, the right to COBRA coverage is forfeited.

Further, failure to timely notify the Plan of a divorce, legal separation, or a Child losing eligibility gives the Plan the right to hold the participant and his/her Spouse separately and fully liable for any benefits paid by the Plan which would not have been paid had the Plan received timely notification of such event. At its sole election, the Plan may suspend the payment of future benefits until such amount has been recovered.

8.5 How COBRA Coverage Is Provided

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Participants may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. The COBRA notice will contain information regarding the premium that must be paid for COBRA coverage, which is 102% of the cost to the Plan for such coverage. If the period of COBRA coverage is extended due to disability, discussed below, the premium is 150% of the cost to the Plan.

Coverage under the Plan will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium. See section 8.7 below regarding the election period for COBRA coverage.

8.6 Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage, as follows:

(1) When the qualifying event is the death of the Participant, the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce, legal separation, or a dependent Child's losing eligibility as a dependent Child, COBRA continuation coverage lasts for up to a total of 36 months.

(2) When the qualifying event is the end of employment or reduction of the Participant's hours of employment, and the Participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement.

- For example, if a Participant becomes entitled to Medicare eight months before the date on which his eligibility terminates, COBRA continuation coverage for his Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

(3) In all other events, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

(A) Disability Extension

If the qualified beneficiary or anyone in his family covered under the Plan is determined by the Social Security Administration to be disabled and notifies the Plan Administrator in a timely fashion, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

(B) Second Qualifying Event Extension

If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered Spouse and dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent Children receiving continuation coverage if the participant or former Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, legally separated, or if the dependent Child stops being eligible under the Plan as a dependent Child, but only if such event would have caused the Spouse or dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

The Plan Administrator must be notified of this second qualifying event within 60 days of such event.

(4) Notwithstanding the foregoing, months on self-payment will count towards allowable months of COBRA coverage allowed pursuant to the terms of section 2.1(c).

8.7 The Election Period for COBRA Continuation

Qualified beneficiaries have 60 days after receipt of the Election Notice, which will be sent to each qualified beneficiaries' last known address, to elect COBRA continuation coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

8.8 Premium Payment for COBRA Coverage

Following an election, a qualified beneficiary has 45 days to pay the initial COBRA premium. If this is not timely paid, coverage will not be reinstated and the qualified beneficiary will not be given a second chance to reinstate coverage.

Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. If payments are not made within this period, coverage will terminate and the qualified beneficiary will not be given an opportunity to reinstate coverage.

If, for whatever reason, the Plan pays medical benefits for a month in which the premium was not timely paid, the qualified beneficiary will be required to reimburse the Plan for such benefits.

The premium equals the cost to the Plan of providing coverage plus a 2% administration fee. In the event of extended coverage as a result of a disability for the 19th – 29th months of coverage, the Plan will charge 150% of the cost of providing coverage.

8.9 Scope of Coverage

COBRA coverage only pertains to health benefits available under the Plan. Coverage for such benefits under COBRA is the same as those the qualified beneficiary had the day before coverage initially terminated. Coverage may change while on COBRA coverage due to Plan amendments that effect all Participants in the Plan. A qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated active employees.

8.10 Enrollment of Dependents During Period of COBRA Coverage and Coverage Options

A Child born to, adopted by, or placed for adoption with a Participant during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the Participant has elected continuation coverage for himself/herself. If a Participant desires to add such a Child to COBRA coverage, he must notify the Plan Office within 30 days of the adoption, placement for adoption, or birth. During the COBRA coverage period, a Participant may add an eligible dependent who initially declined COBRA coverage because of alternative coverage and later lost such coverage due to certain qualifying reasons. If a Participant desires to add such a Child to COBRA coverage, he must notify the Plan Office within 30 days of the loss of coverage.

8.11 Qualified Medical Child Support Orders

If a Child is enrolled in the Plan pursuant to a qualified medical child support order while the Participant was an active employee under the Plan, he is entitled to the same rights under COBRA as any dependent Child.

8.12 Termination of COBRA Coverage

COBRA continuation coverage terminates the earliest of the last day of the maximum coverage period, the first day timely payment (including payment for the full amount due) is not made, the date upon which the Plan terminates, the date after election of COBRA that a qualified beneficiary becomes covered under any other group health plan, or the date after election if a qualified beneficiary becomes entitled to Medicare benefits and such entitlement would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred.

In the case of a qualified beneficiary entitled to a disability extension, COBRA continuation coverage terminates the later of: (a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination from Social Security that the qualified beneficiary is no longer disabled, whichever is earlier; or (b) the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

8.13 Keep the Plan Informed of Address Changes

A participant or his spouse must keep the Plan Administrator informed of any changes in the addresses of family members and is advised to keep a copy of any notices sent to the Plan Administrator.

ARTICLE 9 – QUALIFIED MEDICAL CHILD SUPPORT ORDER

In accordance with §609 of ERISA, the Fund shall provide benefits as required by a Qualified Medical Support Order ("QMCSO"). In general, a QMCSO is a medical child support order which creates or recognizes the right of an alternate recipient (i.e. a child of the Participant) to receive benefits under a group health plan. A QMCSO must meet certain requirements and cannot require a Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of 42 USC § 1396g-1. Procedures for determining the qualified status of medical support orders are available, without charge, from the Plan Office.

ARTICLE 10 – FAMILY AND MEDICAL LEAVE

Certain Employers are required to continue to make contributions to the Fund on behalf of an employee while such employee is on a medical leave of absence pursuant to the federal Family and Medical Leave Act ("FMLA"). Details concerning FMLA leave are available from the Participant's Employer. Requests for FMLA leave must be directed to such Employer; the Plan cannot determine whether or not a person qualifies for FMLA leave. If a dispute arises between a Participant and his Employer concerning eligibility for FMLA leave, the Participant may continue health coverage by making COBRA payments. If the dispute is resolved in the Participant's favor, the Plan will refund COBRA payments made by the Participant upon receipt of the FMLA-required contributions from the Employer. If the Employer continues a Participant's coverage during an FMLA leave and the Participant fails to return to work, he may be required to repay the Employer for all contributions paid to the Plan for such coverage during the leave. The Fund will not return any contributions to the Employer. Failure to return to work at the end of a FMLA Leave may constitute a Qualifying Event under COBRA.

ARTICLE 11 – THIRD PARTY LIABILITY

11.1 Subrogation

(a) In General

Subrogation means the Fund has the right to recover from a Covered Person those amounts paid by the Fund for medical care or other expenses due to an injury caused by a third party (for example, another person or company). For purposes of this Article 11, the term "injury" also includes an illness caused by a third party.

To the extent benefits are paid by the Fund to a Covered Person for medical, dental, Weekly Disability, or other expenses arising out of an injury, the Plan is subrogated to any claims the Covered Person may have against the third party who caused the injury. In other words, the Participant or Dependent must repay to the Plan the benefits paid on his or her behalf out of any recovery received from a third party and/or any applicable insurer.

The Fund's right of subrogation applies to any amounts recovered, whether or not designated as reimbursement for medical expenses or any other benefit provided by the Fund. The right of subrogation applies regardless of the method of recovery, i.e., whether by legal action, settlement or otherwise.

The Fund's right to subrogation applies regardless of whether the injured Participant or Dependent has been fully compensated, or made whole, for his or her losses and/or expenses by the third party or insurer, as the Fund's right to subrogation applies to any full or partial recovery. This provision is intended to make it clear that this provision shall apply in lieu of the "make whole" doctrine. The Fund has first priority to any funds recovered by the injured Covered Person from the third party or insurer.

Further, the Plan does not have any responsibility for the injured Participant or Dependent's attorneys' fees, i.e. the common fund doctrine will not be applied.

The Fund also has a lien on any amounts recovered by a Participant or Dependent due to an injury caused by a third party, and such lien will remain in effect until the Fund is repaid in full for benefits paid because of the injury.

(b) Conditions to Payment of Benefits

If a Covered Person sustains an injury caused by a third party, the Fund will pay benefits related to such injury (provided such benefits are otherwise properly payable under the terms and conditions of the Plan), provided all the following conditions are met:

(1) As soon as reasonably possible, the Covered Person must notify the Plan Office that he or she has an injury caused by a third party.

(2) Prior to the receipt of benefits for such injury, the injured Covered Person must assign to the Fund his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the injury. If such assignment is not made before the receipt of benefits, then the receipt of benefits automatically assigns to the Fund any rights the Participant or Dependent may have to recover payments from any third party or insurer. (If the recovery so assigned exceeds the benefits paid by the Fund, such excess shall be delivered to the Covered Person or other person as required by law.)

(3) The Covered Person does not take any action that would prejudice the Fund's subrogation rights.

(4) The Covered Person cooperates in doing what is necessary to assist the Fund in any recovery, which includes but is not limited to executing and delivering all necessary instruments and papers.

(c) Right to Pursue Claim. The Fund's subrogation rights allows the Fund to directly pursue any claims the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim.

(d) Enforcement. If it becomes necessary for the Plan to enforce this provision by initiating any action against the Covered Person, the Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome. The Plan shall be entitled to enforce this provision by way of an equitable restitution, constructive trust, or any other equitable remedy. At the Fund's option, it may enforce this section 11.1 by deducting amounts owed from future benefits.

11.2 Workers' Compensation

The Fund does not pay any claims covered by workers' compensation. If a Participant or Dependent receives any benefits that are properly payable by workers' compensation, then this Fund must be indemnified by the Participant or Dependent for the amount paid for such benefits. The Fund shall be indemnified out of the proceeds received from the Participant or Dependent in settlement of any workers' compensation claim. The Participant must complete any forms required by the Fund to preserve its rights under this section. At the

Fund's option, it may enforce this provision by deducting amounts owed from future benefits. If the Fund authorizes the payment of benefits pending resolution of a contested workers' compensation claim, eligibility for and payment of such benefits remains subject to all other terms and conditions set forth in this Plan.

11.3 Fund's Rights

Failure of a Covered Person to notify the Fund that an injury is due to the action of a third party is considered a fraud on the Fund. Notwithstanding any term of this Article 11, and in addition to the rights of the Fund set forth in this Article 11, where an injury is due to the actions of a third party, or results in a claim compensable by workers compensation, the Trustees have the right to require a Covered Person to repay any benefits paid by the Fund for such injury. Where a Covered Person accepts a settlement or receive an award, future medical expenses for any injury caused by the responsible third party, including workers' compensation, are not eligible expenses under this Plan.

ARTICLE 12 - HIPAA PLAN SPONSOR PROVISIONS

12.1 Protected Health Information ("PHI"), as defined in the Health Insurance Portability and Accountability Act (HIPAA), will only be disclosed to the Plan Sponsor when and if necessary to carry out the Fund's payment and health care operations. In particular, it is anticipated that such disclosures may be necessary to verify eligibility or to make a decision on appeal. All such disclosures will be made in accordance with HIPAA and its corresponding regulations. The Fund otherwise complies with the terms of HIPAA.

12.2 The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to HIPAA. The Plan Sponsor shall, among other things, implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan.

ARTICLE 13 – MISCELLANEOUS PROVISIONS

- **Interpretation of Plan Documents**. The Trustees have full discretionary authority to determine eligibility for benefits, interpret Plan documents and procedures, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

- **Changes to or Termination of Coverage.** The Trustees reserve the right to amend, alter, or terminate any or all coverages under the Plan, for any or all classes of Participants or Dependents, including Retirees, at any time. The Trustees also have the right to change required self-payment amounts for any benefit or class of Participants or Dependents, including the right to impose self-payment for coverage that previously had been provided without requiring such self-payments.
- **Recession of Coverage.** Rescission means the retroactive cancellation of coverage. Where coverage was provided as a result of fraud or an intentional misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan will rescind coverage. A 30-day notice of rescission will be provided, but termination of coverage will be retroactive to the date coverage should or would have been terminated if the fraud or intentional misrepresentation had not occurred (Date of Rescission). The intent of this provision is to rescind coverage to the full extent allowed by federal law.

  Providing false information to maintain or obtain coverage, or knowingly cooperating in any actions designed to provide false information to maintain or obtain coverage, is an example of a fraud or intentional misrepresentation of material fact. Examples of fraud or intentional misrepresentation of material fact also include, but are not limited to, failing to inform the Fund Office of: (1) a divorce, (2) a Dependent no longer meeting the definition of dependent, or (3) any other event which makes a Participant or Dependent ineligible for coverage.

In the event coverage is rescinded, in addition to any legal and equitable means of recovery available, the Plan has the right to pursue the Participant or Dependent, jointly, and severally, for the full amount paid for such coverage from the date of cancellation, including all costs and attorney's fees, expended in collecting the amount owed. At the Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered.Nothing in this section limits the rights of the Plan to prospectively terminate coverage where such coverage was previously provided as a result of a mistake, intentional misrepresentation, or fraud. Further, nothing in this section limits the right of the Plan to cancel coverage retroactively for failure of a Participant or Dependent to make a self-payment, where there has been a reasonable delay in terminating coverage due to administrative recordkeeping.

ARTICLE 14 – REQUIRED PROVISIONS

A. Type of Administration/Plan Administrator/Plan Sponsor

The Board of Trustees of the Flint Plumbing and Pipefitting Industry Health Care Fund is the Plan Administrator and Plan Sponsor. As such, the Trustees are responsible for overall Plan administration. There are three Trustees appointed by the Union and three Trustees appointed by the Association. The current Trustees are:

Union Trustees

Harold T. Harrington, Chairman
Local Union 370
2151 W. Thompson Road
Fenton, MI 48430

Todd Collins
9252 Pine Needle Trail
Flushing, MI 48433

Daniel Gaudet
9141 West Carpenter Road
Flushing, MI 48433

Employer Trustees

Dominic Goyette, Secretary
Goyette Mechanical Company
382 Gorey Ave.
Flint, MI 48506

Kristine Menzing
Dickerson Mechanical
P.O. Box 250
Davison, MI 48428

David Hendershot
Ecker Mechanical Contractors, Inc.
P.O. Box 19099
Burton, MI 48529

Legal Counsel for the Plan
Michael J. Asher
Jacqueline A. Kelly
AsherKelly
25800 Northwestern Highway, Suite 1100
Southfield, MI 48075
(248) 746-2748

The Trustees have delegated the day-to-day responsibilities for Plan administration to TIC International Corporation, 6525 Centurion Dr., Lansing, MI 48917-9275, telephone number (517) 321-7502.

B. **Effective Date of Plan/Fiscal Year:** The effective date of the Plan is January 1, 1954. The Plan's fiscal year ends July 31st.

C. **Agent for Service of Legal Process:** Service of process should be made upon TIC International Corporation, 6525 Centurion Dr., Lansing, MI 48917-9275, telephone number (517) 321-7502. Service of legal process may also be made upon any Plan Trustee.

D. **Type of Plan/Employer Identification Number/Plan Number:** The Plan is a welfare benefit plan hospitalization, medical, prescription drugs, dental, vision, disability and death benefits. The employer identification number assigned by the IRS is 38-6208007. The Plan Number is 501.

E. **Collective Bargaining Agreements:** The Plan is maintained pursuant to collective bargaining agreements. Copies of such agreements may be obtained upon written request to the Plan Administration Office or are available for examination by participants and beneficiaries at the Plan Administration Office. Alternatively, within 10 days of a written request, such agreements will be made available at the Union Hall or at any employer establishment where at least 50 or more participants are customarily working. The Plan may impose a reasonable charge for such copies.

F. **Source of Plan Contributions:** The primary source of financing for the benefits provided under the Plan and for the expenses of the Plan operations are employer contributions. The rate of contribution is set forth in the Collective Bargaining Agreement. Additionally, under certain circumstances pursuant to the terms of the Plan, a Participant may make self-payments to retain eligibility. A portion of Plan assets are invested, and this also produces additional Plan income. A complete list of the employers contributing to the Plan may be obtained upon written request to the Plan Administration Office and may be examined at the Plan Administration Office.

G. **Welfare Trust Assets and Reserves:** The Board of Trustees holds all assets in trust for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses.

H. **Compliance with Federal Laws.** The extent applicable, the Plan will comply with the following laws:

- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) was enacted to provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
- The Women's Health and Cancer Rights Act of 1998 (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans and health insurance issuers that provide coverage for medical and surgical benefits with respect to mastectomies must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema).
- The Patient Protection and Affordable Care Act of 2010, and the Health Care and Education Reconciliation Act (collectively known as Healthcare Reform) was enacted to provide various protections, including but not limited to the provision of minimum essential health benefits and certain preventative services without cost sharing.

I. **Copies of Schedule of Benefits or Benefit Booklet/List of Network Providers.** A copy of any schedule of benefits or benefits booklet referred to in this SPD is available without cost to any participant or beneficiary

under the Plan upon request to the Plan Office. Additionally, a list of network providers is also available without cost upon request to the Plan Office.

J. Statement of ERISA Rights: As a participant in the Flint Plumbing and Pipefitting Industry Health Care Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Administration Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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

a. A covered person may contact the Plan Office, TIC International Corporation, 6525 Centurion Drive, Lansing, MI 48917-9275, in writing to request a certificate of creditable coverage, or by phone (517) 321-7502 by phone (ask for a representative of the Flint Plumbing and Pipefitting Industry Health Care Fund Plan).

b. The requested certificate shall be provided by the earliest date that the Plan Administrator, and the Plan's third-party administrator, TIC International Corporation, acting in a reasonable and prompt fashion, can provide the certificate. In that regard, the parties shall use best and reasonable efforts to process and mail (first class, postage paid) the requested certificate of creditable coverage to the requesting party within five business days of receipt by TIC International Corporation.

c. The above applies to requests for certificates made by a covered person before losing coverage or within 24 months after losing coverage.

d. This procedure is in addition to the automatic issuance of certificates of creditable coverage to covered persons upon termination of coverage.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who

operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Assistance with Your Questions: If you have any questions about your plan you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

K. **Termination of the Plan:** The Trustees reserve the right to amend, alter, or terminate any or all coverages hereunder, for any or all classes of Participants or Dependents, at any time. The Trustees also have the right to change required self-payment amounts for any benefit or class of Participants or Dependents, including the right to impose self-payment for coverage that previously had been provided without requiring such self-payments. If the Plan is terminated, plan assets shall be used to pay eligible claims and expenses incurred prior to termination and expenses incident to the termination. The Trustees will, in their discretion, allocate any remaining assets in a manner which best effectuates the purposes of the Trust. In no event will plan assets revert to or inure to the benefit of contributing employers or the Association.

This Summary Plan Description is not intended to cover every detail of the Plan or every situation that might occur. The complete Plan is available for inspection at any time at the Plan Office. If there is any conflict between this summary and the Plan, the Plan controls. For a more detailed statement of your rights and obligations, consult the Plan document.

W2494515

FLINT PLUMBING & PIPEFITTING INDUSTRY INSURANCE FUND
GROUP 007003760

Managed for the Trustees by : TIC INTERNATIONAL CORPORATION

HEALTH CARE (BCBSM) ENROLLMENT FORM &
YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

Please print (First, Middle, & Last Names, as applicable) Birthdate:(NN/NN/NNNN format) Member ID or SSN (NNN-NN-NNNN format) Telephone (NNN-NNN-NNNN)

Address:

MARITAL STATUS (Check One): ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widow** ☐ **Separated**

Spouse's Name Birthdate Social Security No.

Dependent's Name Relationship Birthdate Social Security No.

FAMILY CONTINUATION COVERAGE

-NOTE: PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN 19-26 ON THE REVERSE SIDE OF THIS FORM-

Are you or your dependents covered by any other medical insurance. This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.
Check One ☐ Yes ☐ No If Yes, please complete the section below:
Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance Telephone number

Address of Other Insurance

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy

Are you or your dependents covered by any other dental insurance.
Check One ☐ Yes ☐ No If Yes, please complete the section below:
Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance Telephone number

Address of Other Insurance

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy

Are you or your dependents covered by any other vision insurance.
Check One ☐ Yes ☐ No If Yes, please complete the section below:
Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance Telephone number

Address of Other Insurance

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy

PLEASE READ CAREFULLY AND SIGN BELOW

I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, Medical claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

Member's Signature: **Date:**

Spouse's Signature: **Date:**

Return this form to: Flint Plumbing & Pipefitting Industry Insurance Fund, 6525 Centurion Drive, Lansing MI 48917

FLINT PLUMBING & PIPEFITTING INDUSTRY INSURANCE FUND

ADULT CHILD UNDER AGE 26

PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN 19-26 BELOW

(If you have more than two adult children under age 26, please use a separate sheet of paper)

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend dependent child coverage up to age 26. Dependents qualify whether they are married or unmarried. Even if your dependent has employer-based coverage through his or her job they are eligible to enroll under this Plan – however their employer based Plan will be primary.

NAME OF ADULT CHILD _____ **SOCIAL SECURITY NUMBER** _____

COMPLETE ADDRESS OF ADULT CHILD _____ **BIRTH DATE** _____

FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is your adult child ***eligible to enroll*** in employer-based coverage? ☐ Yes ☐ No

If yes, is your adult child enrolled in employer-based coverage? ☐ Yes ☐ No

If Yes, please complete the section below

Effective date of other medical insurance:_____ Is this policy (check one) ☐ Group or ☐ Individual?

Name of Other Insurance _____ Telephone number _____

Address of Other Insurance _____

Policy Number _____ Group Number _____ Policyholder's Name _____

Family Members Covered under the Policy _____

NAME OF ADULT CHILD _____ **SOCIAL SECURITY NUMBER** _____

COMPLETE ADDRESS OF ADULT CHILD _____ **BIRTH DATE** _____

FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is your adult child ***eligible to enroll*** in employer-based coverage? ☐ Yes ☐ No

If yes, is your adult child enrolled in employer-based coverage? ☐ Yes ☐ No

If Yes, please complete the section below

Effective date of other medical insurance:_____ Is this policy (check one) ☐ Group or ☐ Individual?

Name of Other Insurance _____ Telephone number _____

Address of Other Insurance _____

Policy Number _____ Group Number _____ Policyholder's Name _____

Family Members Covered under the Policy _____

FLINT PLUMBING & PIPEFITTING INDUSTRY INSURANCE FUND

BENEFICIARY DESIGNATION FORM

(To be completed by the participant)

Participant Name:_____

Address:_____

_____

Social Security Number or Participant Identification Number_____

Date of Birth:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Participants Telephone Number:_____Local Union Number:_____

HEALTH CARE FUND DEATH BENEFIT BENEFICIARY

Name:_____

Address:_____

Social Security Number:_____Date of Birth:_____

Relationship:_____

I understand that this beneficiary designation cancels any previous designation I may have made

_____ _____

Date Participant Signature

Except for your signature, please PRINT or type all other information.

Return completed form to:

FLINT PLUMBING & PIPEFITTING INDUSTRY INSURANCE FUND

6525 Centurion Drive

Lansing, MI 48917-9275

FLINT PLUMBING AND PIPEFITTING FRINGE BENEFIT FUNDS

Flint Plumbing & Pipefitting Industry Health Care Fund
Flint Plumbing & Pipefitting Industry Pension Fund
Flint Plumbing & Pipefitting Industry Defined Contribution Plan
Scholarship Fund of Flint Plumbing & Pipefitting Industry
Supplemental Unemployment & Disability Plan of Local Union 370

Managed for the Trustees by:
TIC INTERNATIONAL CORPORATION

March 2022

Over-the-Counter COVID-19 Testing

At-Home Testing Options

The federal government is offering four free COVID-19 at-home tests to all households, regardless of insurance coverage. You can order tests at covidtests.gov.

Blue Cross Blue Shield has launched a preferred pharmacy network for over-the-counter, at-home COVID-19 tests, effective Feb. 1, 2022. The network enables commercial members with Blue Cross or BCN pharmacy coverage to obtain a number of free COVID-19 tests when purchased in person at a preferred pharmacy. The preferred COVID-19 test network includes Rite Aid, Sam's Club, and Walmart pharmacies. Members must get the tests through the pharmacy counter by presenting their Blue Cross Blue Shield ID card. Members also have access to get their OTC tests through the BCBSM.com website under the Optum/BCBSM Pharmacy home page.

For reimbursement of purchases at nonpreferred pharmacies, a new form will be available at bcbsm.com on Feb. 1, 2022, that uses OptumRx to process these claims. You will need to provide a receipt indicating the amount you paid and documentation from a qualified health care provider that ordered the testing. Tests purchased outside of the preferred network pharmacies will be reimbursed for up to $12 per test.

Additional Information

- Tests must be authorized by the U.S. Food and Drug Administration.
- Tests must be purchased on or after Feb. 1, 2022, to qualify for the preferred network.
- Up to eight qualifying at-home tests can be obtained per member each month. Some COVID-19 test kits include two tests per box. Those kits count as two tests.
- An order from a qualified health professional is not required to obtain over-the-counter, at-home tests from one of the network pharmacies.
- Reimbursement does not apply for tests used for employment purposes.

When to use COVID-19 Test Kits

Testing is an important tool to help mitigate the spread of COVID-19. Public health experts and the Centers for Disease Control and Prevention recommend that Americans use at-home tests if they begin to have symptoms, at least five days after coming in close contact with someone who has COVID-19 or are gathering indoors with a group of people who are unvaccinated or at risk of severe disease.

Reminder: Blue Cross will still cover other types of COVID-19 diagnostic tests if they are FDA authorized and ordered by a qualified health professional.

6525 Centurion Drive • Lansing, MI 48917-9275
(517) 321-7502 • FAX (517) 321-7508
TOLL-FREE: (888) 797-5862
www.ualocal370benefits.org

Medicare Advantage Participants
Currently, Original Medicare doesn't pay for over-the-counter COVID-19 tests. You can pick up free at-home tests from community health centers and Medicare-certified health clinics, or you can visit COVIDtests.gov to order a free COVID-19 at-home test. In early Spring 2022, members with Medicare will be able to go to a network of pharmacies and health care facilities to get up to 8 free, over-the-counter COVID-19 tests a month through Medicare.

Sincerely,

Board of Trustees
Flint Plumbing & Pipefitting Industry Health Care Fund

Free N95 Masks

The CDC has updated its face mask guidance to emphasize the better protection offered by N95 and KN95 face masks. The Federal government is distributing 400 million N95 masks for free, available through pharmacies and community health centers across the country. Starting in February, three free N95 facemasks will be available per adult. Meijer, Kroger, Walgreens, and CVS are among the participating pharmacies participating in the free N95 mask distribution.

FLINT PLUMBING AND PIPEFITTING FRINGE BENEFIT FUNDS

Flint Plumbing & Pipefitting Industry Health Care Fund
Flint Plumbing & Pipefitting Industry Pension Fund
Flint Plumbing & Pipefitting Industry Defined Contribution Plan
Scholarship Fund of Flint Plumbing & Pipefitting Industry
Supplemental Unemployment & Disability Plan of Local Union 370

Managed for the Trustees by:
TIC INTERNATIONAL CORPORATION

To: **Flint Plumbing and Pipefitting Industry Health Care Fund Participants**

From: **Board of Trustees of the Flint Plumbing and Pipefitting Industry Health Care Fund**

Re: **Summary of Material Modification – KEEP WITH SUMMARY PLAN DESCRIPTION**

Date: **September 2023**

Please read this notice carefully as it contains important information about changes to the Flint Plumbing and Pipefitting Industry Health Care Fund Plan (Plan) effective July 18, 2023. This document should be read carefully and attached to your Flint Plumbing and Pipefitting Industry Health Care Fund Summary Plan Document (SPD). Please contact the Fund Office if you have any questions about the changes described in this notice.

PLAN CHANGES

Additional Short Term Disability Coverage for Active Employees

The Plan currently provides that an Active Employee's Dollar Bank will be credited each week he/she has a short-term disability in the amount equal to the monthly requirement divided by 20, not to exceed the monthly requirement per month, i.e., Short-Term Disability Credit to continue eligibility via your Dollar Bank. Previously, the Short-Term Disability credit was provided for up to 26 weeks for any single period of disability.

The Plan has been amended to provide that an Active Employee who remains disabled after a 26- week period of continuous disability may receive an additional 13-week extension of coverage upon written application to the Trustees. An additional 13-week extension of eligibility may then be granted upon another application in writing to the Trustees.

The first and second 13-week extensions will **only** be granted if the Active Employee continues to have a short-term disability and presents a statement from his/her physician that his/her disability is not permanent and he/she will be able to return to work as a plumber or pipefitter.

Notwithstanding the foregoing, any Participant who has been awarded Social Security disability benefits (other than for a closed period) will be considered permanently disabled and unable to return to work as a plumber or pipefitter.

If you have any questions, please contact the Fund Office.

FLINT PLUMBING AND PIPEFITTING FRINGE BENEFIT FUNDS

Flint Plumbing & Pipefitting Industry Health Care Fund
Flint Plumbing & Pipefitting Industry Pension Fund
Flint Plumbing & Pipefitting Industry Defined Contribution Plan — Managed for the Trustees by:
Supplemental Unemployment & Disability Plan of Local Union 370 — TIC International Corporation

July 2022

TO: ALL PARTICIPANTS OF THE FLINT PLUMBING & PIPEFITTING INDUSTRY HEALTH CARE FUND

RE: FLINT PLUMBING & PIPEFITTING INDUSTERY SUMMARY OF MATERIAL MODIFICATIONS

PLAN CHANGES EFFECTIVE AUGUST 1, 2022

Timeline for Submitting Claims

Please be advised that all claims for medical, dental, prescription drugs, and supplemental benefits must be submitted within 365 days of the date the claim was incurred. All claims for weekly disability (loss of time) benefits must be submitted within 365 days of the date the covered person was first eligible for such benefits. Claims not timely submitted will not be covered by the Plan.

Changes to External Review Eligibility

Currently, the external review process applies to any final internal adverse benefit determination (for example, an appeal determination) that involves:

(1) medical judgment, including but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or legal interpretation without any use of medical judgment); or
(2) a rescission of coverage (whether or not the recession has any effect on any particular benefits at that time.

Effective August 1, 2022, the external review process will also apply to any final internal adverse determination that involves:

- whether the Plan is complying with the nonquantitative treatment limitation provisions which, in general, require parity in the application of medical management techniques; and
- consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in ERISA sections 716 and 717.

Weekly disability benefits are not subject to external review. Further, a denial, reduction, or termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan, or based on a Plan exclusion, is not eligible for the external review process.

If you have any questions regarding your benefits, please contact the Fund Office at (888) 797-5862 for assistance.

Sincerely,

Board of Trustees
Flint Plumbing & Pipefitting Industry Health Care Fund

W2580874

FLINT PLUMBING & PIPEFITTING INDUSTRY INSURANCE FUND
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A - Requesting an Authorization

I authorize the use/disclosure of my protected health information as described in Section B below. I understand that this authorization is voluntary and the Flint Plumbing & Pipefitting Industry Insurance Fund ("Fund") and entities with which the Fund has contracted to perform administrative duties ("Fund Entities"), will not condition treatment, payment, enrollment, or eligibility for benefits on receiving this authorization. If Fund Entities disclose this information, the recipient must obtain an additional authorization from me before it may re-disclose the information. Otherwise, information disclosed under this authorization may be re-disclosed by the recipient and no longer protected.

Name: _____ Social Security Number:_____
Address:_____ Telephone Number:_____
_____

Section B – Information for Use/Disclosure (NOTE: An additional form must be used if you are authorizing the use/disclosure of psychotherapy notes.)

Describe in detail the information to be used or disclosed (providers, dates of treatment, type of service, etc.):
_____
_____

☐ **Check here if your authorization includes the disclosure of information regarding AIDS, ARC or HIV testing/treatment**

Check if your authorization includes the disclosure of information regarding:

☐ **Substance abuse (including alcoholism). The recipient of this information must obtain an additional authorization from me before they may re-disclose the information.**

☐ **Mental Health Services (excluding psychotherapy notes)**

Section C – Authorized Uses / Disclosures

☐ **Disclosure by Fund Entities:**
I authorize the Fund Entities to disclose my protected health information described in Section B to the following persons and/or entities for their use: _____
I authorize the persons and / or entities listed above to use my protected health information described in Section B for the following purposes (or write "At My Request"): _____

☐ **Disclosure to Fund Entities:**
I authorize the following persons and/or entities to disclose my protected health information described in Section B to the Fund Entities: _____
I authorize the Fund Entities to use my protected health information described in Section B for the following purposes:
_____

Section D – Expiration and Revocation

This authorization will expire: On____/_____/_____; OR when the following occurs:_____

I may revoke this authorization at any time by sending a written request on a standard form available by contacting 517-321-7502. I understand that revocation will not affect actions taken before receiving my request.

Section E – Signature

SIGNATURE: _____ DATE: _____

If a personal representative signs this authorization on behalf of the individual, specify your relationship to the individual including your authority to sign.

Personal Representative's Name: _____
Relationship to the individual and authority to sign: _____
(Unless you are the parent of a minor child, please provide proof of your relationship to the individual.)

WE WILL PROVIDE YOU A COPY OF THIS SIGNED AUTHORIZATION

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Authorization is not valid unless it is filled out completely.

Section A: Requesting an Authorization

1) Fill in the participant's or beneficiary's first and last name
2) Fill in the participant's full street address, including city, state and ZIP code
3) Fill in the participant's or beneficiary's Social Security number
4) Fill in the participant's or beneficiary's telephone number, including area code

Section B: Information for Use/Disclosure

1) List in detail the information to be used or disclosed. Fund participants and beneficiaries must check the appropriate boxes, if applicable for disclosures that:
    a. Include information related to substance abuse (including alcoholism)
    b. Include information related to mental health services

Section C: Authorized Uses/Disclosures

1) If the member would like the Fund to disclose his/her protected health information (PHI), check "Disclosure by Fund Entities" and list to whom this information shall be disclosed and the purpose for the disclosure.
2) If the member is requesting that others disclose their PHI to the Fund, check "Disclosure to Fund Entities" and list the person(s) who will disclose the information.

Section D: Expiration and Revocation

1) Fill in the date for when the authorization expires (day, month and year) or if applicable, the event/activity that will trigger the expiration of the authorization.
2) If the participant or beneficiary would like to revoke the authorization he/she may do so at any time. The request must be submitted in writing using the standard Fund revocation form. The participant or beneficiary may obtain a standard form by calling (517) 321-7502

Section E: Signature

1) The participant or beneficiary must sign and date the authorization. If the individual that signs the authorization form is a personal representative, the individual must specify the relationship to the participant or beneficiary.
2) The personal representative must print his/her name and detail relationship to participant or beneficiary and authority to sign. If the personal representative is someone other than the parent of a minor child, written proof must be provided.

The requesting individual must be provided a copy of the completed authorization form. The original authorization form should be saved for future review and action surrounding the authorization.

Internal Use Only

This document needs to be retained and stored according to Fund procedures.

SUPPLEMENTAL BENEFIT ACCOUNT REIMBURSEMENT REQUEST FORM

Return Completed Form to:
Flint Plumbing & Pipefitting Industry Health Care Fund
Supplemental Benefit Account
6525 Centurion Drive
Lansing, MI 48917

Participant's Name _____ Member ID or SS#_____

Home Address _____
Street City State Zip Code

Telephone Number (_____) _____ Date of Birth _____

Enclosed claims are for (check only one) ☐ Self ☐ Spouse ☐ Son ☐ Daughter

Dependent's Name _____ Date of Birth _____

Is dependent covered by another health insurance plan? ☐ Yes ☐ No

When Filing Claims

Eligible expenses include reimbursement of self-payments, hearing aids, vision services, laser eye surgery, co-payments and/or benefits in excess of the benefit maximum <u>for preventive services only</u> and dental benefits (including orthodontics) above what is currently covered in the Plan
NOTE: You must be eligible on the date services are incurred <u>and</u> have a balance of $1,040 or more in your SBA account on the date services are incurred.

All claims must be filed within one (1) year from the date of service

1. **Supporting documentation must accompany this Request Form. Supporting documentation includes the following:**
   - **Itemized bills from doctor, dentist or other supplier for recognized medical/dental/vision expenses not covered by your Medical/Dental/Vision Plans.**
   - **Explanation of benefits (EOB) for each medical/dental/vision expense submitted**
   - **<u>Proof of payment</u> (evidence sufficient to the Trustees that the amount has been paid by the participant)**
2. **Retain copies of supporting documentation for your records, as those submitted will not be returned.**
3. **Send completed Reimbursement Request Form and supporting documentation to the Fund Office at the address above.**

-Please itemize expenses on the reverse side of this form-

I certify that either I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Supplemental Benefit Account.

_____ _____
Employee's Signature Date

Flint Plumbing & Pipefitting
INDUSTRY HEALTH CARE FUND

Participant Name:_____

ID or SS#:_____

SUPPLEMENTAL BENEFIT ACCOUNT FORM – PAGE 2

NOTE: Claim is not acceptable unless both pages of the claim form are submitted

NOTE: Bills/receipts must clearly indicate the patient name, provider name, date of service, etc. In addition, if your bill/receipt is for a co-payment, this must be clearly indicated on your bill/receipt. Please circle or high-light the amount you are requesting reimbursement for.

-Missing information may cause a delay in the processing of your claim(s)-

Service Date	Description of Charges	Provider Name	Patient Name	Amount Requested
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				
15)				
16)				
17)				
18)				
19)				
20)				
21)				
22)				
23)				
24)				
25)				
26)				
27)				
28)				
29)				
30)				
	Total			$ 0.00

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.ualocal370benefits.org or call 1-888-797-5862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $250 / individual or $500 / family; for out-of-network providers $1,000 / individual or $2,000 / family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan?	For network providers $1,000 individual / $2,000 family; for out-of-network providers $2,000 individual / $4,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. The overall OOP for deductibles, copayments and coinsurance is $6,350 / individual; $12,700 / couple or family.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, deductibles and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit	40% coinsurance	Out-of-Network may balance bill.
	Specialist visit	$20 copay/visit	40% coinsurance	Out-of-Network may balance bill.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Out-of-Network may balance bill.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Out-of-Network may balance bill.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/pharmacy	Generic drugs (Tier 1)	Retail: $10 copay for 30 day supply Mail Order: $20 copay for 90 day supply	$10 copay plus an additional 25% of BCBSM approved amount for the drug.	Mandatory Generic Program effective August 1, 2018. If you choose a brand name drug, the Fund will only cover the cost of the generic drug less your applicable co-pay. **Prior-authorization and step-therapy required or the prescription may not be covered.** For information on women's contraceptive coverage, contact the Fund Office. Mail order drugs are not covered out-of-network. Specialty drugs can be generic, preferred or non-preferred drugs. Contact BCBSM/AllianceRx at 866-515-1355 for a list of specialty drugs.
	Preferred brand drugs (Tier 2)	Retail: $30 copay for 30 day supply Mail Order: $60 copay for 90 day supply	$30 copay plus an additional 25% of BCBSM approved amount for the drug	
	Non-preferred brand drugs (Tier 3)	Retail: $60 copay for 30 day supply Mail Order: $120 copay for 90 day supply	$60 copay plus an additional 25% of BCBSM approved amount for the drug	
	Specialty drugs (Tier 4)	Copay will vary based on drug class		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Out-of-Network may balance bill.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Out-of-Network may balance bill.
If you need immediate medical attention	Emergency room care	$100 copay	$100 copay	Out-of-Network may balance bill; copay waived if admitted or for an accidental injury.
	Emergency medical transportation	Ground: 20% coinsurance Air: 20% of lesser of billed charges or the Qualifying Payment Amount, after deductible.	Ground: 20% coinsurance Air: In-network deductible and in-network out-of-pocket maximum apply and this co-insurance and deductible to be counted towards in-network out-of-pocket maximum.	Out-of-Network may balance bill; must be medically necessary.
	Urgent care	$20 copay/visit	40% coinsurance	Out-of-Network may balance bill.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Unlimited day; must be pre-certified. Not pre-certified $500 penalty; semi-private room. Non-emergency services must be rendered in a participating hospital.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Out-of-Network may balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Must be in approved facilities only. In-Network cost sharing if there is no PPO Network. Out-of-Network may balance bill.
	Inpatient services	20% coinsurance	40% coinsurance	Unlimited day; out-of-Network may balance bill.
If you are pregnant	Office visits	No charge	40% coinsurance	Out-of-Network may balance bill.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Certain prenatal services may be covered under the preventive care benefit on page 2.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Out-of-Network may balance bill. Must be medically necessary and provided and billed by a participating home health care agency.
	Rehabilitation services	20% coinsurance	40% coinsurance	Out-of-Network may balance bill. Physical, occupational and speech therapy is limited to a combined maximum of 60 visits per individual per calendar year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Out-of-Network may balance bill. Must be in a participating skilled nursing facility. Limited to a maximum of 120 days per individual per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Out-of-Network may balance bill.
	Hospice services	No charge	No charge	Provided through a participating hospice program only; contact BCBSM for additional information.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	50% coinsurance for preventative services; once every 6 months.	50% coinsurance for preventative services; once every 6 months.	$1,000 maximum benefit per individual per calendar year. Out-of-Network may balance bill. Active employees only. Participants have the right to opt out.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Cosmetic surgery (not medically necessary)
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Hearing Aids
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Autism spectrum disorders
- Non-emergency care when traveling outside
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (medically necessary) • Chiropractic care	the U.S. • Online visits	• Routine dental care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is Department of Labor, Employee Benefit Security Administration 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Flint Plumbing and Pipefitting Industry Health Care Fund at 1-888-797-5862.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-797-5862.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-797-5862.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-797-5862.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-797-5862.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,320**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$240
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,160**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$250
Copayments	$50
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Blue Cross Blue Shield of Michigan

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

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Effective Date: 04/01/2020

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

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

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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

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Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. 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.

Eligibility Information

Members	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
Sponsored dependents	• Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.

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

Benefits	In-network	Out-of-network
Deductible	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $20 copay for office visits and office consultations • $20 copay for chiropractic and osteopathic manipulative therapy • $100 copay for emergency room visits • $20 copay for urgent care visits	• $100 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year	$2,000 for one member, $4,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.

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Benefits	In-network	Out-of-network
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

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Benefits	In-network	Out-of-network
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$20 copay per office visit	60% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	$20 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	$20 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$100 copay per visit (copay waived if admitted or for an accidental injury)	$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

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Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. 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.

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Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible Unlimited days	60% after out-of-network deductible
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	80% after in-network deductible Limited to a maximum of 120 days per member per calendar year	80% after in-network deductible
Hospice care	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay/coinsurance)
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible

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Benefits	In-network	Out-of-network
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	80% after in-network deductible	60% after out-of-network deductible
Voluntary abortions	Not covered	Not covered

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities **only**
• Online visits - by physician or **BCBSM** selected vendor must be medically necessary	$20 copay per online visit	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay per visit	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	

Benefits	In-network	Out-of-network
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

BCBSM Preferred RX Program

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Note: If your prescription is filled by any type of in-network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber HSA not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable copay/coinsurance.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay $10 copay	You pay $10 copay	You pay $10 copay	You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $20 copay	No coverage	No coverage
	84 to 90-day period	You pay $20 copay	You pay $20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $30 copay	You pay $30 copay	You pay $30 copay	You pay $30 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $60 copay	No coverage	No coverage
	84 to 90-day period	You pay $60 copay	You pay $60 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $60 copay	You pay $60 copay	You pay $60 copay	You pay $60 copay plus an additional 25% of BCBSM approved amount for the drug

ADM PLANYR AUG;ASCMOD 9119 DRG;BLUE DENTAL;CB ASC;CB-AMB ASC;CB-ECM-IN $1K A;CB-ECM-ON $2K A;CB-ET $100 ASC;CB-MTC $20 ASC;CB-OLV$0ASC;CB-OPMIN 6350 A;CB-OV $20 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-ON ASC;CBD $250-IN ASC;CBOPMON 12.7K A;CR-50;DC 26-ME ASC;MBL-1000;MOPD-2X ASC;PD-XED-MHP ASC;PDRX ASC;PDTTC 5/30/60 A;PRX-MM ASC;RX-90-2X ASC;RXP ASC;SD ASC;XVA ASC

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	31 to 83-day period	No coverage	You pay $120 copay	No coverage	No coverage
	84 to 90-day period	You pay $120 copay	You pay $120 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs. * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Mandatory preauthorization	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Elective lifestyle drugs	Benefits are excluded for elective lifestyle drugs. **Note:** Elective lifestyle drugs are lifestyle drugs that treat sexual impotency or infertility, or help in weight loss. They are not designed to treat acute or chronic illnesses. These medications are prescribed for medical conditions that have no demonstrable physical harm if not treated. (Smoking cessation drugs are not considered an elective lifestyle drug and are a payable benefit.) BCBSM determines when a drug is an elective drug.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Dental Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

Network access information
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.

Blue Dental PPO network- Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**

**A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices is two dentist locations.*

Blue Par Select℠ arrangement- Most non-PPO(out-of-network) dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services, and members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for dental coverage through the end of the calendar year in which they turn age 26, provided all eligibility requirements are met.

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	50%
• Class II services	50%
• Class III services	50%
• Class IV services	Not covered
Dollar maximums • Annual maximum for Class I, II and III services	$1,000 per member
• Lifetime maximum for Class IV services	Not applicable

ADM PLANYR AUG;ASCMOD 9119 DRG;BLUE DENTAL;CB ASC;CB-AMB ASC;CB-ECM-IN $1K A;CB-ECM-ON $2K A;CB-ET $100 ASC;CB-MTC $20 ASC;CB-OLV$0ASC;CB-OPMIN 6350 A;CB-OV $20 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-ON ASC;CBD $250-IN ASC;CBOPMON 12.7K A;CR-50;DC 26-ME ASC;MBL-1000;MOPD-2X ASC;PD-XED-MHP ASC;PDRX ASC;PDTTC 5/30/60 A;PRX-MM ASC;RX-90-2X ASC;RXP ASC;SD ASC;XVA ASC

Class I services

Benefits	Coverage
Oral exams	50% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	50% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	50% of approved amount **Note:** Once every 60 months
Prophylaxis (cleaning)	50% of approved amount **Note:** Twice per calendar year
Sealants - for members age 19 and younger	50% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	50% of approved amount
Fluoride treatments	50% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	50% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	50% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	50% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older	50% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	50% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery	50% of approved amount
Root canal treatment	50% of approved amount **Note:** Once per tooth per lifetime; retreatment of previous root canal therapy (after 12 months from the date of the original therapy) once per tooth per lifetime.
Scaling and root planing	50% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	50% of approved amount **Note: Limited** occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	50% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	50% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	50% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	50% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	50% of approved amount **Note:** Once per arch in any 36 consecutive months

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Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount **Note:** Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

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Blue Cross Blue Shield of Michigan

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

FLINT PLUMBING & PIPEFITTING
0070037600000 - 04MD7
Effective Date: 04/01/2020

Dental Coverage

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Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for dental coverage through the end of the calendar year in which they turn age 26, provided all eligibility requirements are met.

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	50%
• Class II services	50%

ADM PLANYR AUG;BLUE DENTAL;CR-50;MBL-1000

Benefits	Coverage
• Class III services	50%
• Class IV services	Not covered
Dollar maximums • Annual maximum for Class I, II and III services	$1,000 per member
• Lifetime maximum for Class IV services	Not applicable

Class I services

Benefits	Coverage
Oral exams	50% of approved amount **Note:** Twice per calendar year
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Fluoride treatments	50% of approved amount **Note:** Two per calendar year
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General anesthesia or IV sedation	50% of approved amount **Note:** When medically necessary and performed with oral surgery
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Benefits	Coverage
Relining or rebasing of a partial or complete denture	50% of approved amount **Note:** Once per arch in any 36 consecutive months
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Class III services

Benefits	Coverage
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Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

FLINT PLUMBING AND PIPEFITTING FRINGE BENEFIT FUNDS

Flint Plumbing & Pipefitting Industry Health Care Fund
Flint Plumbing & Pipefitting Industry Pension Fund
Flint Plumbing & Pipefitting Industry Defined Contribution Plan
Scholarship Fund of Flint Plumbing & Pipefitting Industry
Supplemental Unemployment & Disability Plan of Local Union 370

Managed for the Trustees by:
TIC MIDWEST

December 2024

TO: PLAN PARTICIPANTS OF THE SUPPLEMENTAL UNEMPLOYMENT & DISABILITY PLAN OF LOCAL UNION 370

Dear Participants:

We have attached the following Important Notices and Annual Reports for your review. These Notices and Reports are required to be mailed to each Plan Participant annually as provided by the Employee Retirement Income Security Act of 1974 (ERISA):

If you have any questions, please contact your Local Union Office or the Fund Office.

Sincerely,

Board of Trustees,
Supplemental Unemployment & Disability Plan of Local Union 370

6525 Centurion Drive • Lansing, MI 48917-9275
(517) 321-7502 • FAX (517) 321-7508
TOLL-FREE: (888) 797-5862
www.ualocal370benefits.org

SUMMARY ANNUAL REPORT

FOR THE SUPPLEMENTAL UNEMPLOYMENT & DISABILITY TRUST PLAN OF LOCAL UNION 370 UNITED ASSOCIATION OF JOURNEYMEN & APPRENTICES OF PLUMBING & PIPEFITTING INDUSTRY

This is a summary of the annual report of the Supplemental Unemployment & Disability Plan of Local Union 370 United Association of Journeymen & Apprentices of Plumbing & Pipefitting Industry, EIN 23-7314233, Plan No. 501, for period January 1, 2023 through December 31, 2023. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $958,754 as of December 31, 2023, compared to $845,579 as of January 1, 2023. During the plan year the plan experienced an increase in its net assets of $113,175. This increase includes unrealized appreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $260,898 including employee contributions of $203,742, and earnings from investments of $57,156.

Plan expenses were $147,723. These expenses included $29,052 in administrative expenses, and $118,671 in benefits paid to participants and beneficiaries.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. an accountant's report;
2. financial information and information on payments to service providers;
3. assets held for investment;
4. transactions in excess of 5% of the plan assets;

To obtain a copy of the full annual report, or any part thereof, write the Trustees of Supplemental Unemployment & Disability Trust Plan of Local Union 370, United Association of Journeymen & Apprentices of Plumbing & Pipefitting Industry, 6525 Centurion Drive, Lansing, MI 48917-9275, (888) 797-5862. The charge to cover copying costs will be $0.00 for the full annual report or $0.00 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (Trustees of the Supplemental Unemployment & Disability Trust Plan of Local Union 370, United Association of Journeymen & Apprentices of Plumbing & Pipefitting Industry, 6525 Centurion Drive, Lansing, MI 48917-9275) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Sincerely

Board of Trustees
Supplemental Unemployment &
Disability Trust Plan of Local Union 370
United Association of Journeymen &
Apprentices of Plumbing & Pipefitting Industry

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

NOTICE OF HIPAA PRIVACY POLICY

This Notice is intended to confirm that the Fund complies with the Privacy Regulations issued under the Health Insurance Portability and Accountability Act (HIPAA). The law restricts the use and disclosure of the non-public "protected health information" of the Participant and the Participant's covered dependents, if any, with regard to benefits provided under the Fund's group health plan. That protected health information can generally be disclosed only by the Fund, its vendors and the Participant's/dependent's health care provider(s) only if necessary for the payment of claims, treatment of illness or other health care operations, including the administration of health care benefits, as permitted by law and the HIPAA Privacy Regulations.

For a complete copy of the Fund's Notice of Privacy Policy, write or call the Fund Office at the address and telephone number and listed below:

The Supplemental Unemployment & Disability Plan of Local Union 370
6525 Centurion Drive
Lansing, MI 48917-9275

Telephone (517)321-7502
Fax 517-321-7508

CONSUMER PORTAL QUICKSTART GUIDE

Welcome to your Flint Plumbing and Pipefitting Industry Health Care Fund Benefit Accounts Consumer Portal. This one-stop portal gives you 24/7 access to view information and manage your Supplemental Benefit Account Reimbursements. It enables you to:

- File a claim online
- Upload receipts and track expenses
- View up-to-the-minute account balances
- View your account activity, claims history and payment (reimbursement) history
- Report a lost/stolen Card and request a new one
- Change your login password
- Download plan information, forms and notifications

The portal is designed to be easy to use and convenient. You have your choice of two ways to navigate this site:

1. Work from sections within the Home Page,
2. Hover over or click on the six tabs at the top.

HOW DO I LOG ON TO HOME PAGE?

1. Go to [https://tici.lh1ondemand.com/Login.aspx]
2. Enter your login ID and password (login will be your first initial, last name, and the last four of your social security number. Example: John Smith 123-45-6789 John will enter jsmith6789 as his login. Your password is: password
3. Click **Login**.

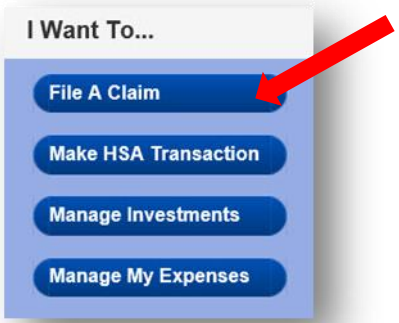
The **Home Page** is easy to navigate:

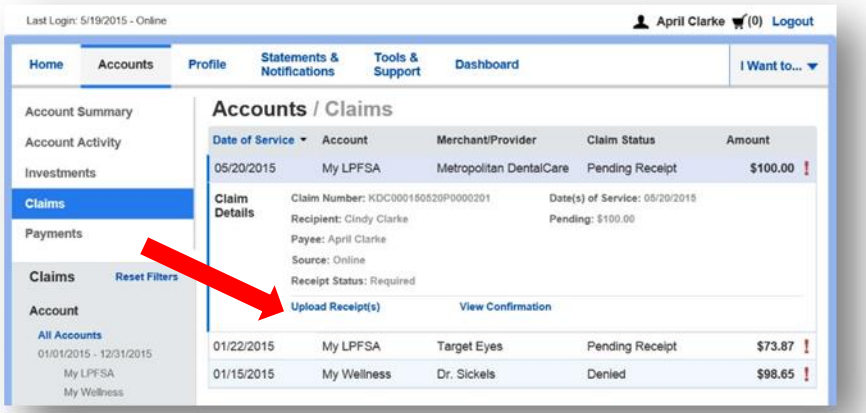
- Easily access the **Available Balance** and **"I Want To"** sections from the left-hand navigation area.
- The **I Want To** section contains the most frequently used features for the Consumer Portal.
- In the left-hand column Available **Balance** links to the Account Summary page, where you can see and manage your accounts.
- The **Message Center** section displays alerts and relevant links that enable you to keep current on your accounts.
- The **Quick View** section graphically displays some of your key account information.

You can also hover over the tabs at the top of the page.

HOW DO I FILE A CLAIM AND UPLOAD A RECEIPT?

1. On the **Home Page**, you may simply select the "**File a Claim**" under the "I want to…" section which can be located on the left-hand side of the home page.
   OR from any page on the portal, expand the "I want to…" section on the right hand side of the screen.
2. The claim filing wizard will walk you through the request including entry of information, payee details and uploading a receipt.
3. For submitting more than one claim, click **Add Another**, from the **Transaction Summary** page.
4. When all claims are entered in the **Transaction Summary**, agree to the terms and conditions click **Submit** to send the claims for processing.
5. The **Claim Confirmation** page displays. You may print the **Claim Confirmation Form** as a record of your submission. If you did not upload a receipt, you can upload the receipt from this screen or print a **Claim Confirmation Form** to submit to the administrator with the required receipts.





NOTE: If you see a **Receipts Needed** link in the Message Center section of your Home Page, click on it. You will be taken to the **Claims** page where you can see the claims that require documentation. You can easily upload the receipts from this page. Simply click to expand the line item to view claim details and the **upload receipts link.**

HOW DO I VIEW CURRENT ACCOUNT BALANCES AND ACTIVITY?

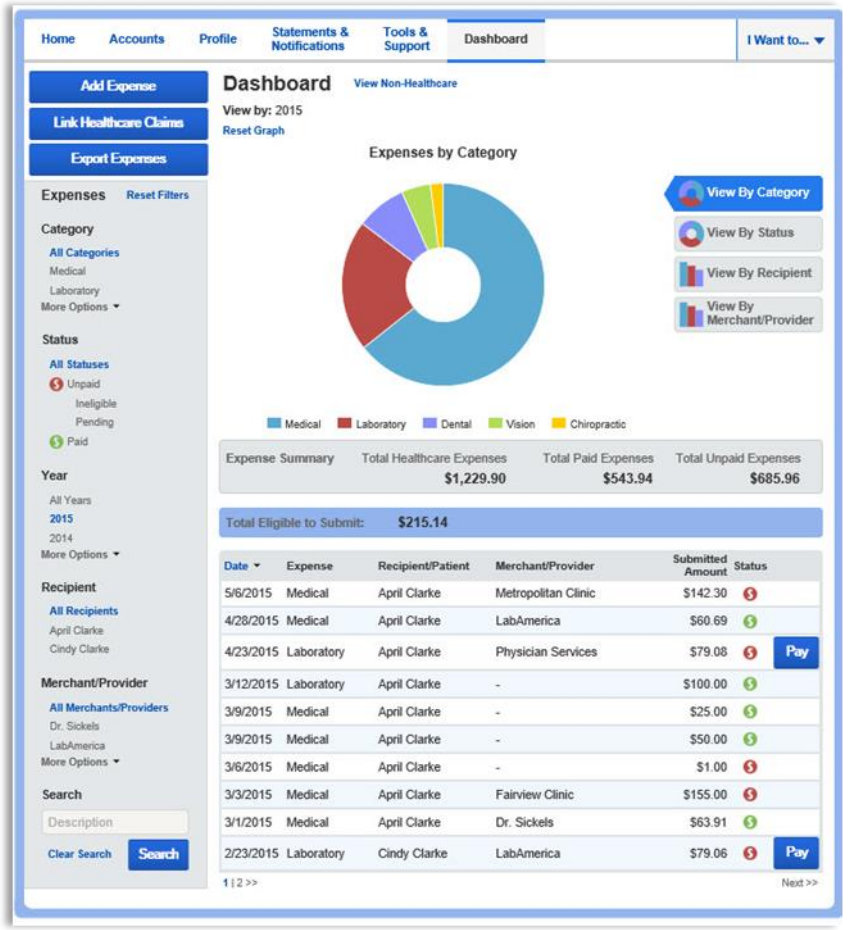
1. For current Account Balance only, on the **Home Page**, see the **Available Balance** section.
2. For all Account Activity, click on the **Available Balance** link from the Home Page to bring you to the Account Summary page. Then you may select the underlined dollar amounts for more detail. For example, click on the amount under "Eligible Amount" to view enrollment detail.

NOTE: You can see election details by clicking to expand the line item for each account.

ALL HEALTH CARE EXPENSE ACTIVITY IN ONE PLACE

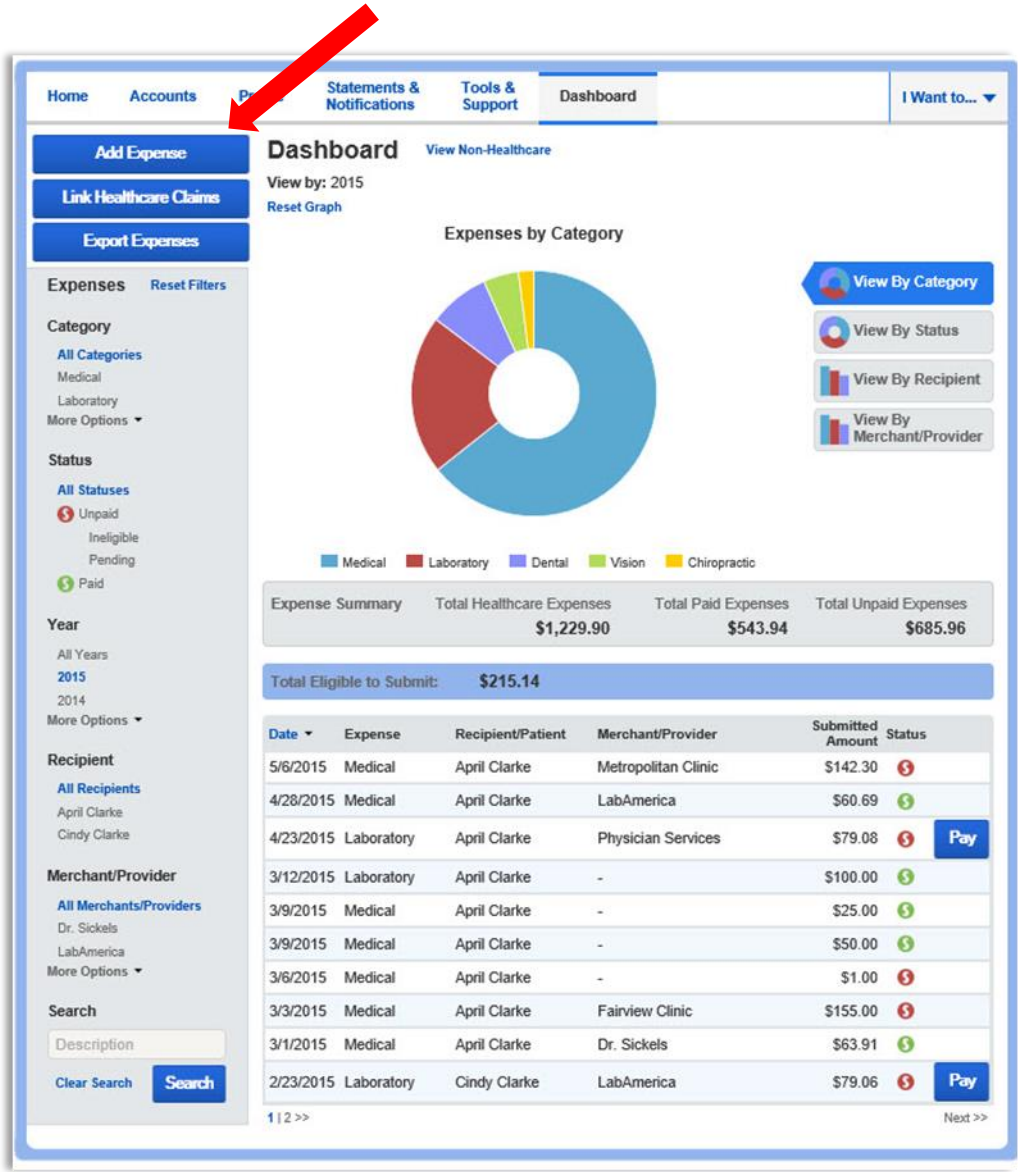
To view and manage ALL healthcare expense activity from EVERY source, use the DASHBOARD

1. On the **Home Page**, under the Dashboard tab. The 1View Dashboard provides you with an easy-to-use consolidated view of healthcare expenses for ongoing management of medical claims, premiums, and card transactions.
2. Easily filter expenses by clicking on the **filter options** on the navigation pane on the left side of the screen or, by clicking on the **field headers** within the Dashboard.
3. You can search for specific expenses using the **search field** on the bottom left side of the screen.
4. Expenses can be exported into an Excel spreadsheet by clicking on the **Export Expenses** button on the upper left side of the page.



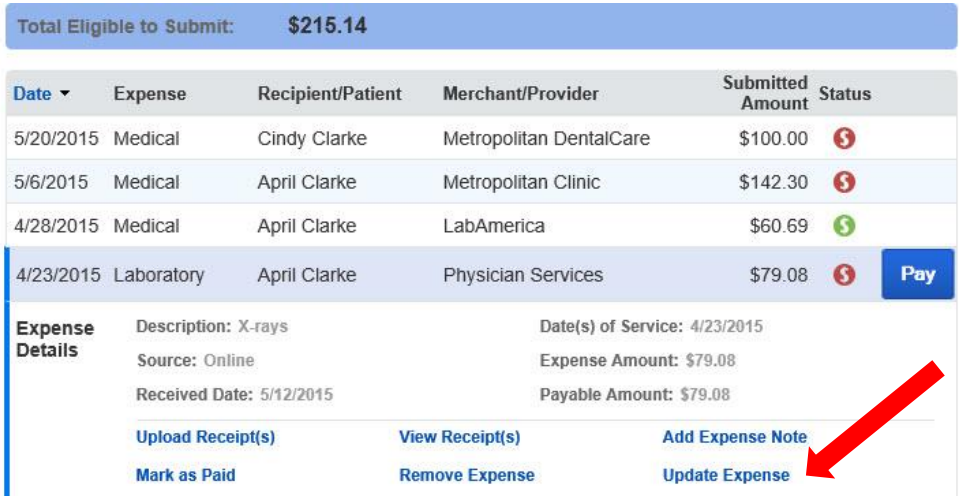
HOW DO I ADD AN EXPENSE TO THE DASHBOARD?

1. From the Dashboard click on the **Add Expense** button in the upper left side of the page.
2. Complete the expense detail fields. You can even upload a copy of the receipt and, add notes for your records.
3. Once the expense has been added to the dashboard you can pay the expense, if desired.



HOW DO I EDIT AN EXISTING EXPENSE IN THE DASHBOARD?

1. You can edit expense details for all claim statuses directly from the Dashboard page.
2. Expand the claim details visible by clicking on the expense line item from the Dashboard.
3. You will be presented with options to add expense notes, update the expense details, mark the expense as paid/unpaid or, remove the expense from the Dashboard.



HOW DO I VIEW MY CLAIMS HISTORY AND STATUS?

1. From the **Home Page**, click on the **Accounts Tab,** and then click on the **Claims** link to see your claims history. You can apply filters from the left-hand side of the screen. You can filter by plan year, account type, claim status or receipt status.
2. By clicking on the line of the claim, you can expand the data to display additional claim details.

Did you Know? For an alternative perspective, you may also view claims history and status for all claim types including dependent care on the **Dashboard** page. You can apply filters from the left-hand side of the screen. Filter options on the Dashboard screen include: expense type, status, date, recipient or merchant/provider. You may also search for a specific expense by entering a description into the search field.

HOW DO I VIEW MY PAYMENT (REIMBURSEMENT) HISTORY?

1. From the **Home Page**, under the **Accounts** tab, click **Payments**. You will see reimbursement payments made to date, including debit card transactions.
2. By clicking on the line of a payment, you can expand the data to display additional details about the transaction.

HOW DO I REPORT A DEBIT CARD MISSING AND/OR REQUEST A NEW CARD?

1. From the **Home Page**, under the **Profile**, click the **Banking/Cards** link on the left-hand side of the screen.

Under the Debit Cards column, click **Report Lost/Stolen** or **Order Replacement** and follow instructions.

HOW DO I UPDATE MY PERSONAL PROFILE?

1. From the **Home Page**, under the **Profile,** you will find links to update profile information including profile summary details, dependents, and beneficiaries.
2. Click the appropriate link on the Profile screen for your updates: **Update Profile** or **Add/Update Dependent** or **Add Beneficiary.** Some profile changes will require you to answer an additional security question.
3. Complete your changes in the form.
4. Click **Submit**.

HOW DO I CHANGE MY LOGIN PASSWORD?

1. From the **Home Page**, click on the **Profile** tab, and click **Login Information** on the left-hand navigation bar.
2. Follow instructions on the screen. (For a new account, the first time you log in, you will be prompted to change the password that was assigned by your plan administrator. Follow the instructions.)
3. Click **Save**.
4.

HOW DO I VIEW OR ACCESS…

…DOCUMENTS & FORMS?

1. From the **Home Page**, click the **Tools & Support** tab.
2. Click any form or document of your choice.

…NOTIFICATIONS?

1. From the **Home Page**, click the **Statements & Notifications** tab.
2. Click any link of your choice. **Receipt Reminders**, **Account Statements**, **Advice of Deposits**, **Denial Letters**, or **Denial Letters with Repayments** are a few options.

…PLAN INFORMATION?

1. On the **Home Page**, under the **Accounts** tab, you will be directed to the **Account Summary** page
2. Click onto the applicable account name and the **Plan Rules** will open in a pop-up window.
   OR from the **Home Page**, under the **Tools & Support** tab, you may view **Plan Summaries** for basic information. Then click each applicable plan to see the plan details.

FLINT PLUMBING & PIPEFITTING INDUSTRY PENSION PLAN

SUMMARY PLAN DESCRIPTION

REVISED: JANUARY 2023

To All Participants:

We are pleased to provide you with this Summary Plan Description. As a Summary Plan Description (SPD), this document summarizes the terms of the Flint Plumbing and Pipefitting Industry Pension Plan (Plan). It is designed to help you understand how the Plan works, your rights and benefits and those of your beneficiaries, and how to obtain these benefits. Please note that the use of any word in this SPD in the masculine gender is also intended to be in the feminine gender, and vice versa, where appropriate.

This SPD is not intended to cover every detail of the Plan or every situation that might occur. It is simply a summary. The complete Plan is available for inspection at any time at the Plan Office. If there is any conflict between this SPD and the Plan, the Plan controls. For a more detailed statement of your rights, benefits, and obligations consult the Plan document.

The Trustees reserve the right to amend the Plan at any time. However, no amendment can or will decrease a benefit already accrued, unless allowed by law.

Please read this SPD carefully and keep it for future reference. If you have any questions, please contact the Fund Office.

--Board of Trustees of the Flint Plumbing and Pipefitting Industry Pension Fund

TABLE OF CONTENTS

ARTICLE 1 – DEFINITIONS

The following words have the following meanings (other terms are defined in the Plan and govern the meaning of terms used in this SPD, even if not set forth below):

Active Participant means a Participant who has not retired, become disabled, deceased or incurred a Break-in-Service.

Actuarial Equivalent means a benefit of equal value to the benefit it replaces. Actuarial Equivalents expressed in the form of monthly benefit payments under the Plan shall be determined by using a 6.5% interest assumption and a Unisex Pension – 1984 Mortality Table.

Association means the Flint Association of Plumbing & Mechanical Contractors, Inc.

Break-in-Service means:

(a) For Plan Years prior to August 1, 1976, a period of two consecutive Plan Years in which an Employee is not credited with at least one-tenth of a Year of Service. In the event the Employee did not have at least five Years of Service at the time he incurred a Break-in-Service the Employee will lose his pre-break Years of Service;

(b) For Plan Years ending after August 1, 1976, an Employee who is not credited with at least 160 Hours of Service in two consecutive Plan Years will incur a Break-in-Service. An Employee who had no vested accrued benefit in the Plan will lose his pre-break service when his consecutive one-year Breaks-in-Service equal or exceed his pre-break Years of Service, except that as to Plan Years commencing after December 31, 1984, pre-break Years of Service will not be lost until the Employee has at least five consecutive Breaks-in-Service;

(c) An Employee who is absent from work for maternity or paternity reasons (e.g., by reason of the Employee's pregnancy, birth of the Employee's child, placement of a child with the Employee for adoption or for the purpose of caring for such Child for a reasonable period following such birth or placement), shall not incur a Break-in-Service due to such absence in the Plan Year the absence begins or in the following Plan Year if the Employee did not otherwise incur a Break-in-Service in the Plan Year in which the absence began if the requirements of subparagraph (e) under the definition of Hour of Work, below, are met;

(d) An Employee's failure to earn sufficient Hours of Service in a Plan Year due to service in the Armed Forces of the United States, resulting from his induction or first voluntary enlistment therein shall not constitute a Break in Service and such military service shall be considered as service for purposes of Years of Service under the Plan as described under Section 7.07 of this SPD, provided that the Employee complies with all of the requirements of Federal law in effect on the date of his separation from such service.

(e) An Employee who incurs a Break-in-Service as described in this Section, and returns to work for an Employer, and who works for an Employer continuously for 20 or more years, shall be considered not to have incurred a Break-in-Service for purposes of eligibility for retirement benefits and pre-Break-in-Service credits shall be valued in accordance with the schedule attached as Exhibit "A" at the time the Employee was last credited with an Hour of Work.

Code, IRC, or Internal Revenue Code means the Internal Revenue Code of 1986, as amended from time to time.

Covered Service means service with an Employer within the geographical limits of the Union's jurisdiction in categories of work under the jurisdiction of the applicable collective bargaining agreement for which contributions are required to be made to the Pension Trust Fund and service as an Employee of the Union for which the Union has agreed to contribute to this Pension Trust Fund.

Deceased Participant means a Participant who has deceased and whose beneficiaries (including his spouse) are eligible to receive benefits under the Plan.

Disabled Participant means an Active Participant who has a Total and Permanent Disability and who is entitled to receive benefits under the Plan.

ERISA means the Employee Retirement Income Security Act of 1974 as amended.

Employee means:

(a) Any person employed by an Employer covered by the terms of a collective bargaining agreement between the Union and such Employer which requires such Employer to make contributions to the Pension Fund on behalf of such person;

(b) Any person employed by an Employer as an Estimator who has come from the United Association of Plumbers, Pipefitters and Service Trades and maintains membership therein. Provided, however, such Estimator shall participate only upon the written consent of such Estimator and his Employer;

(c) Any person employed by the Union on behalf of whom the Union agrees to make contributions to the Pension Fund;

(d) Any person employed by the Board of Trustees, committee or other agency established to administer or be responsible for fringe benefit funds, educational or other programs established through collective bargaining by the Union and the association for whom such persons' employer agrees to make contributions to the Fund; or

(e) Solely for nondiscrimination testing purposes under the Code, including any individual who is employed by a related business or employer required to be aggregated with such Employer under Section 414(b), (c), (m) or (o) of the Code. The term "Employee" also shall include solely for nondiscrimination testing purposes any Leased Employee who is deemed to be an employee of an Employer as provided in Section 414(n) or (o) of the Code. Such term shall not include, however, a person

who is an owner-employee (as defined in Code Section 401(c)(3)) or a self-employed individual (as defined in Code Section 401(c)(1)).

The Plan adopts the "alumni rule" as set forth in Treasury Regulation § 1.410(b)-6(d)(2)(ii) for the purposes of defining a "collectively bargained employee" under the Code.

Employer means:

(a) Any member of the Association or other Employer association, bound by the terms of a collective bargaining agreement between the Union and such association to make contributions to the Pension Fund;

(b) Any individual, partnership, joint venture, trust or corporation, the Employees of which are covered by a collective bargaining agreement between the Union and such person or organization which requires such person or organization to make contributions to the Pension Fund;

(c) The Union, to the extent and solely to the extent, that it acts in the capacity of an Employer of its Employees on whose behalf it agrees to make contributions to the Pension Fund;

(d) Any Board of Trustees, committee or other agency established to administer or be responsible for Employee benefit funds, educational or other programs established through collective bargaining by the Union and the Association shall be considered an Employer solely for the purpose of making contributions to the Trust Fund on behalf of Employees employed by such Board of Trustees, committee or other agency for whom such persons agree to make contributions to the Fund;

(e) Any other employer who is obligated by any other written agreement satisfying the requirements of the National Labor Relations Act and acceptable to the Trustees, to make Contributions to the Fund.

Former Participant means a Participant who has incurred a Break-in-Service and is not entitled to receive benefits under the Plan.

Hour of Work means:

(a) Each hour for which an Employee is paid, or entitled to payment, for the performance of duties for an Employer during the Plan Year. Such hours shall be credited to the Plan Year in which the duties are performed;

(b) Each hour for which an Employee is paid, or entitled to payment, by the Employer on account of a period of time during which no duties are performed (irrespective of whether the employment relationship has terminated) due to vacation, holiday, illness, incapacity (including disability), lay off, jury duty, military duty or leave of absence. Notwithstanding, no more than 501 Hours of Work will be credited under this paragraph for any single continuous period (whether or not such period occurs in a single computation period). Hours under this paragraph will be calculated and

credited pursuant to Section 2530.200b-2 of the Department of Labor Regulations which is incorporated herein by this reference.

Notwithstanding the foregoing, Hours of Work shall not include hours for which an Employee is directly or indirectly paid, or entitled to payment, on account of a period for which no duties are performed (irrespective of whether the employment relationship has terminated) if such payment is made or due under a plan maintained solely for purposes of complying with applicable workers compensation or unemployment compensation or disability insurance laws or hours for a period during which payments are made to an Employee solely to reimburse the Employee for medical or medically related expenses incurred by the Employee;

(c) Each hour for which back pay, irrespective of mitigation of damages, is either awarded or agreed to by an Employer for the performance of duties for an Employer. Such hours shall be credited to the Plan Year in which the duties were performed. In no event shall the same hours be credited under this paragraph if already credited under paragraph (a) above;

(d) Pursuant to rules adopted by the Board of Trustees, hours required to be credited to the Employee by the Veterans Reemployment Rights statute codified at 38 USC Sections 4301-4307 or the Uniformed Services Employment and Reemployment Rights Act of 1994, as may be applicable;

(e) Solely for purposes of preventing a Break-in-Service from occurring in a Plan Year, Hours of work will be credited to a Participant who is absent from work for maternity or paternity reasons. The Hours of Work which shall be credited shall be equal to the Hours of Work which would otherwise be credited to him for such absence, or, in any case, in which such hours cannot be determined, eight Hours of Work per day of absence. For purposes of this provision, an absence from work for maternity or paternity reasons means an absence occasioned by: (1) the pregnancy of the Participant; (2) the birth of a child of the Participant; (3) the placement of a child with the Participant in connection with the adoption of such child by such Participant; or (4) for purposes of caring for such child for a period beginning immediately following such birth or placement. The Hours of Work credited under this provision shall be credited: (1) in the Plan Year in which the absence begins if the crediting is necessary to prevent a Break-in-Service in that Plan Year; or (2) in all other cases, in the following Plan Year. Notwithstanding the foregoing, no Hours of Work shall be credited hereunder unless the Participant furnishes the Trustees with timely information as the Trustees may require to establish that the Participant's absence from work is due to one of the reasons described herein and the number of days for which there was such an absence.

All Hours of Work, as set forth above, shall be computed in accordance with the Department of Labor Regulations Section 2530.200b-2(b) and (3), including the rule against double credit.

Inactive Participant means a Participant who has incurred a Break-in-Service and is entitled to receive deferred vested benefits under the Plan.

Participant means an Employee who has met the eligibility requirements in Article II of this SPD. Once an Employee becomes a Participant, he shall remain a Participant until his Normal or Early Retirement, death, Disability, Deferred Vested Retirement, Rule 85 Retirement, or other termination of participation.

Pension Fund or Fund means the fund created by the Flint Plumbing and Pipefitting Industry Pension Fund Trust Agreement.

Pension Plan or Plan means the Flint Plumbing and Pipefitting Industry Pension Plan, as amended from time to time.

Plan Year means the consecutive 12-month period beginning August 1 and ending July 31 of each year.

Retired Participant means a Participant who has retired and who is eligible to receive benefits under the Plan.

Surviving Spouse or Spouse means the person to whom a Participant, Retired Participant, Disabled Participant or Inactive Participant was legally married for at least one year as of the date of his death, except that, whenever benefits became payable under a Qualified Joint and Survivor Form described in Article 5 after the death of the Participant, his Surviving Spouse, if any, shall mean the person to whom he was legally married at the time such benefits became payable (provided such person is still alive at the time of the Participant's death and she was legally married to Participant for at least one year as of the date of his death). Further, “Spouse” or “Surviving Spouse” as used in this Plan means the Participant’s legal spouse who has met all requirements of a valid marriage contract in the State of marriage of such parties.

Total and Permanent Disability means, effective July 26, 1992, a totally and permanently disabled Participant is one who is determined by the Trustees, on the basis of medical evidence satisfactory to them, to have a physical or mental condition which has rendered him totally unable to engage in any regular occupation or employment for remuneration or profit and which condition is likely to be permanent and continuous during the remainder of his life; provided, however, that no Participant shall be deemed to be totally and permanently disabled if such incapacity is due to current illegal use of narcotics, was contracted, suffered or incurred while he was engaged in a felonious enterprise or resulted therefrom or resulted from an intentionally self-inflicted injury.

Trustees or Board means the Employer Trustees and the Union Trustees, collectively, as appointed under the Trust Agreement to administer the Plan.

Union means UA Local Union 370 Plumbers, Pipefitters and Service Trades.

Year of Credited Service means the number of Years of Service earned by a Participant for benefit accrual purposes computed to the nearest one-tenth of a Year of Service for benefit accrual purposes credited to a Participant less any Years of Service forfeited because of a Break-in-Service. Service shall be credited for all Hours Worked under reciprocal agreements as set forth in Section 7.03 of this SPD.

Year of Service means:

(a) For the purpose of eligibility for retirement and vesting:

(i) For the period prior to August 1, 1976:

(1) An Employee will receive one Year of Service for each full year of continuous employment in Covered Service for the period August 1, 1957, through August 1, 1962, provided he has worked 2,400 hours or more in Covered Service during the period August 1, 1962, through August 1, 1964. In the event he works less than 2,400 hours in Covered Service during the period August 1, 1962, through August 1, 1964, he will receive that percentage of his Years of Service for the period August 1, 1957, through August 1, 1962, equal to the number of hours actually worked in covered service during the period August 1, 1962, through August 1, 1964, divided by 2,400; or

(2) For the period August 1, 1962, through August 1, 1976, an Employee will earn the following Years of Service:

Hours Worked During Plan Year for Which Contributions are Made to the Fund for Covered Employment	Years of Service
1,760 or more	1.1
1,600 but less than 1,760	1.0
1,440 but less than 1,600	0.9
1,280 but less than 1,440	0.8
1,120 but less than 1,280	0.7
960 but less than 1,120	0.6
800 but less than 960	0.5
640 but less than 800	0.4
480 but less than 640	0.3
320 but less than 480	0.2
160 but less than 320	0.1
Less than 160	0.0

(ii) For the purpose of vesting and eligibility for retirement for the period beginning August 1, 1976, and all future Plan Years, a Plan Year in which an Employee is credited with at least 870 Hours of Work, including non-covered employment with an Employer which is contiguous to covered employment. Non-covered employment shall be employment with an Employer which does not come within the jurisdiction of the Union. If an Employee who was employed in non-covered employment becomes a Participant in the Plan while working for an Employer, he shall be given Years of Service for his contiguous employment with that Employer immediately prior to the date his work comes within the jurisdiction of the Union, but in no event for any such employment prior to the date the

Employer became a contributing Employer to the Fund. The Years of Service thus granted retroactively shall be based on Hours of Work as opposed to hours for which contributions were received or required and shall be used for determining eligibility for benefits only and shall not be used for purposes of benefit accrual.

A Participant who becomes employed in non-covered employment for an Employer immediately after he has been working under the jurisdiction of the Union shall continue to accrue Years of Service for such contiguous non-covered employment based on his Hours of Work; but such years shall be used for determining eligibility for benefits only and shall not be used for purposes of benefit accrual.

(b) For the purposes of benefit accrual:

(i) For the period prior to August 1, 1976:

(1) An Employee will receive one Year of Service for each full year of continuous employment in Covered Service for the period August 1, 1957, through August 1, 1962, provided he has worked 2,400 hours or more in Covered Service during the period August 1, 1962, through August 1, 1964. In the event he works less than 2,400 hours in Covered Service during the period August 1, 1962, through August 1, 1964, he will receive that percentage of his Years of Service for the period August 1, 1957, through August 1, 1962, equal to the number of hours actually worked in covered service during the period August 1, 1962, through August 1, 1964, divided by 2,400; or

(2) For the period August 1, 1962, through August 1, 1976, an Employee will earn the following Years of Service:

Hours Worked During Plan Year for Which Contributions are Made to the Fund for Covered Employment	**Years of Service**
1,760 or more	1.1
1,600 but less than 1,760	1.0
1,440 but less than 1,600	0.9
1,280 but less than 1,440	0.8
1,120 but less than 1,280	0.7
960 but less than 1,120	0.6
800 but less than 960	0.5
640 but less than 800	0.4
480 but less than 640	0.3
320 but less than 480	0.2
160 but less than 320	0.1
Less than 160	0.0

(ii) For the period commencing August 1, 1976, through July 31, 1998, an Employee will earn one-tenth of a Year of Service for every 160 Hours of Work. At the end of the Plan Year, each hour of work under 160 Hours of Work for the Plan Year will carry over and be credited to the Participant in the next Plan Year.

(iii) For the period commencing August 1, 1998, through July 31, 2011, an Employee will earn one-tenth of a Year of Service for every 150 Hours of Work. At the end of the Plan Year, each Hour of Work under 150 Hours of Work for the Plan Year will carry over and be credited to the Participant in the next Plan Year.

(iv) For the period commencing August 1, 2011, through July 31, 2018, an Employee will earn one-tenth of a Year of Service for every 150 Hours of Work, but not to exceed 1.2 Years of Service in any Plan Year. At the end of the Plan Year, each Hour of Work under 150 Hours of Work for the Plan Year will carry over and be credited to the Participant in the next Plan Year. A Participant may not earn more than 1.2 Years of Service and may not carry over more than 149 Hours of Work in any such Plan Year.

(v) For the period commencing August 1, 2018, and all future Plan Years, an Employee will earn one-tenth of a Year of Service for every 150 Hours of Work. At the end of the Plan Year, each Hour of Work under 150 Hours of Work for the Plan Year will carry over and be credited to the Participant in the next Plan Year.

(vi) For hours worked on or after December 1, 2013, and for all future Plan Years, a Year of Service will be based on Prorated Benefit Hours a Participant earns during a Plan Year. Prorated Benefit Hours are calculated by dividing total contributions reported on behalf of a Participant by the current hourly journeyman contribution rate.

ARTICLE 2 – ELIGIBILITY

Section 2.01 Initial Eligibility
Each person who becomes an Employee, shall become a Participant on the first day of the calendar month in which he commences work in Covered Service.

Section 2.02 Status
A Participant shall remain an Active Participant until he becomes an Inactive, Retired, Deceased, Disabled or a Former Participant.

Section 2.03 Retroactive Amendments
Any Plan amendment or Plan restatement which takes effect after a person becomes an Inactive, Retired, Deceased, Disabled or a Former Participant shall not apply to such person, unless such amendment or restatement is specifically made retroactive to cover such persons.

Section 2.04 Reinstatement of Eligibility
A Former Participant, Disabled Participant, or Inactive Participant will become an Active Participant as of the first day of the Plan Year in which he is credited with at least 150 hours of Covered Service. This does not mean that the pre-break Years of Service for a Former Participant are restored.

ARTICLE 3 – ELIGIBILITY FOR AND AMOUNT OF RETIREMENT BENEFITS

Section 3.01 - Normal Retirement

(a) **Eligibility**. An Active Participant's or Disabled Participant's "Normal Retirement Age" shall be the earlier of:

(1) The later of: (i) The date on which the Participant attains age 62; or (ii) The tenth year after participation commenced; or

(2) The later of: (i) The time the Participant attains age 65; or (ii) The fifth anniversary of the time a Participant commenced participation in the Plan.

An Employee who becomes a Participant after attainment of age 53 and prior to attainment of age 58 will be deemed to reach his Normal Retirement Age pursuant to (a)(1) above and will not be required to have ten Years of Service provided he has earned at least 870 Hours of Work in each Plan Year between his date of hire and the date he attains age 62.

Upon attainment of Normal Retirement Age, a Participant's accrued benefits shall be non-forfeitable. An Active Participant or Disabled Participant who retires on or after his Normal Retirement Date shall be entitled to the Normal Retirement Benefits set forth in this Section.

A Participant’s Normal Retirement Date shall mean the first day of the month coincident with or next following the date that the Participant satisfies all requirements for a Normal Retirement Benefit, including election to receive such benefits by submission of an application form to the Trustees on a form prescribed and furnished by them and accompanied by personal data as required by them.

(b) **Amount.** An Active Participant or Disabled Participant who retires on or after his Normal Retirement Age shall be entitled to a monthly pension commencing on the first day of the month following his Normal Retirement Date in accordance with the schedule attached to this SPD as Exhibit "A" as of the date the Participant last was credited with an Hour of Work.

An Inactive, Retired, or Disabled Participant shall have his benefits determined per the schedule attached to this SPD as Exhibit "A" in effect as of the date the Participant last performed an Hour of Work. In the event an Inactive, Retired, or Disabled Participant returns to work and completes 20 post-break Years of Service as of the date of his retirement, his benefits shall be determined in accordance with the schedule attached to this SPD as Exhibit "A" in effect as of the date the Participant last performed an Hour of Work.

Distribution of such benefit, in the absence of an earlier commencement date being elected by the Participant, shall commence no later than the Participant’s Required Beginning Date.

Section 3.02 - Late Retirement

(a) **Eligibility.** An Active Participant who continues to work for an Employer subsequent to his Normal Retirement Age shall not be eligible to receive a monthly pension until he actually retires. Upon his actual retirement he shall be entitled to the Late Retirement Benefits.

(b) **Amount.** Late Retirement benefits are the greater of: (a) the Normal Retirement Benefit actuarially increased to reflect the later starting date, or (b) the Normal Retirement Benefit calculated with the increased contributions made on behalf of the Participant after he reached age 62. A Participant's Late Retirement Date is the first day of the month following his actual retirement and after the Participant elects to receive such benefits by submission of an application to the Trustees on a form prescribed and furnished by them and accompanied by personal data required by them.

Distribution of such benefit, in the absence of an earlier commencement date being elected by the Participant, shall commence no later than the Participant's Required Beginning Date.

Notwithstanding the above, no late retirement benefit will be provided for any period during which a Participant retiring with a Deferred Vested Retirement has engaged in Plan Related Employment under Article 6 of this SPD after his/her Normal Retirement Date.

Section 3.03 - Early Retirement

(a) **Eligibility.** For all benefits earned prior to August 1, 2011, an Active Participant who has attained age 53 and who has ten or more Years of Service may retire early. For all benefits earned on or after August 1, 2011, an Active Participant must attain the age of 55 and be credited with ten or more Years of Service to be entitled to an Early Retirement Benefit.

(b) **Amount.** For benefits earned before August 1, 2011, an Active Participant who is entitled to an Early Retirement Benefit may receive a monthly pension, beginning on his Early Retirement Date equal to his Normal Retirement Benefit, but reduced by .0833% for each complete full month that the Employee is under age 62 but over age 55, and reduced further by .1666% for each complete full month that the Employee is under age 55 but over age 53.

For benefits earned on or after August 1, 2011, an Active Participant who is entitled to an Early Retirement Benefit may receive a monthly pension, beginning on his Early Retirement Date, equal to his Normal Retirement Benefit, but reduced by 2% for each year that the Employee is under age 62, but over age 60, and reduced further by 4% per year that the Employee is under age 60, but over age 58 on his Early Retirement Date, and reduced further by 7% per year that the Employee is under age 58 but over age 55.

A Participant's Early Retirement Date shall be the first day of the month following the date on which his employment terminates after having met the requirements of the preceding sentence and after the Participant elects to receive such benefits by submission of an application to the Trustees on a form prescribed and furnished by them and accompanied by personal data required by them. The Retired Participant may elect to postpone the commencement of his Early Retirement Benefit to a later date in which event the reduction

will be computed as of the date the benefit commences using the reduction factors in effect on the date that such Retired Participant last performed an Hour of Work.

Section 3.04 - Disability Retirement

(a) Eligibility. An Active Participant shall be entitled to the Disability Retirement Benefit set forth in Section 3.04(f) of this SPD if he/she:

(1) either:

(i) has ten or more Years of Service, or

(ii) is at least 58 years of age and has had contributions to the Plan of at least 250 Hours of Service for 10 consecutive Plan Years prior to a Break in Service; or

(iii) Has at least 15,000 Hours of Service within the last 15 years preceding the requested Disability Retirement Date.

(2) is Totally and Permanently Disabled, and

(3) has received a Social Security Disability award with an effective date prior to a Break in Service.

(b) Application and Effective Date

The "Disability Retirement Date" shall be the first day of the month next following the later of:

(1) The date on which the Board determines the Employee to be Totally and Permanently Disabled; or

(2) The date on which he files his written application for a Disability Retirement Benefit with the Trustees on a form prescribed and furnished by them and accompanied by personal data as required by them. If the Trustees determine in their sole discretion of that a Participant is incapacitated to the extent that he/she is unable to file an application on his/her own behalf, for purposes of this paragraph (b) the date he/she files a written application shall be the first of the month following the effective date of the Participant's Social Security Award.

A Disabled Participant who meets the eligibility requirements for a monthly Total and Permanent Disability Benefit as set forth in Section 3.04 of this SPD, upon submission of an application form to the Trustees, on a form prescribed and furnished by them and accompanied by personal data required by them, shall become entitled to a monthly Total and Permanent Disability Benefit commencing as of the first day of the month next following the date as of which he has both completed the eligibility requirements as set forth in the definition of “Total and Permanent Disability” under Article 1 of this SPD and this subsection and submitted said application.

(c) Delay in Social Security Disability Award

In the event an Active Participant, having reached the earliest retirement age under the Plan, makes application to the Board for disability benefits and has met all criteria therefore except he/she has not received a Social Security Disability award, such Participant may retire under the Early Retirement provisions of the Plan and if he/she receives a Social Security Disability award within four years of the date of retirement, he/she shall be paid retroactive benefits under the disability benefit provisions of the Plan back to the date of application.

(d) No Coordination

Disability Retirement Benefits received pursuant to this Plan shall not be coordinated pursuant to Michigan Compiled Laws Annotated Section 418.354, if that provision is found to be applicable to this Plan, or with any Workers Disability Compensation Benefits to which the Disabled Participant may be or may become entitled.

(e) Conversion

A Disability Retirement Benefit automatically converts to a Normal Retirement Benefit when a participant reaches Normal Retirement Age.

(f) Amount.

An Active Participant entitled to a Disability Retirement Benefit shall receive a monthly pension equal to his Normal Retirement Benefit. The monthly pension payable under this paragraph shall terminate if prior to his Normal Retirement Age:

(a) The Participant returns to regular and substantially gainful occupation or employment, except for purposes of rehabilitation approved by the Board, or except as the Board shall find that such occupation or employment is of a type sponsored and operated by a public or private agency for the sole purpose of providing employment for physically handicapped persons;

(b) The Board determines on the basis of competent medical evidence that the Participant has sufficiently recovered to resume a regular and substantially gainful occupation or employment; or

(c) The Participant refuses to undergo a medical examination requested by the Board, provided that he may not be required to undergo a medical examination more often than semi-annually.

Beginning with the first day of the month following the Disabled Participant's attainment of Normal Retirement Age, the monthly benefit shall no longer be subject to termination for any of the foregoing reasons and shall continue as the Participant's Normal Retirement Benefit.

Section 3.05 - Deferred Vested Retirement

(a) Eligibility. For accruals prior to February 1, 2022, an Inactive Participant shall be entitled to a Deferred Vested Retirement Benefit as set forth in Section 3.05(b) of this SPD as of his/her Deferred Vested Retirement Date, which is the first day of the month following his attainment of Early Retirement Age in effect at the time he/she terminated employment provided he/she has:

(1) Ten or more Years of Service prior to August 1, 1977; or

(2) Five Years or more Years of Service on or after August 1, 1977, but less than ten Years of Service as of July 31, 1997; or

(3) One or more Hours of Service on or after August 1, 1997, and Five Years of Service; or

(4) Ten or more Years of Service and terminates employment after August 31, 1982, provided such Employee is not engaged in suspendible employment under Article 6 of this SPD.

For accruals on or after February 1, 2022, an Inactive Participant with Five or more Years of Service shall be entitled to a Deferred Vested Retirement Benefit as set forth in Section 3.05(b) of this SPD as of the first day of the month following the later of the date he/she ceases all Plan Related Employment under Article 6 of this SPD or attainment of the Early Retirement Age in effect at the time he/she terminated employment.

Notwithstanding the foregoing, no benefit shall be paid until the first of the month following the date an Inactive Participant elects to receive such benefits by submitting an application to the Trustees on a form prescribed and furnished by them and accompanied by personal data required by them.

(b) **Amount.** An Inactive Participant entitled to a Deferred Vested Retirement Benefit whose employment is terminated (other than by reason of death) before being eligible for a Normal or Early Retirement Benefit shall be entitled to a monthly pension commencing on his Deferred Vested Retirement Date.

The benefit shall be computed as provided in Sections 3.01(b) or 3.03(b) of this SPD, whichever is applicable, using the benefit formula in effect per year of Credited Service at the time the Participant last was credited with an Hour of Work, with accruals earned on or after February 1, 2022, subject to full actuarial reduction from Normal Retirement Age. As applicable, Section 3.02(b) of this SPD will apply to the computation of Deferred Vested Retirement Benefit.

Notwithstanding, the benefit an Inactive Participant who qualifies for a Deferred Vested Retirement Benefit because he had five or more Years of Service on or after August 1, 1977, but less than ten Years of Service before January 1, 1997 (and did not have one Hour of Service after 1/1/97), shall be computed by multiplying his/her accrued benefit by the following Vested Percentage:

Credited Service	Vested Percentage
5 years but less than 6 years	50%
6 years but less than 7 years	60%
7 years but less than 8 years	70%
8 years but less than 9 years	80%
9 years but less than 10 years	90%
10 years or more	100%

Section 3.06 - Rule 85 Retirement

(a) **Eligibility**. An Active Participant whose age in full years (not fractions thereof) plus Years of Credited Service totals 85 shall be considered to have reached Normal Retirement Age. Effective 8/1/2001, no further service credits will be accrued under this Section.

(b) **Amount**. An Active Participant who retires under Rule 85 Retirement shall be entitled to a monthly pension commencing on the first day of the month following his Rule 85 Retirement Date in accordance with the Schedule attached to this SPD as Exhibit "A" as of the date the Participant was last credited with an Hour of Work.

Section 3.07 - Required Distributions

The Fund will make required minimum distribution as required by and subject to the provisions of 401(a)(9) the Internal Revenue Code. For those who turn 70½ on or before December 31, 2019 (i.e. whose birthdate is on or before June 30, 1949), distributions will generally be made the later of April 1 of the calendar year following the calendar year in which the Participant attains age 70½ or April 1 of the calendar year in which the Participant retires (this latter date, however, does not apply to any Participant who is a 5% owner).

For those who turn 70 ½ after December 31, 2019 (i.e. whose birthdate is on or after July 1, 1949), distributions will generally be made the later of April 1 of the calendar year following the calendar year in which the Participant attains age 72 or April 1 of the calendar year in which the Participant retires (this latter date, however, does not apply to any Participant who is a 5% owner).

For those who turn 72 after December 31, 2022, and 73 before January 1, 2033 (ie., whose birthdate is on or after January 1, 1951, and on or before December 31, 1959), distributions will generally be made the later of April 1 of the calendar year following the calendar year in which the Participant attains age 73 or April 1 of the calendar year in which the Participant retires (this latter date, however, does not apply to any Participant who is a 5% owner).

Section 3.08- Maximum Benefit

Notwithstanding any other provision of this Plan, no benefit shall exceed maximum benefit amounts for qualified plans as set forth in the Internal Revenue Code.

ARTICLE 4 – FORM OF BENEFITS

Section 4.01 - Normal Form of Benefits

For single Participants: Unless another form of benefit is payable in accordance with 4.02 of this SPD, the Normal Form of Benefit is a single life annuity providing for equal monthly installments throughout the remainder of such individual's lifetime, but subject to the suspension or termination of said benefits by application of the provisions of Article 6 of this SPD. Unless the Participant elects otherwise, distribution of benefits will begin no later than the 60th day after the latest of the close of the Plan Year in which:

(a) The Participant attains normal retirement age;

(b) Occurs the tenth anniversary of the year in which the Participant commenced participation in the Plan; or

(c) The Participant terminates Covered Service and becomes an Inactive Participant.

For married Participants: The Normal Form of Benefits is the 50% Qualified Joint and Survivor Form, unless the Participant waives such benefit and elects an optional form of benefit and his spouse consents in writing to his waiver in accordance with the Plan. Any such waiver and spousal consent must be on a form prescribed and furnished by the Trustees. The Participant's waiver of the 50% Qualified Joint and Survivor Form and the spouse's consent thereto must be executed within the 180-day period immediately prior to the date as of which monthly benefit payments are to begin.

The 50% Qualified Joint and Survivor Form shall provide the Participant with a reduced monthly benefit for his remaining lifetime with 50% of such reduced benefit for the remainder of her life to his Surviving Spouse, if any. The amounts payable hereunder shall be the Actuarial Equivalent of the Participant's accrued benefit based on the respective ages of the Participant and his spouse at the time benefit payments begin.

Waiver - Spousal Consent to Waive Normal Form of Benefit: An election to waive the Normal Form of Benefit and elect an optional form of benefit must be made by a Participant in writing during an election period, in accordance with the Plan Document. If married, the election must be consented to by his/her Spouse in writing. Notwithstanding, no consent is needed for the Participant to elect either the 100% or 75% Joint and Survivor Options. Additional information regarding waiver is available from the Fund Office.

Pop-Up: In the event the Spouse of a Participant who is receiving the 50%, 75%, or 100% Joint and Survivor dies within five years of the date of commencement of the Joint and Survivor Annuity, the Participant shall receive, commencing with the first day of the month following the Spouse's death, a single life annuity which is the Actuarial Equivalent of such Joint and Survivor Annuity.

Section 4.02 - Optional Forms of Benefits

Instead of the Normal Form of Benefit set forth in Section 4.01, subject to the waiver requirements set forth above, a Participant retiring under the Normal or Early Retirement provisions of the Plan or an Inactive Participant whose monthly payments are to begin, may, at the time of making application for benefits, elect to receive his benefits under one of the optional forms described below. A Disabled Participant receiving a Disability Benefit may also elect to receive his benefits under one of the optional forms described below at the time he attains age 62 and is to begin to receive his Normal Retirement Benefit. A Participant who elects optional form (a) or optional form (e) need not obtain spouse consent to the election. Any other optional form requires spousal consent as provided above. The benefits payable under any optional form shall be the Actuarial Equivalent of the Normal Form of Benefits:

(a) A 100% Joint and Survivor Option: The percentage payable to the Surviving Spouse is 100% of the Participant's reduced benefit.

(b) **A 75% Joint and Survivor Option:** The percentage payable to a Surviving Spouse is 75% of the Participant's reduced benefit.

(c) **Social Security Adjustment Option:** A Participant will receive an increased retirement benefit until age 62. Upon attaining age 62, the Participant receives a reduced retirement benefit. Payments under this option are calculated so that the pre-age 62 monthly payments approximate the post-age 62 monthly payment plus estimated Social Security payments for which the Participant will be eligible at age 62. This form of benefit may be elected by a Participant who elects to receive benefits in
the Normal Form, 100% Joint or Survivor Option, or 75% Joint and Survivor Option. To receive this benefit, a Participant must provide a Social Security Statement, dated within the preceding 12 months, from the Social Security Administration containing his/her estimated Social Security retirement benefits.

(d) **Life-Ten Years Certain Option:** A Participant may elect to receive a reduced monthly benefit for life with the provision that if his death should occur before he has received at least 120 such monthly payments, the same reduced monthly benefit shall be continued to his Beneficiary until a total of 120 monthly payments combined have been paid by the Fund to the Deceased Participant and his Beneficiary.

(e) **Life-Five Years Certain Option:** A Participant may elect to receive a reduced monthly benefit for life with the provision that if his death should occur before he has received at least 60 such monthly payments, the same reduced monthly benefit shall be continued to his Beneficiary until a total of 60 monthly payments combined have been paid by the Fund to the Deceased Participant and his Beneficiary.

Section 4.03 - Election of Form of Payment

The Fund must furnish each Participant, as required by law, no less than 30 days and no more than 180 days prior to the date as of which monthly benefit payments are to commence, information regarding benefit options and the effect of certain elections. The foregoing options may be elected by a Participant within a period of at least 90 days (the “Election Period”) immediately following the date which is 90 days after the date on which the Board furnishes the information. Elections must be made in writing on forms provided by the Fund and may be revoked at any time prior to the commencement of benefits. Additional information is available from the Fund Office.

Section 4.04 - Beneficiary for Ten and Five Year Certain Options

Every single Participant or married Participant who has obtained spousal consent to waive the Normal Form may designate any person to be his/her Beneficiary for the Ten and Five Year Certain Options. The Surviving Spouse shall be the Beneficiary in the event there is no proper waiver. If there is no Surviving Spouse and no designated Beneficiary, such benefits shall be paid to the person or persons in the first of the following categories:

(a) The Participant's surviving children in equal shares; or
(b) The Participant's estate.

No events, such as marriage, will automatically change the designated Beneficiary. Once a Participant properly designates a Beneficiary, that Beneficiary will continue to be the designated Beneficiary until changed in writing, on a form approved by the Trustees, by the Participant.

Section 4.05 - Distribution for Minor Beneficiary
In the event a distribution is to be made to a minor, the Administrator may, in the Administrator's sole discretion, direct that such distribution be paid to the legal guardian, or if none, to a parent of such Beneficiary with whom the Beneficiary maintains his residence, or to the custodian for such Beneficiary under the Uniform Gift to Minors Act or Gift to Minors Act, if such is permitted by the laws of the state in which said Beneficiary resides. Such a payment shall fully discharge the Fund and any related party from further liability for payment.

ARTICLE 5 – DEATH BENEFITS

Section 5.01 - Death After Normal Retirement Age
In the event of a Participant's death after his Normal Retirement Age and before his actual retirement, such Participant shall be deemed to have retired on the date of his death. If such Participant was married for at least one year as of the date of his death, and is survived by his spouse, his Surviving Spouse shall be entitled to receive the 50% Surviving Spouse's survivor benefit calculated as if the deceased Participant had retired on the date of his death. Such benefits will begin as of the first day of the month coincident with or next following the date of death of the Deceased Participant, but no monthly payments shall actually be made until approved by the Trustees after an application is submitted to them by or on behalf of the Surviving Spouse on a form prescribed and furnished by them accompanied by personal data required by them.

Section 5.02 - Death Before Normal Retirement Date
Unless otherwise elected, a Deferred Surviving Spouse's Benefit shall be payable to a Participant's Surviving Spouse in monthly installments beginning, unless the Surviving Spouse elects a later date, as of the first day as of which the Deceased Participant could have first started to receive Normal or Early Retirement Benefits or Deferred Vested Benefits had he lived based on his Years of Service for benefit accrual purposes as of the date of his death. Such monthly benefit shall be payable for life under the provisions of the 50% Qualified Joint and Survivor Form computed as if the Deceased Participant had lived to the first date as of which he could have commenced receiving Normal or Early Retirement Benefits or Deferred Vested Benefits, applied therefore and received such benefits as of such date under said Form and died immediately thereafter. Such computation shall be based on the age the Deceased Participant would have been when benefits would first have become payable and the age the Surviving Spouse is as of such date.

Section 5.03 – Beneficiary
The Designated Beneficiary of any vested single Participant who dies prior to his annuity starting date, shall receive a death benefit equal to Five Thousand Dollars ($5,000.00) for each Year of Service for benefit accrual purposes, payable in a lump sum. This benefit is the sole benefit payable under the Plan in the event a single Participant dies prior to his annuity starting date. Every single Participant may designate any person to be his/her Beneficiary on a form approved by the Trustees, and such person shall remain the designated Beneficiary until changed in writing by the Participant on a form approved by the Trustees. In the event there is no designation, this benefit shall be paid to the person or persons in the first of the following categories:

(a) The Participant’s surviving children in equal shares; or
(b) The Participant’s estate.

ARTICLE 6 – SUSPENSION OF RETIREMENT BENEFITS

Section 6.01 - Suspension of Retirement Benefits

(a) **General Rule:** The Normal Retirement Benefit, the Late Retirement Benefit, or the Early Retirement Benefit shall be suspended, if an Employee who is receiving any such benefit under this Plan returns to active service or employment, or continues in active service or employment past Normal Retirement Age, prior to reaching age 70 ½ with any employer in the same industry engaged in by employers maintaining the Plan, the same trade or craft in which he was working before he began receiving such benefits in the State of Michigan (for benefits accrued prior to April 1, 2001, the Counties of Genesee, Shiawassee, and Lapeer) for a period of at least eight days or 40 hours in any one month ("Plan Related Employment"). The Trustees shall have sole and complete discretion to determine whether work falls within the definition of "Plan Related Employment" and their decision shall be binding upon any Retired Participant or any other interested party. The terms of Section 6.01 of this SPD shall otherwise be interpreted consistently with 29 CFR 2530.203-3.

(b) **For All Retired Participants Whose Benefits Are Suspended**

(1) **When Benefits are Suspended:** Benefits shall be suspended for any calendar month in which the Retired Participant returns to or continues in Plan Related Employment. Such suspension shall continue until the Retired Participant notifies the Trustees in writing that he has stopped working in Plan Related Employment. Thereafter, payments of benefits shall resume not later than the first day of the third calendar month after the calendar month in which the Retired Participant ceases such employment or the first day of the calendar month after receipt of the Retired Participant's written notice to the Trustees, whichever is later. The initial payment to the Retired Participant upon resumption shall include the payment scheduled to occur in the calendar month in which such payments resume plus amounts withheld during the period between the cessation of Plan Related Employment and the date of resumption of payments, less any amount which are subject to offset or deduction.

(2) **Offset**: Deductions shall be made from the resumed benefits payment for any payments previously made by the Plan during those calendar months in which the Retired Participant was employed in Plan Related Employment. Any such deduction or offset shall not exceed in any month 25% percent of that month's total benefit payment which would have been due but for the offset, except that deduction or offset may be made without limitation as to any initial resumption payment which is due to be made to Retired Participant no later than the first day of the third calendar month after the Retired Participant ceased Plan Related Employment. Any such offsets or deductions shall also be made to any benefit payments to the Beneficiary of a Retired Participant in the event the Retired Participant dies before the total amount subject to offset has been recovered.

(3) **Verification and Determination of Status:** Every Retired Participant who is receiving Retirement Benefits and every Participant who would be eligible to receive Retirement Benefits but for his reemployment or continued employment who engages in any employment described in this Section, shall promptly notify the Trustees in

writing of such employment or reemployment and shall provide the Trustees will all reasonable information and assistance for the purpose of verifying such employment.

A Retired Participant may request an advance determination from the Trustees as to whether any specific contemplated employment will be regarded as Plan Related Employment for purposes of this Section. Requests for such advance determinations may be considered in accordance with the claims procedure adopted by the Trustees and shall be submitted on such forms as may be required by the Trustees.

(4) **Presumptions:** If the Trustees become aware that a Retired Participant is working in employment which would constitute Plan Related Employment and if the Retired Participant has not complied with the Plan's reporting requirements as to such employment, the Trustees may, unless it is unreasonable to do under the circumstances, act upon a rebuttable presumption that such employment constitutes Plan Related Employment and suspend payment of benefits to such Retired Participant. Such suspension shall commence with the next regularly scheduled payment of benefits after the Trustees become aware of the employment which would constitute Plan Related Employment.

In addition, if the Trustees become aware that a Retired Participant is working in employment at a construction site which would constitute Plan Related Employment and if the Retired Participant has not complied with the Plan's reporting requirements as to such employment, the Trustees may, unless it is unreasonable to do so under the circumstances, act on the basis of a rebuttable presumption that the Retired Participant engaged in such employment for so long as the employer of the Retired Participant performed work at the construction site at which the Retired Participant is working.

(5) **Notification:** The Trustees shall notify each Retired Participant whose benefit payments are suspended pursuant to this Section of such suspension in writing, by personal delivery or first class mail, during the first calendar month in which suspension takes place. Such notification shall contain the following information:

(A) A description of the specific reasons why benefit payments are being suspended;
(B) A general description of the Plan provisions relating to the suspension of benefits;
(C) A copy of such Plan provisions;
(D) A statement referring to the applicable Department of Labor regulations concerning suspension of benefits;
(E) An explanation of the Plan's procedures for affording a review of a Retired Participant's suspension of benefits;
(F) An explanation of the requirements to file a notice of termination of Plan Related Employment in order to resume benefit payments, including procedures and forms related to such notice; and
(G) If offset is applicable, an explanation of the offset procedures, identifying specifically the periods of employment in Plan Related Employment, the suspendible amounts which are subject to offset and the manner in which the Plan intends to offset such suspendible amounts.

(6) In their sole discretion the Trustees may waive, in whole or in part, the forfeiture aspect of these provisions provided any such waiver applies equally to similarly situated Retired Participants.

(c) Recomputation of Benefit Upon Termination of Plan Related Employment

(1) On termination of Plan Related Employment (Subsequent Retirement Date) and proper notice of same to the Trustees, the pension benefit of the Retired Participant shall be recomputed based on any additional Credited Service.

(2) The recomputed benefit shall be the greater of:

(A) The original pension benefit; or

(B) The pension benefit calculated as of his Subsequent Retirement Date, reduced by the actuarial equivalent of pension payments received prior to Normal Retirement Age. The actuarial equivalent is determined by dividing the amount pension payments received by the Retired Participant prior to Normal Retirement Age by the factor appropriate to his age upon his subsequent retirement.

Such benefit will be recalculated in accordance with Proposed Treasury Regulation section 1.411(b)-2(b)(4)(ii).

(3) For those whose original pension benefit commenced on or after Normal Retirement Age, the recomputed benefit shall be paid in the same optional form of benefit as the original pension benefit. If such optional form of benefit is a 5 or 10 year certain, the period over which such payments are made will not be changed from that calculated at the original retirement date. For purposes of calculating actuarial adjustments, ages at the Subsequent Retirement Date shall be used to calculate additional accruals, if any, for Year of Services earned during the period of Plan Related Employment. For purposes of the pop-up provision, the five-year period shall continue to be measured from the original retirement date.

(4) For those whose original pension benefit commenced before normal retirement age, the accrual date for additional accruals only shall be the date the recomputed benefit is payable. The recomputed benefit shall be paid in the Normal Form of Benefit or other optional form of benefit in effect immediately prior to a suspension of benefits, however the Retired Participant may elect a new form of benefit for the additional accruals only.

ARTICLE 7 – MISCELLANEOUS

Section 7.01 - Outstanding Payments

If any benefit payment approved by the Trustees or required to be distributed under the Plan remains unclaimed for a period of two years, such benefit payment will revert to and become the property of the Fund. However, if a claim is made by a Participant or Beneficiary for an unclaimed benefit to which he/she is entitled under the terms of this Plan after the two-year period, then such benefit shall be reinstated by the Trustees. The Fund shall comply with any procedure or requirement to locate a Participant or Beneficiary applicable to the Plan as required under law. In the event any other

payment issued by the Fund, for any reason, has not been redeemed by the payee for a period 24 months, or such lesser time set forth on the payment issued by the Fund, such payment is void and reverts to the Plan as a plan asset.

Section 7.02 –Overpayments
The Fund has the right to recover from any Participant, Retiree, Spouse, Surviving Spouse, Beneficiary, or other payee any amounts paid by the Fund which were not properly owing under the terms of the Plan, whether such amounts were paid by mistake, fraud, or any other reason. The Fund has the right to pursue the payee (including the Participant/Retiree and his/her Spouse jointly and severally), for the full amount due and owing under this provision. At the Fund's sole option, it may enforce this provision by offsetting future benefits, or crediting Contributions received against the debt owed the Fund under this provision, until the amount owed has been recovered.

Section 7.03 - Reciprocal Agreements
For the purposes of ensuring, so far as possible, continuous coverage of Employees who may move from area to area, the Trustees are authorized to enter into agreements which they deem necessary or expedient with Trustees of other pension funds for the purpose of establishing portability on a reciprocal basis. Participants who have contributions transferred to the Fund pursuant to reciprocity agreements shall be credited to one Hour of Work for vesting purpose for each contribution hour transferred to the Fund. Notwithstanding the foregoing, a Participant's credit for benefit accrual purposes with respect to any contribution hours transferred shall be the product of: (a) the number of contribution hours transferred, and (b) a fraction, the numerator of which is the dollar value of such contribution hour transferred and the denominator of which is the current hourly dollar amount of required Employer contributions to the Fund for Journeyman at the time the transferred contribution hour was earned by such Participant.

Section 7.04 - Non-Alienation of Benefits/QDROs
Except as may be required to comply with Qualified Domestic Relations Orders under the provisions of the Retirement Equity Act of 1984, no benefit payable under this Plan shall be subject in any manner, to alienation, sale, transfer, assignment, pledge or encumbrance. Any attempt to alienate, sell, transfer, assign, pledge or otherwise encumber, shall be void. Neither the Pension Fund nor any pension benefit shall in any manner be liable for or subject to the debts or liabilities of any Employee entitled to any pension benefit or of any Beneficiary. If a domestic relations order satisfies the requirements to be "qualified" as described in the Retirement Equity Act of 1984, the Trustees shall administer distributions from the Plan in accordance with such order. All such payments pursuant to Qualified Domestic Relations Orders shall be subject to reasonable rules and regulations promulgated by the Trustees; provided that such rules and regulations are not contrary with IRC Section 414(p).

Section 7.05 – Amendment
No amendment to the Plan (including a change in the actuarial basis for determining optional or Early Retirement Benefits) shall be effective to the extent that it has the effect of decreasing a Participant's accrued benefit, except to the extent allowed by law.

Section 7.06 – Strikes
Absence during an authorized and lawful strike occurring after the effective date, which strike is not in violation of the Collective Bargaining Agreement then in effect, if any, between the Employer and the Union, shall not for the period of such strike result in loss of Credited Service, nor shall Hours of Work accrue during such a period except for purposes of determining whether a Break-in-Service has

occurred. In the event there is a dispute as to whether a strike is authorized and lawful, the same shall be determined by the Board. In the event the Participant fails to return to employment with an Employer after the termination of the strike or if the Participant is lawfully and permanently replaced, then the provisions of the Plan shall fully apply.

Section 7.07 - Service Credit with Respect to Qualified Military Service
Notwithstanding any provision of the Plan to the contrary, contributions, benefits and service credit with respect to qualified military service will be provided in accordance with IRC §414(u). The cost of providing such contributions, benefits and service credit shall be considered a liability of the entire Trust Fund and shall not fall to any one Employer or group of Employers. The following procedures shall be used to implement IRC §414(u):

- **Notification.** Prior to entering military service, a Participant is required to provide advance written or verbal notice to his employer unless giving such notice is precluded by military necessity or is otherwise impossible or unreasonable.
- **Disclosure Requirement.** Upon application for re-employment, a Participant shall be required to provide documentation to establish the timeliness of his application for re-employment (A copy of the Participant's discharge papers shall be sufficient).
- **Crediting Military Service.** To determine the number of hours to be credited for military service, the Board of Trustees shall review the Participant's work history during a period equal to at least two times the amount of time spent in military service.
- **Allocation of Liability.** Liability associated with the crediting of military service shall be added to all other Plan liabilities for a particular Plan year and funded in the same manner as any other Plan liability.
- **Service and Discharge.** Credit will be given under this section only if service is for no more than five years, unless extended at the government's request, and the Participant is discharged under honorable conditions.

A Participant will only be entitled to the benefits of this section if he returns to Covered Service under the collective bargaining agreement within the following time frames:

- **For uniformed service of less than 31 days:** by the next work-day after the end of service plus eight hours, or as soon as possible after the end of the eight hour period if reporting earlier is impossible through no fault of the Participant;
- **For service of more than 30 days but less than 181 days:** within 14 days of completing the service, or the next full calendar day if returning earlier is impossible through no fault of the Participant; or
- **For service of more than 180 days:** within 90 days after completion of service.

Notwithstanding the foregoing, the beneficiary of a Participant on a leave of absence to perform military service with reemployment rights under IRC §414(u) shall be entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) that would be provided under the Plan had the Participant died as an Active Participant in accordance with IRC §401(a)(37).

Section 7.08 - Direct Rollover
As required by law, when applicable, Participants will receive information regarding the ability to rollover distributions to Eligible Retirement Plans.

ARTICLE 8 – CLAIM AND APPEAL PROCEDURES

Section 8.01 - Claims Procedure

(a) Timing of Notice of Denial of Claims Other Than Disability Claims

If a claim, except for a claim for disability benefits, is wholly or partially denied, the Plan Administrator shall notify the claimant, in accordance with subsection (d) of this Section, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(b) Timing of Notice of Denial of Disability Claims

A claim for disability benefits includes an initial claim for disability benefit or any recission of coverage of a disability benefit.

In the case of an adverse benefit determination concerning disability benefits, the Plan Administrator shall notify the claimant, in accordance with subsection (d) of this Section, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(c) Calculation of Time

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

(d) Content of Notice

The Plan Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR §2520.104b-1(c)(1)(i), and (iv).

Before the Plan can issue a notice of benefit determination based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of benefit determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Plan can issue a notice of benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

The notification shall set forth, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination;
(2) Reference to the specific Plan provisions on which the determination 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 material or information is necessary;
(4) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; and
(5) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; or, if applicable a statement that such rule, guideline, protocol or other criterion does not exist;
(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

With respect to an adverse benefit determination regarding disability benefits, the determination must also include the following:

(1) An explanation of the basis for disagreeing with any of the following:

(i) The health care professionals that treated the Claimant;
(ii) The advice of the health professional obtained by the Plan; or
(iii) A disability determination from the Social Security Administration.

(2) A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.

(3) If the denial was based on medical necessity or experimental treatment, the denial must include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claim or statement or a statement that such explanation will be provided free of charge upon request.

(4) The denial must be in a culturally and linguistically appropriate manner.

Section 8.02 - Appeals Procedure

The following rules apply to claims:

(a) The claimant shall have 60 days (180 days for appeals involving disability benefits) following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(b) The claimant shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) The claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as that term is defined at 29 CFR §2560.503-1(m)(8), to the claimant's claim for benefits;

(d) The review on appeal 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;

(e) The Trustees shall make a benefit determination no later than the date of the meeting of the Trustees that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan

Administrator shall notify the claimant, in accordance with subsection (i) of this Section, of the benefit determination as soon as possible, but not later than five days after the benefit determination is made;

(f) The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to subsection (f) of this Section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information; and

(g) Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence the Fund must provide the Claimant free of charge, with an new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund)in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date;

(h) Before the Fund can a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficient in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date; and

(i) The Plan Administrator shall provide a claimant with written or electronic notification of a Plan's benefit determination on review. Any electronic notification shall comply with appropriate regulations. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant;

(1) The specific reason or reasons for the adverse determination;
(2) Reference to the specific Plan provisions on which the benefit determination is based;
(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant, as that term is defined at 29 CFR §2560.503- 1(m)(8), to the claimant's claim for benefits;
(4) A statement of the claimant's right to bring an action under Section 502(a) of ERISA;
(5) A statement describing any contractual limitation period that applies to the Claimant's right to bring an action under ERISA 502(a) and the calendar date on which such contractual limitations expires;
(6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline,

protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request; or, if applicable, a statement that such rules or guidelines do not exist; or

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

(8) 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."

In addition to the above, a notice of decision on appeal pertaining to a claim for disability benefits will include the following:

(1) An explanation of the basis for disagreeing with any of the following:

(i) The health care professionals that treated the Claimant;
(ii) The advice of the health professional obtained by the Plan; or
(iii) A disability determination from the Social Security Administration.

(2) The benefit denial must be in a culturally and linguistically appropriate manner.

Section 8.03 - Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret Plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

Section 8.04 - Timely Submission of Appeals

All appeals must be timely submitted. A Participant or dependent who does not timely submit an appeal waives his/her right to have the benefit denial further reviewed by the Fund or in a court of law.

Effective March 1, 2020, the Plan will implement the Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak, set forth at 85 FR 26351 (May 4, 2020), as follows: The Plan will disregard the period from March 1, 2020, until the earlier of: (1) 1 year from the date a Participant or Beneficiary becomes eligible for an extended deadline or: (2) 60 days after the announced end of the National Emergency or such other date announced by the applicable federal agency (the "Outbreak Period") for all participants and dependents in determining the following periods and dates relating to claims submission and the claims and appeal procedures:

a. The date within which individuals may file a benefit claim, and
b. The date within which claimants may file an appeal of an adverse benefit

determination.

Section 8.05 - Limitation of Actions
No action may be brought to recover benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal.

Section 8.06 - Facility of Payment
In the event that the Board determines that a payee is mentally or physically unable to give valid receipt for any benefit due to him under the Plan, such payment may, unless claim shall have been made therefore by a legally appointed guardian, or other legal representative, (by power of attorney or otherwise) be paid to any person or institution then in the judgment of the Board providing for the care and maintenance of such payee. Any such payment shall be a payment for the account of the person involved and shall be a complete discharge of any liability of the Plan or the Board therefore.

Section 8.07 – Failure to Follow Claims Procedures
If the Plan fails to follow claims procedures with respect to any claim for benefits, the Claimant is deemed to have exhausted administrative remedies and is entitled to pursue all remedies under ERISA 502(a)on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits.

In addition to the above, if the plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the claimant chooses to pursue remedies under section ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees.

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten days), the Plan shall provide the Claimant with the notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

Section 8.08 – Avoiding Conflicts of Interest
The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring compensation, termination, promotion or other similar matters with respect to an individual such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

ARTICLE 9 – OTHER PROVISIONS

The following information is required to be provided by law:

A. **Type of Administration/Plan Administrator/Plan Sponsor/Counsel**: The Board of Trustees of the Flint Plumbing and Pipefitting Industry Pension Plan is the Plan Administrator and Plan Sponsor. As such, the Trustees are responsible for overall Plan administration. There are three Trustees appointed by the Union and three Trustees appointed by the Association. The current Trustees are:

Union Trustees	Employer Trustees
Daniel J. Gaudet, Chairman Local Union 370 2151 W. Thompson Road Fenton, MI 48430	Dominic Goyette, Secretary Goyette Mechanical Company 382 Gorey Ave. Flint, MI 48506
Zach Desrochers Local Union 370 2151 W. Thompson Road Fenton, MI 48430	Kristine Menzing Dickerson Mechanical P.O Box 250 Davison, MI 48428
Paul Gonzales Local Union 370 2151 W. Thompson Road Fenton, MI 48430	David Hendershot Ecker Mechanical Contractors, Inc. P.O. Box 19099 Burton, MI 48529

Legal Counsel for the Plan
Michael J. Asher
Jacqueline A. Kelly
AsherKelly
25800 Northwestern Highway, Suite 1100
Southfield, MI 48075
(248) 746-2748

The day-to-day responsibilities for Plan administration are performed by the Administrative Manager and Plan Office, TIC International Corporation, 6525 Centurion Drive, Lansing, MI 48917-9275, Toll Free (888) 797-5862, (517) 321-7502, Fax (517) 321-7508.

B. Effective Date of Plan: May 1, 1963

C. Agent for Service of Legal Process: Service of process should be made upon the Plan Office, TIC International Corporation, 6525 Centurion Drive, Lansing, MI 48917-9275, Toll Free (888) 797-5862, (517) 321-7502, Fax (517) 321-7508. Service of legal process may also be made upon any Trustee.

D. **Type of Plan/Employer Identification Number/Plan Year:** The Flint Plumbing and Pipefitting Industry Pension Plan is a defined benefit pension plan. The employer identification number assigned by the IRS is 38-6254230. The Plan number is 001. The Plan Year begins August 1st of each year and runs to the following July 31st.

E. **Collective Bargaining Agreements:** The Plan is maintained pursuant to collective bargaining agreements. Copies of such agreements may be obtained upon written request to the Plan Office or are available for examination by participants and beneficiaries at the Plan Office. Alternatively, within 10 days of a written request, such agreements will be made available at the Union Hall or at any employer establishment where at least 50 or more participants are customarily working. The Plan may impose a reasonable charge for such copies.

F. **Source of Plan Contributions:** The primary source of financing for the benefits provided under the Plan and for the expenses of the Plan operations are employer contributions. The rate of contribution is set forth in the Collective Bargaining Agreement, or other written agreement requiring contributions to the Fund. A complete list of the employers contributing to the Plan may be obtained upon written request to the Plan Office and may be examined at the Plan Office. Additionally, plan assets are invested which results in investment income to the Plan.

G. **Pension Trust Assets and Reserves:** The Board of Trustees holds all assets in trust for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses.

H. **PBGC:** Benefits under this pension plan are guaranteed by the Pension Benefit Guaranty Corporation ("PBGC"). Your pension benefits under this multiemployer plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. A multiemployer plan is a collectively bargained pension arrangement involving two or more unrelated employers, usually in a common industry.

Under the multiemployer plan program, the PBGC provides financial assistance through loans to plans that are insolvent. A multiemployer plan is considered insolvent if the plan is unable to pay benefits (at least equal to the PBGC's guaranteed benefit limit) when due.

The maximum benefit that the PBGC guarantees is set by law. Under the multiemployer program, the PBGC guarantee equals a participant's years of service multiplied by (1) 100% of the first $11 of the monthly benefit accrual rate and (2) 75% of the next $33. The PBGC's maximum guarantee limit is $35.75 per month times a participant's years of service. For example, the maximum annual guarantee for a retiree with 30 years of service would be $12,870.00.

The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan becomes insolvent; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law; (2) benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the earlier of: (i) The date the plan terminates or (ii) the time the plan becomes insolvent; (3) benefits that are not vested because you have not worked long enough; (4) benefits for which you have not met all of the

requirements at the time the plan becomes insolvent; and (5) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street, N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

I. Statement of ERISA Rights: As a participant in the Flint Plumbing and Pipefitting Industry Pension Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

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

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 62) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights: If your claim for a pension benefit is denied or ignored, in whole or

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

Assistance with Your Questions: If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

J. Termination of the Plan: If the Plan is completely or partially terminated, the rights of all Participants, and others having an interest in the Plan, to benefits accrued to the date of such complete or partial termination, to the extent then funded, shall be nonforfeitable. Pursuant to the terms of the Trust, the Plan may be terminated by the Union and Association. If the Plan is terminated, the Trustees will direct the Plan's actuary to determine if the assets of the Plan are sufficient to satisfy all Plan liabilities, including Plan benefits and all Plan expenses. In the event of Plan termination, the Trustees shall:

(a) Make provision out of the Pension Fund for the payment of any and all obligations to the Plan and Trust; including expenses incurred up to the date of termination of the Plan and the expenses incidental to such termination;
(b) Arrange for a final audit and report of their transactions and accounts, for the purpose of termination of their Trusteeship;
(c) Give any notice and prepare and file any report which may be required by law; and
(d) Apply any remaining surplus in such manner as will best effectuate the purposes of the Trust.

No Employer shall have the right, title or interest in the Pension Fund, or amounts due the Pension Fund, and no part of the Fund shall revert to any such Employer except if, after satisfying all the liabilities of the Plan arising out of the termination of the Plan, there remain any assets in the Trust Fund, such assets shall be considered to result from variations between

actual requirements and expected actuarial requirements and shall be returned to the Employers on the basis of their share of total contributions.

Subject to relevant provisions of ERISA, there shall be no liability expressed or implied, on the part of an Employer to provide any benefits or further contributions to the Trust Fund after the date of termination of the Trust. The Trust Fund shall be the sole source of benefit payments during continuance of the Pension Plan or after termination of the Trust, if any.

This Summary Plan Description is not intended to cover every detail of the Plan or every situation that might occur. It is simply a summary. The complete Plan is available for inspection at any time at the Plan Office. If there is any conflict between this summary and the Plan, the Plan controls. For a more detailed statement of your rights and obligations consult the Plan document.

EXHIBIT "A"

(Schedule of Applicable Pension Benefits Rates)

Year of Service	**Benefit Rate**		
Prior to 8/1/1983	$70		
8/1/1983-7/31/1998	$120		
8/1/1998-7/31/1999	$100		
8/1/1999-7/31/2001	$116		
8/1/2001-7/31/2018	$87 for Participants who work one hour after June 6, 2005.	$80 for Participants who did not work one hour after June 6, 2005.	$100 for retirees and surviving spouses in pay status as of August 1, 2021. $100 for Participants who were Active Participants on both August 1, 2021, and August 1, 2022. $100 for Participants who were Active Participants as of August 1, 2021 and were unable to work 160 hours in the August 1, 2021 to July 31, 2022 Plan Year due to a Disability.
After 8/1/2018	$100		

FLINT PLUMBING AND PIPEFITTING INDUSTRY DEFINED CONTRIBUTION PLAN

SUMMARY PLAN DESCRIPTION

2023

This document is a SUMMARY of the official Plan document. Additional limitations and exclusions may be found in the official Plan document, which is available without charge at the Plan Office.

To All Participants:

We are pleased to provide you with this Summary Plan Description. As a Summary Plan Description ("SPD"), this document summarizes the terms of the Flint Plumbing and Pipefitting Industry Defined Contribution Plan document ("Plan"). It is designed to help you understand how the Plan works, your rights, benefits, and how to obtain these benefits. Please note that the use of any word in this summary in the masculine gender is also intended to be in the feminine gender, and vice versa, where appropriate.

This SPD is not intended to cover every detail of the Plan or every situation that might occur. It is simply a summary. The complete Plan is available for inspection at any time at the Plan Office. If there is any conflict between this SPD and the Plan, the Plan controls. For a more detailed statement of your rights, benefits, and obligations consult the Plan document.

The Trustees reserve the right to amend the Plan at any time.

Please read this SPD carefully and keep it for future reference. If you have any questions, please contact the Plan Office.

Board of Trustees

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ARTICLE 1 – DEFINITIONS

Account or Participant's Account means the record of each Participant's interest in the Trust. The Account shall include four sub-accounts for record-keeping purposes: (a) the Rollover Account (which holds Participant rollover contributions, and allocable earnings), (b) the Money Purchase Account (which holds Employer contributions attributable to employment prior to August 1, 2005, and allocable earnings), (c) the Profit Sharing Account (which holds Employer contributions attributable to employment on and after August 1, 2005, and allocable earnings), and, (4) the Elective Contribution Account (which holds Elective Contributions made at the election of Participants on and August 1, 2005, and allocable earnings).

Association means the Flint Association of Plumbing & Mechanical Contractors, Inc.

Beneficiary or Beneficiaries means the person or persons to whom the share of a deceased Participant's total Account is payable.

Code or IRC means the Internal Revenue Code.

Collective Bargaining Agreement means the Collective Bargaining Agreements in force and effect between the Union and the Association.

Covered Service means service with an Employer within the geographical limits of the Union's jurisdiction in categories of work under the jurisdiction of the applicable Collective Bargaining Agreement for which contributions are required to be made to the Defined Contribution Trust Fund, and service as an Employee of the Union for which the Union has agreed, in a nondiscriminatory manner, to contribute to the Defined Contribution Trust Fund.

Early Retirement Date means the first day of the month (prior to the Normal Retirement Date) coinciding with or following the Participant's or Former Participant's 53rd birthday.

Elective Contributions or Elective Deferrals mean Employer contributions made to the Plan at the election of the Participant on a pre-tax basis pursuant to the cash or deferred arrangement, which would otherwise be payable to the Participant in case. Elective Contributions or Elective Deferrals are deposited to the Participant's Elective Contribution Account.

Employee means any (a) any person employed by an Employer covered by the terms of a Collective Bargaining Agreement between the Union and such Employer which requires such Employer to make contributions to the Defined Contribution Trust Fund on behalf of such person; or (b) any person employed by the Union, which Employee is subject to the terms of the Collective Bargaining Agreement and on behalf of whom the Union agrees to make contributions to the Defined Contribution Trust Fund; and (c) any person participating pursuant to the terms of a participation agreement between the Fund and such person's Employer. The Plan adopts the "alumni rule" as set forth in Treasury Regulation §1.410(b)-6(d)(2)(ii) for the purpose of defining a "collectively bargained employee" under the Internal Revenue Code.

Employer means:

(a) Any member of the Association of or other employer association, bound by the terms of a Collective Bargaining Agreement between the Union and such association to make contributions to the Fund;

(b) Any individual, partnership, joint venture, trust or corporation, the employees of which are covered by a Collective Bargaining Agreement between the Union and such person or organization which requires such person or organization to make contributions to the Fund; or

(c) The Union to the extent, and solely to the extent, that it acts in the capacity of an Employer of its collectively bargained Employees on whose behalf it makes contributions to the Fund.

Hour of Service means each hour for which an Employee is directly or indirectly compensated by the Employer for the performance of duties during the applicable computation period.

Normal Retirement Date means the first day of the month coinciding with or following the Participant's 62nd birthday.

Participant means

(a) an Employee who has met the eligibility requirements set forth in Article 3.
(b) An Active Participant is a Participant who has not retired, become disabled, deceased or incurred a Two-Year Break in Service.
(c) A Deceased Participant is a Participant who has deceased and whose Beneficiaries (including his spouse) are eligible to receive benefits under the Plan.
(d) A Disabled Participant is a Participant who has a Total and Permanent Disability and who is entitled to receive benefits under the Plan.
(e) An Inactive Participant is a Participant who has incurred a Two-Year Break in Service and is entitled to receive deferred vested benefits under the Plan.
(f) A Retired Participant means a person who has been a Participant, but who has become entitled to retirement benefits under the Plan.
(g) A Terminated Participant means a person who has been a Participant, but whose employment has been terminated other than by death, disability or retirement.

Plan means the Flint Plumbing and Pipefitting Industry Defined Contribution Plan document.

Plan Year means the 12 consecutive month period from August 1st to July 31st.

Pre-Retirement Survivor Annuity means an annuity for the life of the Participant's Spouse the payments under which must be equal to the amount of benefit which can be purchased with the Accounts of a Participant used to provide the death benefit under the Plan.

Retirement Date means the date as of which a Participant retires for reasons other than Total and Permanent Disability, whether such retirement occurs on a Participant's Normal Retirement Date, Early Retirement Date, or Late Retirement Date.

Spouse means the Participant’s legal spouse who has met all requirements of a valid marriage contract in the state of marriage of such parties.

Total and Permanent Disability means a physical or mental condition of a Participant resulting from bodily injury, disease or mental disorder which renders him incapable of continuing any gainful occupations, which constitutes total disability under the federal Social Security Acts, and for which the Participant has received a Social Security Disability Award.

Trust Fund or Fund means the Flint Plumbing and Pipefitting Industry Defined Contribution Fund.

Two-Year Break in Service means two consecutive Plan Years during which an Employee has not completed more than 159 Hours of Service per Plan Year with an Employer for which contributions are made to either the Flint Plumbing and Pipefitting Industry Pension Fund or the Flint Plumbing and Pipefitting Industry Defined Contribution Plan. Solely for the purpose of determining whether a Participant has incurred a Two Year Break in Service, Hours of Service shall be recognized for Authorized Leaves of Absence and Maternity and Paternity Leaves of Absence.

Authorized Leave of Absence means an unpaid, temporary cessation from active employment with the Employer pursuant to an established non-discriminatory policy, whether occasioned by illness, military service or any other reason.

Maternity or Paternity Leave of Absence means an absence from work for any period by reason of the Employee's pregnancy, birth of the Employee's child, placement of a child with the Employee in connection with the adoption of such child, or any absence for the purpose of caring for such child for a period immediately following such birth or placement. For this purpose, Hours of Service shall be credited for the computation period in which the absence from work begins, only if credit thereof is necessary to prevent the Employee from incurring a One-Year Break in Service, or, in any other case, in the immediately following computation period. The Hours of Service credited shall be those which would normally have been credited but for such absence, or, in any case in which the Board is unable to determine such hours normally credited, eight (8) Hours of Service per day. The total Hours of Service required to be credited for a Maternity or Paternity Leave of Absence shall not exceed 501 hours.

Additional definitions are set forth in the Plan document.

ARTICLE 2 – APPLYING FOR BENEFITS; CLAIM AND APPEAL PROCEDURES

2.1 Application, Forms, and Information.

To receive benefits under the Plan, a Participant or other claimant is required to complete and file an application and all other forms and information required by the Fund within the time periods set by the Fund. Any Participant is required to keep the Fund Office advised of his/her current mailing address. The Fund may rely upon the information provided without further verification.

2.2 Timing and Notification of Benefit Determination.

(a) **Retirement Benefits**. Claims for benefits under the Plan may be filed in writing with the Trustees. Written notice of the disposition of a claim shall be furnished to the claimant within 90 days after the application is filed. This period may be extended by the Fund for up to 90 days, if special circumstances require an extension of the time for processing the claim. In such case, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(b) **Disability Benefits.** A claim for disability benefits includes an initial claim for disability benefit or any rescission of coverage of a disability benefit. In the case of a

claim for disability benefits, the Fund Office shall notify the claimant of the Fund's determination within a reasonable period of time, but not later than 45 days after receipt of the claim. This period may be extended by the Fund for up to 30 days, provided that the Fund Office both determines that such an extension is necessary due to matters beyond the control of the Fund and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Fund Office determines that, due to matters beyond the control of the Fund, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Fund Office notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this provision, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(c) **Extension of Deadlines:** The Plan will disregard the period from March 1, 2020, until the earlier of: (1) 1 year from the date a Participant or Beneficiary becomes eligible for an extended deadline or (2) 60 days after the announced end of the National Emergency or such other date announced by the applicable federal agency (Outbreak Period) for determining the date in which an individual may file a benefit claim above.

2.3 Manner and Content of Notification of Benefit Determination.

The Fund Office shall provide a claimant with written or electronic notification of any claim denial, i.e. adverse benefit determination.

Before the Fund can issue a notice of benefit determination based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of benefit determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Fund can issue a notice of benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of benefit determination is required to be provided, to give the claimant a reasonable opportunity to respond prior to that date.

The notification shall set forth, in a manner calculated to be understood by the Claimant –

(a) The specific reason or reasons for the adverse determination;
(b) Reference to the specific plan provisions on which the determination is based;
(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is

necessary;

(d) A description of the Fund's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review; and

(e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request, or if applicable, a statement that such rule, guideline, protocol or other criterion does not exist.

With respect to an adverse benefit determination regarding disability benefits, the determination must also include the following:

(1) An explanation of the basis for disagreeing with any of the following:
  (i) The health care professionals that treated the Claimant;
  (ii) The advice of the health professional obtained by the Plan; or
  (iii) A disability determination from the Social Security Administration.

(2) A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.

(3) If the denial was based on medical necessity or experimental treatment, the denial must include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claim or statement or a statement that such explanation will be provided free of charge upon request.

(4) The denial must be in a culturally and linguistically appropriate manner.

2.4 Appeal of Adverse Benefit Determination

(a) Appeals must be forwarded to and received by the Fund Office within 60 days (180 days for appeals involving disability benefits) following receipt of a notification of an adverse benefit determination (i.e. denial of claim). As part of any such appeal, a claimant may submit written comments, documents, records, and other information relating to the claim for benefits.

(b) A claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(c) Upon appeal, the Trustees will review 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.

(d) If the appeal is a denial of disability benefits:
  (1) A review on appeal will not afford deference to the initial denial and an individual who made the initial denial, or a subordinate of such individual will not decide an appeal.
  (2) In deciding an appeal of a benefit based on medical judgment, the fiduciary deciding the appeal shall consult with a health care professional who has appropriate training in the field of medicine involved (and who was not

involved in reviewing the initial claim); and

(3) The Plan must provide for the identification of any medical or vocational experts whose advice was obtained by the plan in connection with the initial denial, regardless of whether the advice was relied upon.

(e) The Fund will disregard the Outbreak Period for determining the date in which a claimant may file an appeal of adverse benefit determination.

2.5 Trustees Decision on Appeal

(a) Timing of Decision. The Trustees shall make a benefit determination on appeal no later than the date of the board meeting that immediately follows the Fund Office's receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the benefit determination may be made no later than the date of the second board meeting following the Fund Office's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third board meeting following the Fund Office's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Fund Office shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Fund Office shall notify the claimant of its decision on appeal but not later than five days after the benefit determination is made. Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date. Before the Fund can a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

(b) Manner and Content of Notification of Trustees Decision on Appeal. The Fund Office shall provide a claimant with written or electronic notification of any adverse benefit determination on review. The notification shall set forth, in a manner calculated to be understood by the claimant –

(1) The specific reason or reasons for the adverse determination;
(2) Reference to the specific plan provisions on which the determination is based;
(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
(4) A statement of the claimant's right to bring a civil action under section 502(a) of ERISA;
(5) A statement describing any contractual limitation period that applies to the Claimant's right to bring an action under ERISA §502(a) and the calendar date on which such contractual limitations expires;

(6) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request, or, if applicable, a statement that such rules or guidelines do not exist;

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

(8) 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."

In addition to the above, a notice of decision on appeal pertaining to a claim for disability benefits will include the following:

(1) An explanation of the basis for disagreeing with any of the following:
   (i) The health care professionals that treated the Claimant;
   (ii) The advice of the health professional obtained by the Plan; or
   (iii) A disability determination from the Social Security Administration.

(2) The benefit denial must be in a culturally and linguistically appropriate manner.

2.6 Discretion of Trustees.

The Trustees have full discretionary authority to determine eligibility for benefits, interpret Plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

2.7 Timely Submission of Appeals.

All appeals must be timely submitted. A Participant or other claimant who does not timely submit an appeal waives his/her right to have the benefit denial further reviewed by the Fund or in a court of law.

2.8 Limitations of Actions.

No action may be brought if a Claimant has failed to exhaust the claims and appeal procedures set forth herein. No action may be brought to recover benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal.

2.9 Failure to Follow Claims Procedures.

If the Plan fails to follow claims procedures with respect to any claim for benefits, the Claimant is deemed to have exhausted administrative remedies and is entitled to pursue all remedies under ERISA §502(a) on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits. In addition, if the plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the

claimant chooses to pursue remedies under section ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees. The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

2.10 Avoiding Conflicts of Interest.

The Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

ARTICLE 3 – ELIGIBILITY AND VESTING

3.1 Effective Date of Participation. Any Employee shall be eligible to participate on the first day of the calendar month in which he commences to work in Covered Service.

3.2 Determination of Eligibility. The Board shall determine the eligibility of each Employee for participation in the Plan based upon information furnished by the Employer. Such determination shall be conclusive and binding upon all persons.

3.3 Vesting. A Participant shall become fully vested in his Account immediately upon entry into the Plan and his interest shall be nonforfeitable at all times.

ARTICLE 4 – CONTRIBUTION AND ALLOCATION

4.1 Contributions.

(a) Employer Contributions. Employer Contributions shall be made as required under the Collective Bargaining Agreement or other agreement requiring Employer Contributions to the Fund.

(b) Elective Contributions. An Employer shall contribute a Participant's Elective Contributions to the Plan. Elective Contributions must be deferred before becoming currently available to the Participant. Elective Contributions may be contributed to the Plan only if the amounts would have been received in cash by the Participant in the Plan Year or are attributable to services performed by the Participant in the Plan Year, and except for the Participant's election, would have been received within 2 ½ months following the end of the Plan Year

(1) Enrollment. Participants may enroll to make Elective Contributions upon completion of a 401(k) Election Form by the Participant and his/her Employer and receipt of such completed form by the Fund, effective as of the first day of the next pay period that the Participant’s election can be processed or such other dates as determined by the Trustees. The 401(k) Election Form will be provided by the Fund Office. A Participant's election authorizing

Elective Contributions will remain in effect until he/she leaves the employ of such Employer, unless sooner amended or discontinued. A new 401(k) Election Form must be completed for each Employer.

(2) Amount. A Participant's Elective Contributions for a Plan Year under this Plan and all other cash or deferred arrangements of an Employer shall be made in specific dollar amounts per hour (or such other amount authorized by the Trustees), not to exceed the dollar limitation of Code Section 402(g)(1) as in effect for such calendar year or such limit imposed by the Collective Bargaining Agreement covering such Participant. Such amounts may be limited pursuant to Section 4.15 (ADP test) below.

(3) Revoking an Election to Contribute. A Participant may revoke his election to make Elective Contributions by completing a new 401(k) Enrollment Form indicating "$0.00" deductions per hours, to be effective as of the first day of the next pay period that the Participant's revocation can be processed or such other dates as determined by the Trustees. A Participant's election to revoke shall be made at such time and in a manner approved by the Trustees

(4) Election to Change Contribution Amount. A Participant may increase or decrease the amount of his Elective Contributions by completing a new 401(k) Enrollment Form, to be effective as of the first day of the next pay period that the Participant's change can be processed or such other dates as determined by the Trustees. A Participant's election to change his Elective Contributions shall be made at such time and in a manner approved by the Trustees.

(5) Return of Excess Deferrals. A Participant may notify the Trustees that the Participant has made excess deferrals for a calendar year (e.g. in excess of the amounts set forth in (2), above).

(c) **Crediting of Contributions.** Employer Contributions and Elective Contributions will be credited to the Participant's account on whose behalf the contributions are made. However, although Participants will receive credit for purposes of vesting, Participants will not receive monetary credit for the amount of money that the Employer did not contribute since the Fund did not receive the money. Therefore, each Participant's account will only reflect the amount of contributions made by the Employer that have been received by the Fund.

4.2 Participant Directed Accounts.

A Participant Account shall be established for each Employee. Such Account shall include money purchase, profit sharing, and employee Elective Contributions, as applicable. Each such source of contributions, if any, shall be separately accounted for by the recordkeeper. The maintenance of individual accounts is for recordkeeping purposes.

The Plan is a plan described in section 404(c) of the Employee Retirement Income Security Act, and title 29 of the Code of Federal Regulations, Sec. 2550.440c-1. **This means each Participant is in control of, and solely responsible for, the investment of his Account.** No Trustee or Plan representative or agent is empowered to advise the Participant as to the manner in which his contribution should be invested. The fact that a particular investment option is available is not to be construed as a recommendation of that investment for a Participant's account.

Participants may make changes in their investments daily and their changes will be effective as of the next business day after a change is completed. To select or change the investment in an account, a Participant may access his account by calling Transamerica at 1-800-755-5801, or online at my.trsretire.com, or contact the Fund Office at (888) 797-5862 to request an investment change form. There are no guaranteed results for any investment. Each Participant is responsible for confirming that any investment change requested has been implemented. **All account statements should be carefully reviewed by Participants**.

Participants are provided periodic statements explaining any limitations on making investment changes, any restrictions on the exercise of voting or similar rights pertaining to a particular investment alternative, and a description of any transaction fees and expenses which affect a Participant's account balance in connection with changing his investment alternatives. Participants are also provided a description of the investment alternatives available under the Plan and, with respect to each designated investment alternative, a general description of the investment objectives and risk and return characteristics of each such alternative. Additional information about any of the investment options available in the Plan may be obtained by calling Transamerica at 1-800-755-5801, the Fund Office, or online at my.trsretire.com. The information available includes:

- A description of the annual operating expenses of each available investment alternative (e.g., investment management fees, administrative fees, transaction costs) and the aggregate amount of such expenses expressed as a percentage of average net assets;
- Copies of any prospectuses, financial statements and reports, and of any other materials relating to the investment alternatives available under the Plan;
- Information concerning the value of shares or units in available investment alternatives, as well as the past and current investment performance of such alternatives, determined net of expenses; and
- Information concerning the value of shares or units in investment alternatives held in a Participant's account.

EACH PARTICIPANT IS RESPONSIBLE FOR CONFIRMING THAT ANY INVESTMENT CHANGE REQUESTED HAS BEEN IMPLEMENTED (REGARDLESS OF WHETHER THE CHANGE REQUEST IS MADE ONLINE, REQUESTED VIA PHONE OR IN WRITING). ALL ACCOUNT STATEMENTS SHOULD BE CAREFULLY REVIEWED BY PARTICIPANTS.

If a Participant does not make an election as to how the Fund should invest the assets in his Account, contributions received on a Participant's behalf are directed automatically to a qualified default investment alternative (QDIA) under Department of Labor regulations. Notices regarding the Fund QDIA are provided as required by law.

4.3 Vesting.

A Participant's interest in his Account shall be fully vested and non-forfeitable at all times.

4.4 Valuation of Participant Accounts.

As of each day the United States stock market is open, the value of a Participant's account shall be valued. The fact that Participant Accounts are established and valued as of each Valuation Date shall not give any Employee or others any right, title or interest in the Fund or

its assets, or in the Participant Account, except at the time or times, and upon the terms and conditions herein provided, or as required by law.

4.5 Quarterly Service Fee and Quarterly Statements.

A Participant's Account is charged a quarterly service fee. This fee is automatically deducted from the Participant's Account once a quarter. This fee pays for the expenses incurred by the Fund in providing and managing each Participant's Account and the Plan. These expenses include legal fees, service fees, administration fees and fees and expenses incurred in complying with federal laws. This amount is subject to change from time to time in the discretion of the Trustees. Participants receive quarterly statements setting forth the value of his/her account, including contributions, withdrawals, investment gains and losses, and fees.

4.6 Maximum Annual Additions

Notwithstanding anything to the contrary contained herein, the total annual additions to a Participant's Account for a Plan Year will not exceed the lesser of $57,000 or 100% of the Participant's total "compensation" for the year, subject to adjustment annually as provided in Code Section 415(d) and applicable Treasury Regulations.

ARTICLE 5 – DETERMINATION AND DISTRIBUTION OF BENEFITS

5.1 Determination of Benefits Upon Retirement.

Every Participant may terminate his employment and retire on his Normal Retirement Date or Early Retirement Date. Upon such Retirement Date, all amounts credited to such Participant's Account shall become distributable. However, a Participant may postpone the termination of his employment and benefits will be payable upon retirement on his Late Retirement Date.

5.2 Determination of Benefits Upon Death.

Benefits upon Death shall be determined as follows:

(a) Upon the death of a Participant before his Retirement Date or other termination of his employment, all amounts credited to such Participant's Account shall be fully vested. The value of the deceased Participant's Account shall be distributed to the Participant's Beneficiary as soon as administratively practical after an application for benefits has been submitted to and approved by the Board.

(b) The Board of Trustees, in accordance with the provisions of Section 5.9, shall distribute any remaining amounts credited to the account of such deceased Participant to such Participant's Beneficiary as soon as administratively practical after an application for benefits has been submitted to and approved by the Board.

(c) The Board of Trustees may require such proper proof of death and such evidence of the right of any person to receive payment of the value of the account of a deceased Participant or Participant as the Board may deem desirable. The Board's determination of death and of the right of any person to receive payment shall be conclusive; and

(d) Unless otherwise elected in the manner prescribed in Section 5.9 the Beneficiary of the death benefit shall be the Participant's Spouse, who shall receive such benefit in the form of a Pre-Retirement Survivor Annuity pursuant to Section 5.9. Except, however, the Participant may designate a Beneficiary other than his Spouse if:

(1) The Participant and his spouse have validly waived the Pre-Retirement Survivor Annuity in the manner prescribed in Section 5.6, and the Spouse has waived her right to be the Participant's Beneficiary; or

(2) The Participant is legally separated or has been abandoned (within the meaning of local law) and the Participant has a court order to such effect (and there is no "qualified domestic relations order" as defined in Code Section 414(p) which provides otherwise);

(3) The Participant has no Spouse; or

(4) The Spouse cannot be located.

In such event, the designation of a Beneficiary shall be made on a form satisfactory to the Board. A Participant may at any time revoke his designation of a Beneficiary or change his Beneficiary by filing written notice of such revocation or change with the Board. However, the Participant's spouse must again consent in writing to any change in Beneficiary unless the original consent acknowledged that the spouse had the right to limit consent only to a specific Beneficiary and that the spouse voluntarily elected to relinquish such right. In the event no valid designation of Beneficiary exists at the time of the Participant's death, the death benefit shall be payable to his estate.

(e) Any consent by the Participant's spouse to waive any rights to the death benefit must be in writing, must acknowledge the effect of such consent and must be witnessed by a Plan representative or a Notary Public. Also, the consent must be irrevocable and must acknowledge the specific non-spouse Beneficiary.

5.3 Determination of Benefits in Event of Disability.

In the event of a Participant's Total and Permanent Disability prior to his Retirement Date or other termination of employment, all amounts credited to such Participant's Account shall be fully vested. Following the event of Total and Permanent Disability, the Board of Trustees, in accordance with the provisions of Sections 5.5 and 5.7, shall distribute to such Participant all amounts credited to such Participant's Account as though he had retired as soon as administratively practical after an application for benefits has been submitted to and approved by the Board.

5.4 Determination of Benefits Upon Two Year Break in Service.

At the election of a Participant, he may receive a distribution of his benefits after a Two-Year Break in Service. Notwithstanding any provision in the Plan to the contrary, if the value of a Participant's benefit derived from Employer and Employee contributions does not exceed $1,000, the Board may direct the Board of Trustees to cause the entire vested benefit to be paid to such Participant in a single lump sum without the Participant’s consent. If the value is between $1,000 through $5,000, the amount may be paid if consent to the distribution is made in writing by the Terminated Participant.

5.5 Distribution of Benefits.

(a) The Board, pursuant to the election of the Participant, shall distribute to a Participant or his Beneficiary any amount to which he is entitled under the Plan in one or more of the following methods:

(1) Unless otherwise elected as provided below, a Participant who is married on the "annuity starting date" shall receive the value of his benefits in the form

of a joint and survivor annuity. The joint and survivor annuity shall be equal in value to a single life annuity. Such joint and survivor benefits following the Participant's death shall continue to the spouse during the spouse's lifetime at a rate equal to 50% of the rate at which such benefits were payable to the Participant. The Participant may elect to receive a smaller annuity benefit with continuation of payments to the spouse at a rate of 75% or 100% of the rate payable to a Participant during his lifetime. An unmarried Participant shall receive the value of his benefit in the form of a life annuity. Such unmarried Participant, however, may elect in writing to waive the life annuity. The election must comply with the provisions of this Section as if it were an election to waive the joint and survivor annuity by a married Participant, but without the spousal consent requirement. Such annuity payments are immediately payable upon meeting the eligibility requirements for benefits and the approval of an application for such benefits.

(2) Any election to waive the joint and survivor annuity must be made by the Participant in writing during the election period and be consented to by the Participant's spouse. Such election shall designate a Beneficiary and a form of benefit that may not be changed without spousal consent (unless the consent of the spouse expressly permits designations by the Participant without the requirement of further consent by the spouse). Such spouse's consent must be irrevocable and must acknowledge the effect of such election and be witnessed by a Plan representative or a Notary Public. Such consent shall not be required if it is established to the satisfaction of the Board that the required consent cannot be obtained because there is no spouse, the spouse cannot be located, or other circumstances that may be prescribed by Regulations. The election made by the Participant and consented to by his spouse may be revoked by the Participant in writing without the consent of the spouse at any time during the election period. The number of revocations shall not be limited. Any new election must comply with the requirements of this paragraph. A former spouse's waiver shall not be binding on a new spouse.

(3) The election period to waive the joint and survivor annuity shall be no less than the 30 day period and no more than the 180 day period ending on the "annuity starting date." A Participant may elect to waive the requirement that such notice be provided at least 30 days prior to commencement of benefits provided benefits commence no sooner than eight days following the provision of such notice.

(4) For purposes of this Section, the "annuity starting date" means the first day of the first period for which an amount is payable as an annuity, or, in the case of a benefit not payable in the form of an annuity, the first day on which all events have occurred which entitle the Participant to such benefit.

(5) With regard to the election, the Board shall provide the Participant within a reasonable period of time before the "annuity starting date" (and consistent with Treasury Regulations), a written explanation of:

(A) The terms and conditions of the joint and survivor annuity;

(B) The Participant's right to make an election to waive the joint and survivor annuity;

(C) The right of the Participant's spouse to consent to any election to waive the joint and survivor annuity;

(D) The right of the Participant to revoke such election, and the effect of such revocation;

(E) A description of a Participant's right to defer a distribution; and

(F) A description of the consequences of failing to defer receipt of a distribution.

(b) In the event a married Participant duly elects pursuant to subsection (a)(2) above not to receive the retirement benefit in the form of a joint and survivor annuity, or if such Participant is not married, in the form of a life annuity, the Board, pursuant to the election of the Participant, shall direct the Board of Trustees to distribute to a Participant or his Beneficiary any amount to which he is entitled under the Plan in one or more of the following methods:

(1) One lump sum payment in cash; or

(2) Purchase of or providing an annuity. However, such annuity may not be in any form that will provide for payments over a period extending beyond either the life of the Participant (or the lives of the Participant and his designated Beneficiary) or the life expectancy of the Participant (or the life expectancy of the Participant and his designated Beneficiary).

(3) In equal monthly, payments in an amount determined by the Participant. The monthly payment amount shall not be less than $100. The Participant may change the monthly payment amount one per Plan Year. This Section 5.5(b)(3) is subject to the Required Minimum Distribution rules provided for in Section 5.7 and under Section 401(a)(9) of the Internal Revenue Code.

(c) The present value of a Retired Participant's joint and survivor annuity derived from Employer and Employee contributions, if any, may not be paid without his written consent if the value exceeds $1,000. If the present value is between $1,000 through $5,000, the amount may be paid if consent to the distribution is made in writing by the Participant. Further, the spouse of a Retired Participant must consent in writing to any immediate distribution. If the value of the Retired Participant's benefit derived from Employer and Employee contributions, if any, does not exceed $1,000, the Board may immediately distribute such benefit without such Retired Participant's or spouse’s consent. No distribution may be made under the preceding sentence after the annuity starting date unless the Participant and his spouse consent in writing to such distribution. Any written consent required under this paragraph must be obtained not more than 180 days before commencement of the distribution and shall be made in a manner consistent with Section 5.5(a)(2).

(d) Any distribution to a Participant who has a benefit which exceeds, or has ever exceeded, $1,000 shall require such Participant's consent if such distribution commences prior to the later of his Normal Retirement Age or age 62. With regard to this required consent:

(1) No consent shall be valid unless the Participant has received a general description of the material features and an explanation of the relative values of the optional forms of benefit available under the Plan that would satisfy the notice requirements of Code Section 417;

(2) The Participant must be informed of his right to defer receipt of the distribution. If a Participant fails to consent, it shall be deemed an election to defer the commencement of payment of any benefit. However, any election to defer the receipt of benefits shall not apply with respect to distributions which are required under Section 5.5(e);

(3) Notice of the rights specified under this paragraph shall be provided no less than 30 days and no more than 180 days before the "annuity starting date". A Participant may elect to waive the requirement that such notice be provided at

least 30 days prior to commencement of benefits provided benefits commence no sooner than eight days following the provision of such notice; and

(4) Written consent of the Participant to the distribution must not be made before the Participant receives the notice and must not be made more than 180 days before the "annuity starting date".

5.6 Distribution of Benefits Upon Death.

Upon the death of a Participant, benefits will be distributed as follows:

(a) Unless otherwise elected as provided below, a Participant who dies before the annuity starting date and who has a surviving spouse shall have his death benefit paid to his surviving spouse in the form of a Pre-Retirement Survivor Annuity. The Participant's spouse may direct that payment of the Pre-Retirement Survivor Annuity commence within a reasonable period after the Participant's death. If the spouse does not so direct, payment of such benefit will commence at the time the Participant would have attained the later of his Normal Retirement Age or age 62. However, the spouse may elect a later commencement date. Any distribution to the Participant's spouse shall be subject to the rules specified in Section 5.6(h).

(b) Any election to waive the Pre-Retirement Survivor Annuity before the Participant's death must be made by the Participant in writing during the election period and shall require the spouse's irrevocable consent in the same manner provided for in Section 5.5(a)(2). Further, the spouse's consent must acknowledge the specific non-spouse Beneficiary and the alternative form of death benefit to be paid in lieu of the Pre-Retirement Survivor Annuity. Notwithstanding the foregoing, the non-spouse Beneficiary or the alternative form of death benefit need not be acknowledged, provided the consent of the spouse acknowledges that the spouse has the right to limit consent only to a specific Beneficiary or a specific form of benefit and that the spouse voluntarily elects to relinquish one or both of such rights.

(c) The election period to waive the Pre-Retirement Survivor Annuity shall begin on the first day of the Plan Year in which the Participant attains age 35 and end on the date of the Participant's death. In the event a vested Participant separates from service prior to the beginning of the election period, the election period shall begin on the date of such separation from service.

(d) With regard to the election, the Board shall provide each Participant within the applicable period, with respect to such Participant (and consistent with Regulations), a written explanation of the Pre-Retirement Survivor Annuity containing comparable information to that required pursuant to Section 5.5(a)(5). For the purposes of this paragraph, the term "applicable period" means, with respect to a Participant, whichever of the following periods ends last:

(1) The period beginning with the first day of the Plan Year in which the Participant attains age 32 and ending with the close of the Plan Year preceding the Plan Year in which the Participant attains age 35;

(2) A reasonable period after the individual becomes a Participant. For this purpose, in the case of an individual who becomes a Participant after age 32, the explanation must be provided by the end of the three-year period ending with the first day of the first Plan Year for which the individual is a Participant;

(3) A reasonable period ending after Code Section 401(a)(11) applies to the Participant; or

(4) A reasonable period ending after separation from service in the case of a Participant who separates before attaining age thirty-five (35). For this purpose, the Board must provide the explanation at the time of separation or within one year after separation.

(e) If the value of the Pre-Retirement Survivor Annuity derived from Employer and Employee contributions does not exceed $1,000, the Board may direct the immediate distribution of such amount to the Participant's spouse. No distribution may be made under the preceding sentence after the annuity starting date unless the spouse consents in writing. If the value exceeds $1,000, an immediate distribution of the entire amount may be made to the surviving spouse, provided such surviving spouse consents in writing to such distribution. Any written consent required under this paragraph must be obtained not more than 90 days before commencement of the distribution and shall be made in a manner consistent with Section 5.5(a)(2).

(f) In the event the death benefit is not paid in the form of a Pre-Retirement Survivor Annuity, it shall be paid to the Participant's Beneficiary by either of the following methods, as elected by the Participant (or if no election has been made prior to the Participant's death, by his Beneficiary) subject to the rules specified in Section 5.6(g):

(1) One lump sum payment in cash or in property; or

(2) Purchase of or providing an annuity. However, such annuity may not be in any form that will provide for payments over a period extending beyond the life expectancy of the Participant (or the life expectancies of the Participant and his designated Beneficiary).

5.7 Required Distributions

The Fund will make required distributions as required by and subject to the provisions of the Internal Revenue Code. In general, a Participant's benefits shall be distributed to him not later than April 1st of the calendar year following **the later of** the calendar year in which the Participant attains:

A. age 70½, or age 72 (For Participants whose birthdate is on or after July 1, 1949), or age 73 (For Participants whose birthdate is on or after January 1, 1951, and on or before December 31, 1959)

OR:

B. the calendar year in which the Participant retires (other than a 5% owner).

Please contact the Fund Office for more information.

5.8 Timing of Distribution

Benefits will be distributed as soon as administratively practical after an application for benefits has been submitted to the Board on a form approved by the Board and the application is approved by the Board.

5.9 Distribution for Minor Beneficiary

In the event a distribution is to be made to a minor, the Board may direct that such distribution be paid to the legal guardian, or if none, to a parent of such Beneficiary or a responsible adult with whom the Beneficiary maintains his residence, or to the custodian for such Beneficiary under the Uniform Gift to Minors Act or Gift to Minors Act, if such is permitted by the laws of the state in which said Beneficiary resides.

5.10 Location of Participant or Beneficiary Unknown

In the event that all, or any portion, of the distribution payable to a Participant or his Beneficiary remains, at the expiration of two years after it becomes payable, unpaid solely by reason of the inability of the Fund, after sending a registered letter, return receipt requested, to the last known address, and after further diligent effort, to ascertain the whereabouts of such Participant or his Beneficiary, the benefit is forfeited and will be used to reduce the cost of the Plan. In the event a Participant or Beneficiary is located subsequent to the benefit being forfeited, the benefit will be restored**.**

5.11 Qualified Domestic Relations Orders (QDROs).

All rights and benefits, including elections, provided to a Participant in the Plan shall be subject to the rights afforded to any alternate payee under a QDRO. Furthermore, a distribution to an alternate payee shall be permitted as authorized by a QDRO even if the affected Participant has not reached the earliest retirement age under the Plan. Participants and Beneficiaries may obtain, without charge, a copy of the Plan's QDRO Procedures from the Fund Office.

5.12 Service Credit with Respect to Qualified Military Service

The Plan will comply with providing credit for benefits and vesting for a period of military service (i.e. service covered under the Uniformed Services Employment and Reemployment Act) subject to the following:

- Notification: Prior to entering military service the Participant must provide advance written or verbal notice to his Employer, unless giving such notice is precluded by military necessity or is otherwise impossible or unreasonable.
- Disclosure Requirement: Upon application for re-employment, the Participant must provide documentation to establish the timeliness of his application for re-employment (a copy of discharge papers shall be sufficient).
- Crediting Military Service: To determine the number of hours to be credited for military service, the Board of Trustees shall review the Participant's work history during a period equal to at least two times the amount of time spent in military service.
- Service and Discharge: Credit will be given under this section only if service is for no more than five years, unless extended at the government's request, and the Participant is discharged under honorable conditions.

Further, a Participant will only be entitled to the benefits of this section if he returns to work under the Collective Bargaining Agreement within the following time frames: (1) for uniformed service of less than 31 days, by the next work day after the end of service plus eight hours, or as soon as possible after the end of the eight-hour period if reporting earlier is impossible through no fault of his own; (2) for service of more than 30 days but less than 181

days, within 14 days of completing the service, or the next full calendar day if returning earlier is impossible through no fault of his own; or (3) for service of more than 180 days, within 90 days after completion of the service.

Notwithstanding, a person reemployed under this section shall be entitled to accrued benefits that are contingent on the making of, or derived from, elective deferrals only to the extent the person makes payment to the Plan with respect to such contributions or deferrals. No such payment may exceed the amount the person would have been permitted or required to contribute had the person remained continuously employed by the Employer throughout the period of qualified military service. Any payment to the Plan described in this paragraph shall be made during the period beginning with the date of reemployment and ending on the date which is equal to three times the period of the person's qualified military service, not to exceed five years.

Notwithstanding the foregoing, the beneficiary of a Participant on a leave of absence to perform military service with reemployment rights under Section 414(u) of the Internal Revenue Code shall be entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) that would be provided under the Plan had the Participant died as an active Participant in accordance with Section 401(a)(37) of the Internal Revenue Code.

5.13 Loans to Participating Employees

The Board of Trustees, in its discretion, may authorize a loan to a Participant who is a party in interest, within the meaning of ERISA Section 3(14), upon receipt of a written request from the Participant. Loans may be made with Participant's Elective Contributions and/ or Employer Contributions.

The total amount of any such loan will not exceed the lesser of $50,000 or 50% of the value of the Participant's vested Account balance. The $50,000 limitation will be reduced by the excess, if any, of the highest outstanding balance of loans from the Plan during the one year period ending on the day before the date on which such loan was made over the outstanding balance of loans from the Plan on the date that such loan was made.

No subsequent loans will be allowed if a Participant has defaulted on a loan. No subsequent loans will be allowed if the prior loan has not been repaid in full.

A request by a Participant for a loan will be made in writing to the Board and will specify the amount of the loan, and the Account(s) of the Participant from which the loan should be made. The terms and conditions on which the Board will approve loans under the Plan will be applied on a reasonably equivalent basis with respect to all Participants. If a Participant's request for a loan is approved by the Board, the Board will arrange for the distribution of the specified amount in a single sum payment of cash to the Participant.

Loans will be made on such terms and subject to such limitations as the Board may prescribe, provided any such loan is evidenced by a written promissory note, bears a reasonable rate of interest on the unpaid principal, is adequately secured and will be repaid by the Participant over a period not to exceed five years, unless the loan is for the purpose of acquiring a dwelling unit used or to be used within reasonable time as the principal residence of the

Participant. The interest rate charged on a loan must be at least equivalent to the prevailing interest rate charged by persons in the business of lending money for loans which would be made under similar circumstances. Loan repayments will be suspended while a Participant is performing service in the uniformed services as provided in Code Section 414(i)(4).

Any loan to a Participant under the Plan will be secured by the pledge of 50% of the Participant's right, title and interest in his Account. The pledge will be evidenced by the execution of a promissory note by the Participant.

The Board will have the sole responsibility for ensuring that a Participant timely makes all scheduled loan payments. Repayment will be paid to the Trust accompanied by documentation identifying the Participant on whose behalf the loan repayment is being made. Any loan must be amortized on a substantially level basis, with payments not less frequently than monthly over the term of the loan. A loan may be prepaid without penalty at any time.

In the event of a default by a Participant on a loan repayment, at the discretion of the Board all remaining principal payments on the loan will be immediately due and payable. The Board will be authorized (to the extent permitted by law) to take any and all actions necessary and appropriate to enforce collection of the unpaid loan. However, in the event of a default, foreclosure on the note and attachment of security will not occur until a distributable event occurs under the Plan. A default will be deemed to have occurred if any loan payment has not been made within 90 days of when the payment was due to be paid by the Participant.

Upon a Participant's retirement or death, or upon a Participant's earlier distribution, the unpaid balance of any loan, including any unpaid interest, will be deducted from the payment or distribution from the Plan to which said Participant or his designated Beneficiary may be entitled and the vested interest in the Account will be correspondingly reduced.

The Administrator shall issue written loan guidelines, which shall form part of the Plan, describing the procedures and conditions for making loans, and may revise those guidelines at any time, for any reason.

A Participant must obtain the consent of his spouse, if any, to use the Account balance as security for the loan. Spousal consent shall be obtained no earlier than the beginning of the 90-day period that ends on the date on which the loan is to be so secured. The consent must be in writing, must acknowledge the effect of the loan and must be witnessed by a Plan representative or notary public. Such consent shall thereafter be binding with respect to the consenting spouse or any subsequent spouse with respect to that loan. A new consent shall be required if the Account balance is used for renegotiation, extension, renewal or other revision of the loan.

5.14 Direct Rollover

As required by law, Participants will receive information regarding the ability to rollover distributions to Eligible Retirement Plans.

ARTICLE 6 - MISCELLANEOUS

6.1 Amendment. The Board has the right to amendment the Plan at any time.

6.2 Termination

The Board has the right to terminate the Plan. Upon any full termination, all amounts credited to the affected Participants' Accounts shall become 100% vested and the Board will direct the distribution of assets of the Trust Fund to participants, which is consistent with an satisfies the provisions of 5.5, above.

6.3 Merger or Consolidation

The Plan may be merged or consolidated with, or its assets and/or liabilities may be transferred to any other Plan only if the benefits which would be received by a Participant of this Plan, in the event of a termination of the Plan immediately after such transfer, merger or consolidation, are at least equal to the benefits the Participant would have received if the Plan had terminated immediately before the transfer, merger or consolidation, and such transfer, merger or consolidation does not otherwise result in the elimination or reduction of any "Section 411(d)(6) protected benefits."

6.4 Transfers From Qualified Plans

With the consent of the Board and subject to the terms of the Plan, Participants may transfer funds from other Qualified Multi-Employer Defined Contribution Plans, provided that the Plan from which such Funds are transferred permits the transfer to be made and the transfer will not jeopardize the tax-exempt status of the Plan or create adverse tax consequences to the Employer. The amounts transferred shall be considered an additional Accrued Benefit and shall be fully Vested at all times and shall not be subject to forfeiture for any reason.

6.5 Outstanding Payments

In the event any payment issued by the Fund, for any reason, has not been redeemed by the payee for a period 24 months, or such lesser time set forth on the payment issued by the Fund, such payment is void and reverts to the Plan as a Plan asset.

6.6 Overpayment

The Fund has the right to recover from any Participant, Retiree, Spouse, Surviving Spouse, Beneficiary, or other payee any amounts paid by the Fund which were not properly owing under the terms of the Plan, whether such amounts were paid by mistake, fraud, or any other reason. The Fund has the right to pursue the payee (including the Participant/Retiree and his/her Spouse jointly and severally), for the full amount due and owing under this provision. At the Fund's sole option, it may enforce this provision by offsetting future benefits, or crediting Contributions received against the debt owed the Fund under this provision, until the amount owed has been recovered.

6.7 Reciprocity

The Fund may enter into reciprocity agreements under terms and conditions acceptable to the Trustees.

ARTICLE 7 – REQUIRED PROVISIONS

The following information is required to be provided by law:

A. **Type of Administration/Plan Administrator/Plan Sponsor/Counsel**: The Board of Trustees of the Flint Plumbing and Pipefitting Industry Defined Contribution Plan is the Plan Administrator and Plan Sponsor. As such, the Trustees are responsible for overall Plan

administration. There are three Trustees appointed by the Union and three Trustees appointed by the Association. The current Trustees are:

Union Trustees	**Employer Trustees**
Daniel Gaudet, Chairman Local Union 370 2151 W. Thompson Road Fenton, MI 48430	Dominic Goyette, Secretary Goyette Mechanical Company 3842 Gorey Flint, MI 48506
Zach Desrochers Local Union 370 2151 W. Thompson Road Fenton, MI 48430	Kristine Menzing Dickerson Mechanical P.O. Box 250 Davison, MI 48423
Paul Gonzales Local Union 370 2151 W. Thompson Road Fenton, MI 48430	David Hendershot Ecker Mechanical Contractors, Inc. P.O. Box 19099, Burton, MI 48529 3149 E. Maple, Burton, MI 48529

LEGAL COUNSEL FOR THE PLAN

Michael J. Asher, Esq.
Jacqueline Kelly, Esq.
AsherKelly
25800 Northwestern Highway, Suite 1100
Southfield, MI 48075
(248) 746-2710

The day-to-day responsibilities for Plan administration are performed by the Administrative Manager and Plan Office, TIC International Corporation, 6525 Centurion Drive, Lansing, MI 48917-9275, Toll Free (888) 797-5862, (517) 321-7502, Fax (517) 321-7508. Office hours are Monday through Friday 7:30 a.m. to 5:30 p.m.

B. Effective Date of Plan: July 29, 1994

C. Agent for Service of Legal Process: Service of process should be made upon the Plan Office, TIC International Corporation, 6525 Centurion Drive, Lansing, MI 48917-9275, Toll Free (888) 797-5862, (517) 321-7502, Fax (517) 321-7508. Service of legal process may also be made upon any Trustee.

D. Type of Plan/Employer Identification Number/Plan Year: The Flint Plumbing and Pipefitting Industry Defined Contribution Plan was originally established as a money purchase pension plan on July 29, 1994. It was subsequently converted into a profit sharing plan with a 401(k) feature, effective as of August 1, 2005. The employer identification number assigned by the IRS is 38-6254230. The Plan number is 002. The Plan Year begins August 1st of each year and runs to the following July 31st.

E. Collective Bargaining Agreements: The Plan is maintained pursuant to collective bargaining agreements. Copies of such agreements may be obtained upon written request to

the Plan Office or are available for examination by participants and beneficiaries at the Plan Office. Alternatively, within 10 days of a written request, such agreements will be made available at the Union Hall or at any employer establishment where at least 50 or more participants are customarily working. The Plan may impose a reasonable charge for such copies.

F. **Source of Plan Contributions:** The primary source of financing for the benefits provided under the Plan and for the expenses of the Plan operations are contributions in the form of elective contributions and prior employer contributions and earnings thereon. A complete list of the employers contributing to the Plan may be obtained upon written request to the Plan Office and may be examined at the Plan Office. Other contributions held in the Plan for participants are employer money purchase pension plan contributions and amounts rolled over from other qualified plans. The Plan also provides for discretionary profit sharing contributions.

G. **Pension Trust Assets and Reserves:** The Board of Trustees holds all assets in trust for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses.

H. **PBGC:** Benefits under this pension plan are not guaranteed by the Pension Benefit Guaranty Corporation ("PBGC"), as the PBGC only guarantees benefits under a defined benefit pension plan and the plan is a defined contribution pension plan.

I. **Statement of ERISA Rights:** As a participant in the Flint Plumbing and Pipefitting Industry Defined Contribution Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 62) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for Plan participants,

ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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

Assistance with Your Questions: If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

J. **Termination of the Plan:** If the Plan is terminated, Plan assets shall be used to pay benefits and expenses incurred prior to termination and expenses incident to the termination.

This Summary Plan Description is not intended to cover every detail of the Plan or every situation that might occur. It is simply a summary. The complete Plan is available for inspection at any time at the Plan Office. If there is any conflict between this summary and the Plan, the Plan controls. For a more detailed statement of your rights and obligations consult the Plan document.

W2440430

FLINT PLUMBING & PIPEFITTING INDUSTRY PENSION FUND
PENSION FUND DATA FORM

(DO NOT FILL OUT IF YOU ARE MARRIED OR YOU ARE A BENEFICIARY ALREADY RECEIVING BENEFITS)

Participant Name (Please Print): _____

Address: _____

_____

Social Security Number: _____Date of Birth:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

BENEFICIARY DESIGNATION FOR UNMARRIED PARTICIPANTS ONLY

I understand that this beneficiary designation cancels any previous designation I may have made. Further, I understand that this designation shall automatically be cancelled if I am or become legally married for one year and my spouse will automatically become my beneficiary.

I hereby state that I am **NOT** married and I hereby designate as my beneficiary/beneficiaries to receive any benefits that may be payable under the Pension Plan in the event of my death the following person(s):

PENSION FUND DEATH BENEFIT BENEFICIARY:

Beneficiary's Name (Please Print):_____

Address:_____

_____

Social Security Number:_____Date of Birth:_____

Relationship:_____

_____ _____

Date Participant's Signature

PLEASE RETURN THIS ORIGINAL FORM TO:

FLINT PLUMBING & PIPEFITTING INDUSTRY
PENSION FUND
6525 Centurion Drive
Lansing, MI 48917

If you have any questions, please contact the Fund Office at (517) 321-7502 or (888)797-5862. Office hours are 7:30 A.M. – 5:30 P.M.