Sheet Metal Workers Local 7, Zone 2
Health Care Plan
Summary Plan Description

Revised November 2021

CONTENTS

INTRODUCTION 1

GENERAL INFORMATION 3

EMPLOYEE COVERAGE 4

ELIGIBILITY 4
ENROLLMENT 4
REINSTATEMENT AFTER TERMINATION 5

RETIREE COVERAGE 5

ELIGIBILITY 5
MEDICARE 5
CONTRIBUTIONS 5
REENROLLMENT 6

BENEFITS 6

HEALTH CARE BENEFITS 6
PRE-EMPLOYMENT PHYSICALS 8
SHORT-TERM DISABILITY BENEFITS 8
DEATH BENEFITS 9
MOTOR VEHICLE EXCLUSION – EFFECTIVE JUNE 1, 2021 10

TERMINATION OF COVERAGE 10

CONTINUATION OF COVERAGE 12

SHORT HOURS 12
TOTAL DISABILITY 12
WORKERS' COMPENSATION 13
SURVIVING SPOUSES AND DEPENDENTS 13
EMPLOYER FAILURE TO MAKE REQUIRED CONTRIBUTIONS 13
HEALTH CARE COVERAGE CONTINUATION 14

CLAIMS FOR BENEFITS 17

HEALTH CARE CLAIMS 17
OTHER CLAIMS 17
FACILITY OF PAYMENT 21
LEGAL ACTIONS 21

SUBROGATION AND REIMBURSEMENT 22
Plan's Rights 22
Equitable Lien and other Equitable Remedies 22
Obligations of Covered Person 23
Failure to Comply 23

AMENDMENT AND TERMINATION 23

YOUR RIGHTS UNDER ERISA 23
Receive Information About Your Plan and Benefits 24
Continue Group Health Plan Coverage 24
Prudent Actions by Plan Fiduciaries 24
Enforce Your Rights 24
Assistance with Your Questions 25

INTRODUCTION

The Sheet Metal Workers Local 7, Zone 2 Health Care Plan is maintained under a collective bargaining agreement between the employers association and the union.

The plan administrator is a joint board of trustees, consisting of three trustees appointed by the employers association and three trustees appointed by the union. The trustees have exclusive responsibility for the administration of the plan and all discretionary authority over administration of the plan, including discretionary authority to interpret the plan. The employers and the union do not have any authority to interpret the plan.

Health care benefits are provided under coverage agreements with coverage providers. The coverage providers are responsible for administration of benefits under the coverage agreements. See the Appendix for a list of coverage providers, including website addresses and telephone numbers.

The plan is funded primarily by employer contributions that are made pursuant to the collective bargaining agreement. Employer contributions are based on hours of service by employees.

Participants and beneficiaries are required to make contributions for retiree coverage and for short-hours and other continuation of coverage (self-payments). In all cases, the trustees will determine from time to time the amounts of the self-payments that are required for coverage. Participants and beneficiaries are also responsible for certain deductible amounts, co-payments, amounts that exceed reasonable and customary charges, and other charges or expenses that are not covered by the plan.

The assets of the plan are held in the Sheet Metal Workers Local 7, Zone 2 Health Care Trust under a trust agreement dated May 28, 1996, as amended. All contributions are deposited in the trust fund, which is invested and used for the exclusive purpose of paying benefits and administration expenses. All payments for coverage and benefits are made from the trust fund.

This is a summary plan description (SPD) for the plan as amended through December 31, 2020. It summarizes the major provisions of the plan in order to help you understand more about how the plan works, but it does not describe every provision of the plan, trust, coverage agreements, or applicable law. If any part of this summary conflicts with the provisions of the plan, trust, collective bargaining agreement, coverage agreements, or applicable law, or if a provision is not described or is only partially described in this summary, the provisions of the plan, trust, collective bargaining agreement, coverage agreements, and applicable law will control.

As plan administrator, the trustees have delegated many day-to-day administrative functions to TIC International Corporation (the fund office). If you have questions about the plan, please contact the fund office or visit http://local7zone2benefits.org.

You should notify the fund office of marriage, divorce, birth, adoption, change of address, and other changes in status as soon as possible. The fund office is separate from your employer and the union, so you should notify the fund office separately from any notice to your employer or the union.

You may examine the plan document, trust agreement, collective bargaining agreement, and coverage agreements at the fund office during normal business hours. Upon written request, the fund office will provide a copy of the collective bargaining agreement. Upon written request, the fund office will also provide information about whether a particular employer or employee organization is a sponsor of the plan, including the address of a sponsor.

GENERAL INFORMATION

Plan Name:	Sheet Metal Workers Local 7, Zone 2 Health Care Plan
Plan Sponsor and Administrator:	Joint Board of Trustees of the Sheet Metal Workers Local 7, Zone 2 Health Care Trust c/o TIC International Corporation 6525 Centurion Drive Lansing, MI 48917-9275 (866) 887-4338
Fund Office:	Sheet Metal Workers Local 7, Zone 2 Health Care Plan c/o TIC International Corporation 6525 Centurion Drive Lansing, MI 48917-9275 (866) 887-4338 http://local7zone2benefits.org/
Trustees:	The names and addresses of the trustees are set forth in the appendix to this SPD.
Coverage Providers:	The coverage providers are listed in the appendix to this SPD, including website addresses and telephone numbers.
Agent for Service of Process:	Joint Board of Trustees of the Sheet Metal Workers Local 7, Zone 2 Health Care Trust c/o TIC International Corporation 6525 Centurion Drive Lansing, MI 48917-9275 Legal process may also be served on a trustee.
Type of Plan:	The plan provides health care benefits, short-term disability benefits, and death benefits.
Type of Administration:	Health care benefits are administered by the coverage providers. Short-term disability benefits and death benefits are administered through the fund office.
Employer Identification Number (EIN) and Plan Number (PN):	The employer identification number (EIN) assigned by the Internal Revenue Service to the plan sponsor is 38-6075386. The plan number (PN) assigned by the plan sponsor to the plan is 501.
Plan Year:	The records of the plan are maintained on a calendar year basis ending December 31.

EMPLOYEE COVERAGE

ELIGIBILITY

As an employee, you will become eligible to participate in the plan if you complete 200 or more qualifying hours of service during two consecutive months. Coverage will begin on the first day of the second month beginning after the end of the two-month period, subject to proper enrollment on a timely basis and your employer's timely payment of the required contributions. If you do not enroll on a timely basis, or if your employer does not make the required contributions, your coverage will be delayed until the enrollment process is completed.

After first becoming eligible to participate, you will be eligible for coverage in any particular month if your employer makes the required contributions and you complete—

- 100 or more qualifying hours of service in the month ending two months prior to the month of coverage;
- 400 or more qualifying hours of service in the three months ending two months prior to the month of coverage; or
- 1,600 or more qualifying hours of service in the 12 months ending two months prior to the month of coverage.

The particular benefits offered under the plan may have additional eligibility requirements. These eligibility requirements are described in the coverage descriptions or elsewhere in this SPD. You must also satisfy the eligibility requirements under the particular benefit program in order to receive benefits under that program. You and your dependents are eligible to participate in the plan only to the extent that you are eligible for benefits under the terms of the plan and the applicable benefit program.

ENROLLMENT

You may enroll for coverage when you initially become eligible. You may also enroll your dependents at the same time. Your dependents include —

- Your spouse — the person who is legally married to you.
- Your children — children who are less than 26 years old, including children by birth, marriage (step-children), legal adoption, and placement for foster care by a government agency or court order. Spouses of children, and grandchildren, do not qualify as dependents.

Coverage will not begin unless you properly complete and return the enrollment forms. If you do not complete and return the enrollment forms on a timely basis, coverage will be delayed.

REINSTATEMENT AFTER TERMINATION

If your coverage terminates, you may become eligible again by completing 320 or more qualifying hours of service within a period of six consecutive months. Coverage will be reinstated on the first day of the second month beginning after the month in which you satisfy this requirement, subject to proper enrollment on a timely basis and your employer's payment of the required contributions.

RETIREE COVERAGE

ELIGIBILITY

As a retired employee, you are eligible for retiree coverage if you retire after attaining age 65, or after attaining age 55 with at least ten years of service under the Sheet Metal Workers Local 7, Zone 2 Pension Plan, and you are covered under this plan as an active employee at the time of retirement. Retiree coverage includes health care benefits and death benefits, but not pre-employment physicals or short-term disability benefits.

MEDICARE

You and your dependents must enroll in Parts A and B of Medicare as soon as you are eligible for Medicare, and must maintain coverage under Parts A and B of Medicare for as long as you are eligible for Medicare. The plan offers two Medicare Advantage alternatives for this purpose.

CONTRIBUTIONS

You must pay part of the cost for retiree coverage. If you return to covered employment in the sheet metal trade, the monthly payment for retiree coverage will be reduced by the amount of the employer contributions for your hours of work, but you will continue to be treated as a retiree regardless of the number of hours worked, and you will not be eligible for short-term disability benefits. If you are disabled as of the date of retirement, you may be eligible to continue health care coverage at no cost for a period of time under the coverage continuation provisions of the plan.

Reenrollment

You may discontinue retiree coverage at any time and reenroll for coverage at a later date if you have been covered by another health care plan or health care insurance for at least 12 months prior to the date of reenrollment. You must provide a certificate of coverage from the health care plan or insurance company that provided the coverage. You will be eligible for this reenrollment provision only once.

Benefits

Health Care Benefits

The health care benefits include medical, dental, and vision coverage. These benefits are provided by the coverage providers under the terms of the coverage agreements. All health care coverage and benefits are subject to the terms of the coverage agreements.

The coverage descriptions from the coverage providers have more information about health care benefits. The coverage descriptions are available at the coverage provider's website with your online account. The coverage provider's website address is in the Appendix. If you do not have an online account with the coverage provider, or if you would prefer to receive a paper copy of the coverage description, please call the coverage provider at the customer service number on your membership card, or the phone number in the Appendix, or call the fund office.

The coverage descriptions are updated by the coverage providers with changes from time to time. You should check with the coverage provider or the fund office to confirm that you have the most recent version of the coverage description.

Maternity and Newborn Coverage

Generally, the minimum length for any hospital stay in connection with childbirth for the mother or the newborn is 48 hours following a normal delivery and 96 hours following a caesarian section delivery. The attending health care provider, however, after consulting with the mother, may discharge the mother or her newborn earlier. The provider is not required to obtain authorization for a hospital stay that does not exceed the minimum length of stay specified above.

Breast Reconstruction Benefit

Benefits in connection with a mastectomy and elective breast reconstruction will be determined in consultation with the attending physician and the patient. Coverage must

include reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Coverage is subject to the same deductibles and coinsurance limitations that apply to the mastectomy treatment.

Qualified Medical Child Support Orders

Health coverage will be provided for your children when required by a qualified medical child support order from a court or by a national medical support order from a government agency.

The plan will follow these procedures upon receipt of a medical child support order from a court:

- The plan will promptly notify the employee and each alternate recipient of the receipt of such order and provide a copy of these procedures.
- The plan will determine whether the order is a "qualified" medical child support order as described in ERISA Section 609(a) within a reasonable period of time after receipt of the order and notify the employee and each alternate recipient of its determination.
- If the plan determines that the order is qualified, the plan will provide coverage effective as of the later of the date specified in the order, the date the employee satisfies any applicable waiting periods, or as soon as practicable after the plan determines that the order is qualified.

If the plan receives notice of a national medical support order from a government agency, the plan will comply with the notice by the due date specified and will:

- Notify the parties that it has received the notice; and
- Provide the information requested in the notice to the issuing agency.

If required by the terms of the order, the plan will revoke the employee's previous election and enroll each alternate recipient in the health care program specified in the order. If the alternate recipient is eligible for more than one coverage option under the plan, and the order does not specify the coverage level, the alternate recipient will be enrolled in the least expensive coverage option. The employee's contribution for the cost of the coverage will be determined in the same manner as similarly situated employees who elect dependent coverage at the same level required by the order.

Privacy Rules

The privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply to the health care benefits provided under the plan, but not to other benefits, such as short-term disability or death benefits. The fund office or coverage provider will provide you with a separate notice of privacy practices describing in detail the manner in which the plan or coverage provider uses and discloses protected health information, your rights to inspect, copy, and correct medical records concerning you, and the procedure for filing complaints if you think your privacy rights have been violated.

Pre-Employment Physicals

The plan will pay 50% of the cost of a pre-employment physical obtained by you at the request of an employer prior to the date you become eligible for coverage. This benefit is available only for employees who eventually become eligible for coverage under the plan. The plan will reimburse you for the plan's share of the cost of the physical as soon as administratively feasible after you become eligible for coverage.

Short-Term Disability Benefits

The plan provides short-term disability benefits for eligible employees who become disabled while covered under the plan, including "short hours" coverage, but not including COBRA or other continuation coverage. **Only journeymen, third-, fourth-, and fifth-year apprentices, and classified workers are eligible for this benefit. Pre-apprentices, first- and second-year apprentices, retirees, and dependents are not eligible for this benefit.**

If you are eligible for short-term disability benefits, you can receive benefits of $450 per week, or $90 per day, for up to 26 weeks for each continuous period of disability. A "period of disability" begins on the first day you are absent from work as a result of a disability, and ends when you return to work. Successive periods of disability that result from the same or related cause will be considered as a single period of disability unless separated by at least two weeks in which you are actively at work. The amount otherwise payable will be reduced by any amount you receive or are entitled to receive under Social Security or state disability law for the same period of disability.

Benefits are payable beginning with the first day you are unable to work as a result of a disability caused by an injury that was incurred within the last 30 days. Benefits are payable beginning on the eighth day you are unable to work as a result of a disability that is caused by sickness, mental illness, substance abuse, or an injury that was incurred more than 30 days before the first day you are unable to work.

For purposes of this benefit, "disability" means a condition unrelated to employment or self-employment that requires regular medical care under the direction of a physician and prevents you from being able to perform the major duties of your employment. You are not entitled to short-term disability benefits if you are not under a physician's care, if you are receiving pay in connection with any employment or self-employment, or if you are receiving workers' compensation or any other benefit in connection with your sickness or injury arising out of, or in the course of, employment or self-employment.

DEATH BENEFITS

The plan provides death benefits for eligible employees, retirees, and spouses whose death occurs while they are covered by the plan. The amount of death benefits is as follows:

Journeymen, Third-, Fourth-, and Fifth-Year Apprentices, and Classified Workers	$15,000
Spouses of Journeymen, Third-, Fourth-, and Fifth-Year Apprentices, and Classified Workers	$5,000
Pre-Apprentices, First- and Second-Year Apprentices	$5,000
Spouses of Pre-Apprentices and First- and Second-Year Apprentices	$2,000
Retirees	$3,000
Spouses of Retirees	$1,000

The death benefit will be paid to the beneficiary designated by the employee, retiree, or spouse. Each beneficiary designation must be on a form provided by the fund office and will be effective only when filed with the fund office during the covered person's lifetime. Each beneficiary designation filed with the fund office will cancel all beneficiary designations previously filed. If the covered person fails to designate a beneficiary, or if the beneficiary dies before the covered person, the death benefits will be paid to the covered person's spouse, if surviving, and if not, to the covered person's estate.

You should remember to review your beneficiary designation in connection with marriage, divorce, and other changes in family status. If you have designated your spouse as a beneficiary, and your marriage terminates by divorce or annulment after January 1, 2021, the termination of the marriage will automatically cancel the designation of the spouse as a beneficiary except as otherwise provided in a qualified domestic relations order.

Motor Vehicle Exclusion – Effective June 1, 2021

Effective June 1, 2021, the plan has been amended to exclude coverage for injuries received in or related to an accident involving a motor vehicle, including a car, motorcycle, or any other motor vehicle designed for operation upon a public highway.

This exclusion does not apply if you are involved in an accident outside the state of Michigan for which Michigan no-fault coverage is not legally available. However, this exclusion does apply if you are involved in an accident in your uninsured motor vehicle for which a Michigan no-fault policy is legally required and would have provided coverage.

Michigan's current auto insurance law requires you to have auto insurance that includes Personal Injury Protection (PIP) medical coverage to pay for your expenses if you are injured in an auto accident. You may generally choose from several different levels of PIP medical coverage, including unlimited, $500,000, or $250,000. Additional PIP coverage choices are available to Michigan drivers who meet certain criteria, including limited $250,000 with PIP exclusions, $50,000, or PIP medical opt-out.

If you choose an auto or motorcycle insurance policy option that does not provide unlimited personal injury protection (PIP) medical coverage, you could be responsible for paying all auto accident-related medical, rehabilitation, or attendant care costs that are not covered under your auto policy. This means that once your auto policy has reached its PIP coverage limit (usually $250,000 or $500,000, depending on the policy option selected), you will likely be personally responsible for paying these expenses.

To protect yourself and your family from financial catastrophe in the event of a motor vehicle accident that causes serious injuries, you are urged to purchase unlimited PIP coverage on a primary/uncoordinated basis that will provide comprehensive, lifetime benefits for accident-related claims that will not be covered by the plan.

You are encouraged to share this information with your auto insurance agent. Your agent will be able to help you select the right coverage options for your budget and your personal auto insurance needs. You can also visit www.michigan.gov/autoinsurance for more information about Michigan auto insurance laws, including details about your auto policy choices.

Termination of Coverage

Coverage will terminate as described in this section, subject to coverage continuation rights under COBRA or other applicable law, and subject to other coverage continuation provisions of the plan.

Coverage for employees and their spouses and other dependents will terminate on the earliest of the following days:

- The day the employee ceases to be an eligible employee.
- The first day of any period for which the employee fails to make any required payment for coverage when due;
- If an employer fails to make any required contribution on behalf of the employee, the first day of the month following the month in which the contribution was due;
- The first day of full-time membership in the armed forces of any country or international organization (provided, however, that membership in the United States Military Reserves or National Guard, including up to 30 days of active training each year, will not be considered full-time membership);
- The day the employee's employment terminates for any reason other than death; or
- The day after the employee's death.

Coverage for retirees and their spouses and other dependents will terminate on the earlier of the following days:

- The first day of the period for which the retiree fails to make any required payment for coverage when due; or
- The day after the retiree's death.

Coverage for spouses will also terminate on the day the spouse ceases to be an eligible spouse.

Coverage for other dependents will also terminate on the earlier of the following days:

- The last day of the month in which the dependent ceases to be an eligible dependent; or
- The day the dependent becomes eligible as an employee.

If a covered person knowingly files a fraudulent claim for benefits, the covered person's coverage will terminate as of the date of filing the fraudulent claim and the person will not be eligible for reinstatement for coverage in any capacity. A claim will be considered to be fraudulent if the covered person misrepresents any fact or facts that are material to a determination of whether the person is eligible for coverage by the plan or whether the claim is for benefits that are provided by the plan.

Continuation of Coverage

Short Hours

If you do not have enough hours to qualify for coverage, you may continue coverage for up to 12 months if you are in good standing with the union and available for work or disabled so as to be unable to work, and pay the monthly charge. You will be required to complete a questionnaire periodically so that the trustees can determine your eligibility for coverage.

You will not be eligible to continue coverage if you are not available for work, if you are working at the sheet metal trade for an employer who does not have a collective bargaining agreement with the union, or if you work at the trade on a self-employed basis without having a collective bargaining agreement with the union. The continued coverage will cease on the first day of the month following the first day on which you are not available for work or you work at the trade for a non-union employer.

When you have exhausted your 12 months of coverage under this short-hours provision, you may be eligible to continue coverage under COBRA. You may also elect COBRA continuation coverage before you have used up your 12 months of short-hours coverage and return to the short-hours coverage for the balance of the 12 months after you have exhausted your COBRA coverage. This will allow you to elect COBRA or short-hours coverage, whichever is less expensive.

Total Disability

If you are totally disabled on the date your coverage would otherwise terminate, and the disability does not qualify for workers' compensation benefits, the plan will provide continued coverage as follows:

- If you have been covered under the plan for a continuous period of five or more years immediately prior to the date your coverage would otherwise terminate, the plan will continue your coverage for a period of 29 months, until you reach age 65, until you are no longer totally disabled, or until you obtain a recovery from a third party as a result of the incident that caused the disability, whichever comes first.
- If you have not been covered under the plan for a continuous period of five or more years immediately prior to the date your coverage would otherwise terminate, the plan will continue your coverage for 30 days.

After the applicable period described above, you may continue coverage for as long as you remain disabled if you pay the monthly charge determined by the trustees.

The trustees will determine whether you are totally disabled. For this purpose, “totally disabled” means a condition that requires regular medical care under the direction of a physician and renders you unable to engage in any duty of your employment.

Workers’ Compensation

If you are disabled on the date coverage would otherwise terminate, and your disability qualifies you for workers’ compensation benefits, the plan will provide continued coverage as follows:

- If you have been covered under the plan for a continuous period of five years or more on the date coverage would otherwise terminate, the plan will provide continued coverage for a period of 12 months or until you no longer qualify for worker’ compensation benefits, whichever period is shorter.
- If you have been covered under the plan for a continuous period of at least one but less than five years on the date on which coverage would otherwise terminate, the Plan will provide continued coverage for a period of six months or until you no longer qualify for workers’ compensation benefits, whichever period is shorter.
- If you have been covered under the Plan for a continuous period of at least six months, but less than one year, on the date coverage would otherwise terminate, the Plan will provide continued coverage for a period of three months or until you no longer qualify for workers’ compensation benefits, whichever period is shorter.

After the applicable period described above, you may continue coverage for as long as you remain disabled if you pay the monthly charge determined by the trustees.

Surviving Spouses and Dependents

If you die, and you had at least 10 years of service under the Sheet Metal Workers Local 7, Zone 2 Pension Plan, your surviving spouse and other dependents may continue coverage under the plan by paying the monthly charge determined by the trustees. Surviving spouses may continue coverage on this basis for as long as they remain unmarried. Dependents may continue coverage on this basis for as long as they qualify as dependents. Surviving spouses and covered dependents may choose to continue coverage under this section or under COBRA. If coverage is continued under this section, the coverage will be credited towards the maximum period of coverage under COBRA.

Employer Failure to Make Required Contributions

If your employer fails to make the required contributions, you may continue coverage under the plan, by paying the monthly charge determined by the trustees, while you remain

employed by the delinquent employer. Your payment does not excuse the employer from making the required contributions. If the trustees recover delinquent contributions from the employer, they will reimburse you for amounts that you paid to continue coverage.

HEALTH CARE COVERAGE CONTINUATION

You have a right to health care coverage continuation under three federal laws – the Consolidated Omnibus Budget Reconciliation Act (known "COBRA"), the Family and Medical Leave Act (known as "FMLA"), and the Uniformed Services Employment and Reemployment Rights Act (known as "USERRA"). The plan will provide coverage continuation as required by these federal laws. You must pay the applicable cost for the continuation coverage.

COBRA CONTINUATION COVERAGE

You have the right to continue health care coverage if a qualifying event occurs that causes you or your beneficiaries to lose health care coverage under the terms of the plan. Each person that loses coverage due to the qualifying event has rights as a qualified beneficiary.

Qualifying events include termination of your employment (other than for gross misconduct) or reduction in hours. For spouses and other dependents of employees covered by the plan, qualifying events also include the death of the employee, divorce or legal separation from the employee, the entitlement of the spouse/employee to Medicare, or a dependent child ceasing to be eligible for coverage under the plan as a dependent.

Qualified beneficiaries may maintain COBRA continuation coverage as follows:

- If the qualifying event is your termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is 18 months.
- If you or your dependents are receiving COBRA continuation coverage because of your termination or reduction in hours, the continuation period may be extended up to 11 months, for a total of up to 29 months, if you are determined to be disabled at the time of your termination of employment or reduction of hours, or within 60 days after the start of the 18-month continuation period.
- The 18-month continuation period may be extended if you become entitled to Medicare prior to your termination of employment or reduction in hours. Qualified beneficiaries other than employees are entitled to the greater of 18 months measured from the qualifying event, or 36 months measured from the date of the employee's Medicare entitlement.
- For qualifying events other than termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period is 36 months.

- If, during the 18-month continuation period or during an extension of that period as described above, a second qualifying event occurs that would have caused the qualified beneficiary to lose coverage under the plan had the first qualifying event not occurred, the continuation period for the affected qualified beneficiaries may be extended to 36 months.

After the fund office receives notice of a qualifying event, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. The qualified beneficiary will then have 60 days to inform the plan, in writing, that he or she wants continuation coverage. You or your dependent have the responsibility to inform the fund office, in writing, of a divorce, legal separation, or a child losing dependent status under the plan within 60 days of the date of the event. If notice of one of these events is not received within 60 days of the event, coverage will be terminated as of the date of the event and COBRA continuation coverage will not be offered.

The election due dates will be specified in the COBRA election notice you receive from the plan. If a qualified beneficiary does not choose continuation coverage on a timely basis, health coverage will end on the date specified in the section above entitled "Termination of Coverage".

If a qualified beneficiary chooses continuation coverage, the plan will provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly-situated employees or dependents.

A qualified beneficiary does not have to show that he or she is insurable to choose COBRA continuation coverage. However, COBRA continuation coverage is provided subject to a qualified beneficiary's eligibility for coverage.

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The cost will be 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost for coverage of a similarly-situated participant or beneficiary who is not receiving COBRA coverage. The cost of your COBRA coverage may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA cost changes.

FMLA Continuation Coverage

If you are on a family or medical leave under FMLA, you have a right to FMLA continuation coverage on the same terms and conditions as the coverage that would have been provided had you not taken the FMLA leave. If your coverage lapses during the FMLA leave, coverage will be reinstated upon your return to work at the conclusion of the FMLA leave, but only for the person(s) who had coverage under the plan when the FMLA leave began. The cost for

FMLA continuation coverage will be the same as the employee contribution for similarly-situated active employees. For more information about FMLA leave please contact your employer.

USERRA Continuation Coverage

You have a right to USERRA continuation coverage if you are absent from work for voluntary or involuntary performance of service in the U.S. military. The cost for USERRA coverage will be the same as the cost for COBRA continuation coverage, except that if the period of absence is less than 31 days, the cost will be the same as the employee contribution for similarly-situated active employees.

You have 60 days to elect USERRA continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. If USERRA continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If USERRA continuation coverage is not elected within this period, health coverage will end on the date specified in the section entitled "Termination of Coverage". However, if no election is made in a situation in which you are not required by USERRA to provide advance notice of your service (for instance, because such notice was impossible, unreasonable, or precluded by service necessity), your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

You are generally allowed to maintain USERRA continuation coverage for a 24-month period beginning on the date of your absence from employment for the purpose of performing service begins. Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated employees or dependents that are not on service leave. USERRA continuation coverage may be terminated before the end of the 24-month period if the plan is terminated, if you do not pay the required cost for coverage on time (including the grace period), or if you do not return to employment in time after your service ends.

Unlike COBRA, USERRA does not give your dependents separate rights to elect USERRA continuation coverage. Their USERRA continuation coverage depends on whether you elect USERRA continuation coverage. However, they may have COBRA continuation rights even if you do not elect USERRA continuation coverage.

CLAIMS FOR BENEFITS

HEALTH CARE CLAIMS

Health care benefits are provided under coverage agreements with coverage providers. The coverage provider is responsible for administering health care claims. You must file claims for health care benefits with the coverage provider and follow the claims procedure under the coverage agreement. The claims procedures are included in the coverage descriptions. The trustees do not have any authority to decide claims for benefits under the coverage agreements.

OTHER CLAIMS

The trustees are responsible for administering other claims under the plan, including claims for pre-employment physicals, short-term disability benefits, and death benefits. The trustees have discretionary authority to determine claims, including discretionary authority to interpret the plan, and will make claim determinations according to their interpretation of the plan.

FILING CLAIMS

You must submit claims to the fund office in a manner approved by the trustees. You must also provide any other information the trustees may request in order to consider your claim.

- Claims for short-term disability benefits must include a letter or other written statement from your primary care physician including the diagnosis, the treatment plan, an explanation of why you are unable to work, the projected length of time you will be unable to work, and an explanation as to whether the disability is related to your employment or self-employment.
- Claims for continuation of coverage in case of total disability must include written opinions from two doctors who are qualified and independent. The cost of second opinions will be covered at 80% after the deductible is met.
- Claims for continuation of coverage in case of disability that qualifies for worker's compensation benefits must include copies of the checks for the workers' compensation benefits for the months in which the continued coverage is provided and such other evidence of disability as may be requested by the trustees.

Initial Determination

The trustees will make a determination on the claim within a reasonable period of time, but not later than 90 days after receipt of the claim, unless special circumstances require an extension of time. If the trustees determine that an extension of time is required, they will provide you with written notice of the extension before the end of the initial 90-day period, including the reasons for the extension and the date by which the they expect to make the benefit determination. The extension will not be longer than 90 additional days. If the extension is required because you have not provided information necessary to determine the claim, the notice of extension will specifically describe the necessary information and give you at least 45 days to provide the specified information.

If a claim is wholly or partially denied, the trustees will give you written notice of the determination. The notice will include—

- the reason for the determination;
- a reference to the plan provisions on which the determination is based;
- a description of additional documents or other information, if any, that might permit approval of the claim, and an explanation of why the additional information is necessary; and
- a description of the plan's claims review procedure and the applicable time limits, including a statement of your right to bring a civil action following any adverse determination after appeal of your claim.

Review of Denied Claims

If you disagree with the initial determination, you may request a review of the determination. The request for review must be delivered to the fund office, in writing, within 60 days after receiving the notice of the initial determination. The request should set forth the reasons why you believe the determination was incorrect. You may submit written comments, documents, records, or other information relating to your claim. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The trustees will review the initial determination and make a determination on review no later than the date of the first trustees' meeting after receipt of the request for review or, if the request is received less than 30 days before the date of the meeting, no later than the date of the second meeting after the receipt of the request, unless special circumstances require an extension of time. If the trustees determine that an extension of time is required, the trustees will give you written notice of the extension, including the reasons for the

extension and the date by which the they expect to make the determination on review. The extension will not go past the third meeting after receipt of the request for review.

If the claim is wholly or partially denied on review, the trustees will notify you in writing of the determination. The notice will include—

- the reason for the determination;
- a reference to the plan provisions on which the determination is based; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Claims Involving Disability

If your claim involves a determination of disability, and the determination of disability is not to be made by a third party (such as the Social Security Administration or an insurance company), the claims procedure will be modified as follows:

- The initial determination will be made within 45 days, and the time for any extension will be up to 30 days, but the trustees may further extend this time for up to 30 more days if they provide written notice of the further extension before the end of the initial extension period. In the case of any extension, the notice of extension will specifically explain the standards for the determination of disability, the unresolved issues that prevent a determination on the claim, and the additional information needed to resolve those issues, and will allow at least 45 days for you to provide the specified information.
- If your claim is wholly or partially denied, the notice of determination will be provided in a culturally and linguistically appropriate manner and will include all of the following:
    - a discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views presented to the plan of health care professionals treating you and vocational professionals who evaluated you, (ii) if the trustees obtained advice from medical or vocational experts in connection with the determination, the views of the experts regardless of whether the trustees relied on the advice in making the determination, and (iii) if presented to the trustees, a disability determination by the Social Security Administration;
    - if the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to

your medical circumstances, or a statement that the explanation will be provided free of charge upon request;

    - either the specific internal rules, guidelines, protocols, or other similar criteria of the plan that were relied on in making the determination or, alternatively, a statement that such rules, guidelines, protocols, or other similar criteria of the plan do not exist; and
    - a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

- If you disagree with the initial determination, you may request a review of the determination within 180 days.
  - The determination on review will be conducted without deference to the initial determination, and will be made by a committee composed of individuals who did not take part in the initial claim determination.
  - If the initial determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the committee will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the initial determination nor the subordinate of any such individual.
  - If the trustees obtained advice from medical or vocational experts on behalf of the plan in connection with the initial determination, the trustees will identify the experts regardless of whether the trustees relied on the advice in making the initial determination.
  - Before the committee may make an adverse determination on review, if the committee obtains, considers, or relies on any new or additional evidence in connection with the review, or if the committee is going to base the adverse determination on a new or additional rationale, the trustees will provide the evidence or rationale to you, free of charge, as soon as possible and in time to give you a reasonable opportunity to respond before the date for making a determination on review.
- If the claim is wholly or partially denied on review, the notice of determination will be provided in a culturally and linguistically appropriate manner and will include all of the following:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views presented to the plan of health care professionals treating you and vocational professionals who evaluated you, (ii) if the trustees obtained advice from medical or vocational experts in connection with the determination, the views of the experts regardless of whether the trustees relied on the advice in making the determination, and (iii) if presented to the trustees, a disability determination by the Social Security Administration;
- if the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that the explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, or other similar criteria of the plan that were relied on in making the determination or, alternatively, a statement that such rules, guidelines, protocols, or other similar criteria of the plan do not exist.

Representation

You may designate someone to act on your behalf during any or all stages of review, but you are responsible for the fees and expenses of the representative.

Facility of Payment

The claims administrator may rely on affidavits and other information that the administrator believes to be reliable. The administrator may authorize payment of benefits to any person on behalf of a participant or beneficiary for the convenience of the participant or beneficiary. If the administrator authorizes such a payment, the payment will discharge the plan and the trustees from liability with respect to the payment.

Legal Actions

You may not commence any legal action regarding a claim for benefits before you exhaust the applicable claims procedure, including proper submission of the claim to the appropriate claims administrator and proper request for review of any adverse initial determination. If a coverage agreement specifies a limitation period for commencing legal actions, the limitation period applies to claims under the coverage agreement. In all other cases, you may not commence any legal action more than two years after the final determination on review. Judicial review will be limited to review for abuse of discretion.

SUBROGATION AND REIMBURSEMENT

PLAN'S RIGHTS

By accepting benefits under the plan, you agree to reimburse the plan from any money or other property recovered from any third party, in an amount equal to any amount the plan has paid. In addition, the plan is entitled to recover from any other source of payment, including another group health plan, up to 100% of the benefits paid to or on behalf of a participant or beneficiary.

This right of subrogation and reimbursement allows the plan to pursue any claim that you may have, whether or not you choose to pursue that claim. Therefore, the plan may intervene in any claim or action against a third party or a third party's insurer, and also may assert its own claim or start its own lawsuit to recover the amount of benefits the plan paid to you regardless of whether you choose to pursue the claim.

The plan is entitled to subrogation and reimbursement on a first-dollar basis. This means that the plan's right to subrogation and reimbursement applies whether the funds paid to (or for the benefit of) you constitute a full or a partial recovery, and even applies to funds paid for non-medical charges, attorney fees, or other costs and expenses. The plan's recovery will not be reduced by the costs of recovery, including, but not limited to, attorney fees, costs, or litigation expenses. Further, the plan's rights are not subject to equitable defenses. Specifically, the plan is entitled to subrogation and reimbursement even if you are not "made whole" through the recovery you receive, and the plan's rights will not be subject to reduction under any common fund or similar claim or theory. In addition, the subrogation and reimbursement rights apply regardless of how the third-party recovery is characterized or the application of any rule or state law that would limit or preclude subrogation.

The plan reserves the right to negotiate a return of less than the full amount on a participant-by-participant basis based on the facts and circumstances.

EQUITABLE LIEN AND OTHER EQUITABLE REMEDIES

The plan will have an equitable lien upon any recovery, whether by settlement, judgment, mediation or arbitration, or otherwise, that you receive or are entitled to receive from any third party. This lien will not exceed the amount of benefits paid by the plan for the illness or injury, plus the amount of all future benefits which may become payable under the plan that are due to the same illness or injury or the amount that you recover from the third party.

This equitable lien will also attach to any money or property that is obtained by anybody (including, but not limited to, you, your attorney, and/or a trust) as a result of an exercise of

your rights of recovery. The health plan will also be entitled to seek any other legal or equitable remedy against any party possessing or controlling such proceeds.

Obligations of Covered Person

The plan's rights to subrogation and reimbursement apply to you and any covered spouse or child (the "covered person"). The covered person must cooperate fully with the plan in asserting its subrogation and reimbursement rights. If the covered person retains an attorney to pursue a claim against a third party, the covered person must notify the attorney of the plan's rights to subrogation and reimbursement prior to pursuing the claim. The covered person must notify the fund office immediately if he or she pursues a claim against a third party and, upon the plan's request, provide all information and sign and return all documents necessary for the plan to exercise its rights under this paragraph.

Failure to Comply

If you recover any amount from a third party due to your illness or injury, and you do not reimburse the plan for benefits the plan has paid to you for the illness or injury, you will be personally liable to the plan for the amount of benefits paid to you by the plan, and the plan may reduce future benefits payable for any illness or injury by the amount of the payment that you recover from the third party.

Amendment and Termination

Benefits under the plan are not guaranteed. The plan, including retiree coverage, is subject to amendment or termination in whole or in part at any time. The joint board of trustees has exclusive authority to amend or terminate the plan. The employers and the union do not have any authority to amend or terminate the plan. Generally, if the plan is terminated, you will be entitled to receive benefits for covered health care expenses incurred before the plan termination, but will not have any further rights under the plan.

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). This law provides that all participants in the plan will be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office, all documents governing the plan, including insurance contracts 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 Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts 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, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the welfare 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 the trustees, your employer, 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 you make a claim for a welfare benefit which 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 the 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 plan administrator. If you have a claim for benefits which is denied

or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a 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 fund office. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the fund office, 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.

APPENDIX – TRUSTEES

EMPLOYER TRUSTEES

Jan Green (Co-Chair)
Michigan Chapter Sheet Metal Air
Conditioning Contractors Association
1152 Haslett Rd
PO Box 220
Haslett MI 48440

James Holst
Waltz Holst Company
230 Alta Dale SE
Ada MI 49301

Gwen Henning
Versatile Fabrication Company
2708 9th Street
Muskegon, MI 49444

UNION TRUSTEES

Mike Adams (Co-Chair)
800 Ellis, Suite 165
Norton Shores, MI 49441

Tate Brown
165 E Fruitvale Rd
Montague MI 49437

Brent Prindle
3815 New Holland St
Hudsonville MI 49426

Ryan Kittle (Alternate)
5485 Russell Rd
Twin Lake MI 49457

APPENDIX – HEALTH CARE COVERAGE PROVIDERS

COVERAGE	COVERAGE PROVIDER
Medical	Blue Cross Blue Shield of Michigan www.bcbsm.com
Prescription Drug	Blue Cross Blue Shield of Michigan www.bcbsm.com
Dental	Delta Dental of Michigan www.DeltaDentalMI.com
Vision	Blue Cross Blue Shield of Michigan www.bcbsm.com Vision Service Plan www.vsp.com
Medicare Advantage	Blue Cross Blue Shield of Michigan (PPO) Blue Care Network of Michigan (HMO) www.bcbsm.com

To contact the coverage provider by phone, call the member service number on the back of your member ID card.