HEAT AND FROST INSULATORS

AND

ALLIED WORKERS

LOCAL 47 WELFARE FUND

SUMMARY PLAN DESCRIPTION

January 1, 2019

Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund
Summary Plan Description

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INTRODUCTION

About Your Plan

For you and your fellow workers, your Employer and the Union have created a Welfare Fund, which provides a specific, dependable plan of benefits. This Plan is frequently improved in order to provide the best benefits possible consistent with sound financial management of the Plan.

The Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund was created as a result of a collective bargaining agreement, sometimes referred to as a labor contract, between your Employer and the Union.

Your Welfare Fund receives its money from Employer contributions, on dates and in amounts called for by the labor contract negotiated with the Employer by your Union. **Money is not withheld from your paycheck in order to support the Fund.**

Decisions on Plan operations and benefits are made by a Board of Trustees on which labor and management are equally represented.

Working together, the Board of Trustees establishes the eligibility rules, strives to maintain the schedule of benefits, supervises the investment of the Fund's money, and sees that the Fund complies with all applicable Federal laws and regulations.

In carrying out these responsibilities, the Trustees are assisted by a team of professionals including:

> The **Administrative Manager** who handles the day-to-day business activities of the Fund such as collecting employer contributions, keeping records of money received, crediting each participant's account with the correct number of hours worked, paying claims, and answering inquiries from participants about their eligibility and benefits.

The **Fund Attorney** advises the Trustees about what must be done to assure that all operations of the Fund comply with Federal and State laws.

The **Fund Consultant** assists the Trustees in determining the level of benefits which can be provided from Fund resources and advises the Trustees on other matters important to the Fund's operations.

The largest part of the contributions the Fund receives is returned directly to participants in the form of benefits. Some of the contributions received are set aside for reserves. The Fund's reserves can be drawn on at times when the claims expenses exceed income.

As required by law, the Fund has an independent auditor examine the financial records each year and certifies them as to their accuracy, completeness and fairness. In addition, the Trustees are required to submit annual financial statements and other reports to the U.S. Department of Labor and the Internal Revenue Service. These reports are available for inspection at the Fund Office during normal business hours.

This, then is a brief description of how your Fund was established, its purpose, and how it operates.

FREQUENTLY ASKED QUESTIONS

1. WHAT SHOULD I DO WITH THIS SUMMARY PLAN DESCRIPTION?

This Summary Plan Description (or "SPD" for short) is intended to provide you with a detailed summary of the Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund, or the Plan, so that you will know your rights and benefits under the Fund. Please read it carefully and keep it handy for future reference.

2. WHAT IF I CAN'T FIND THE ANSWER IN THE SPD?

While the answers to many frequently asked questions are in the SPD, your Administrative Manager will be happy to discuss any questions you may have concerning the Plan and how it applies to you.

3. DO THE EXAMPLES IN THE SPD APPLY TO MY BENEFITS?

The SPD is a general explanation about how the Plan works. Some of the provisions of the Plan are explained by means of an example. These examples are included so that the provisions can be easily understood. They are not calculations of the benefits or rights of you or any other participant. Your rights and benefits will be determined on the basis of your actual participation in the Plan.

4. WHAT IF THE TRUST DOCUMENT AND THE SPD DO NOT AGREE?

This SPD is in intended to explain the major provisions of the Plan in a non-technical way. Every effort has been made to accurately present the Plan. In the unlikely event there is any difference between the provisions of this SPD and those of the Trust Document, the Trust Document will always control.

YOUR RESPONSIBILITIES AS A PARTICIPANT

There are certain responsibilities which you, as a participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits payable.

1. Take time to read this Summary Plan Description.
2. File an Employee Data (Enrollment) Card.
3. Notify the Fund Office promptly, in writing, if you have:
    a. a change of address; or
    b. a change in marital status; or
    c. a change in beneficiary; or
    d. a change in dependents.
4. Make self-payments on time and in the correct amount.

A detailed explanation of your responsibilities can be found in the appropriate section of the SPD. Please refer to the Table of Contents for page numbers.

MEDICAL AND DENTAL BENEFITS

Your hospitalization, medical, dental, vision and prescription drug coverage is provided through Blue Cross Blue Shield of Michigan (BCBSM). Information regarding these benefits may be obtained in the **Health Care Handbook for Heat and Frost Insulators and Allied Workers Welfare Fund.** You can also contact BCBSM toll free at 1-800-637-2227 with any questions you may have.

SECTION I

BOARD OF TRUSTEES

Union Trustees

Larry Tolbert, Secretary
PO Box 19541
Kalamazoo, MI 49019
(269) 345-8944

Howard Clark III
640 McCauley Street
Williamston, MI 48895
(517) 655-6768

Joshua Kroell
419 Washington Square
Suite 301
Lansing, MI 48933
(517) 708-0665

Patrick Welch (Alternate)
419 Washington Square
Suite 301
Lansing, MI 48933
(517) 708-0665

Employer Trustees

Robert A. Williams, Chairman
Ticon, Inc.
712 Townsend
Midland, MI 48640
(989) 631-6140

Thomas Dylenski
Mechanical & Industrial Insulation
3001 N. Martin Luther King Blvd
Lansing, MI 48906
(517) 323-4544

John Lyons
Advanced Industrial Services
1564 Poseyville Road
Midland, MI 48640
(989) 486-8457

Michael Williams (Alternate)
Ticon, Inc.
712 Townsend
Midland, MI 48640
(989) 631-6140

Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund
Summary Plan Description

INFORMATION REQUIRED BY EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Name of Plan:

Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund

Established:

October 7, 1952

Name of Employer Association and Employee Organization with which the Plan is identified:

Master Insulators Association and International Association of Heat and Frost Insulators and Allied Workers Local Union No. 47 and Employers who elect to become signatory to an agreement with the Union.

Name and Address of Sponsor:

Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund
6525 Centurion Drive, Lansing, MI 48917

A complete listing of the Trustees can be found on page 1.

Employer Identification Number (E.I.N.) assigned for this Plan by the Internal Revenue Service:

38-60558846

Employer Identification Number Assigned by the U. S. Department of Labor (WP File Number):

WP-113971

Plan Number:

501

Type of Plan:

Self-Funded Insurance Plan providing Weekly Disability (Loss of Time), Health Benefits (Hospital, Surgical, Medical and Major Medical Benefits and Dental and Vision Benefits), Life/Death Benefit and Accidental Death and Dismemberment Benefit. The Trustees may elect to insure any one or more of the Benefit coverages. Currently, Life Insurance and Accidental Death and Dismemberment Benefits are purchased through a Contract underwritten by

Union Labor Life Insurance Company (Ullico), Group Contract/Policy No. G 8202 & C-8202. Health and Welfare, Dental and Vision Coverage is provided Blue Cross Blue Shield of Michigan.

Type of Administration:

The Fund is administered by a Board of Trustees consisting of:

Three (3) Trustees representing the Employers, and

Three (3) Trustees representing the Employees.

There are two (2) alternate Trustees; one (1) representing the Employers and one (1) representing the Employees.

The Board of Trustees has in turn contracted an Administrative Service Organization to administer this Fund under the supervision of the Board of Trustees.

Name, Business Address and Telephone Number of Administrator:

Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund
6525 Centurion Drive
Lansing, MI 48917
Telephone: (517) 321-7502
Fax: (517) 321-7508

Administrative Service Organization Name, Address and Telephone Number:

TIC International Corporation
6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502
Toll Free 1-800-323-8079
Fax (517) 321-7508

Claims Processor — Blue Cross Blue Shield of Michigan

Jacqueline E. Nakfoor
Account Manager — Trust Funds
232 S. Capitol Ave, MC L08A
Lansing, MI 48933-1536
(517) 325-4587
(877) 570-9658 FAX

Name of Person Designated as Agent for Service of Legal Process and Address at which Process may be served on such Person:

Christopher E. LeVasseur, Esq., Plan Attorney
Stark Reagan, P.C.
1111 West Long Lake, Suite 202
PO Box 7037
Troy, MI 48007-7037

Collective Bargaining Agreement:

The Plan is maintained through contributions by Employers who agree to do so in their Collective Bargaining Agreement with the International Association of Heat and Frost Insulators and Allied Workers Local No. 47.

A COPY OF THIS AGREEMENT MAY BE OBTAINED BY WRITTEN REQUEST AND IS AVAILABLE FOR EXAMINATION BY PARTICIPANTS IN THE UNION OFFICE.

Fiscal Year.

January 1 through December 31

Plan's Requirement for Eligibility for Participation and for Benefits:

Eligibility for participation in the Plan and for the receipt of benefits is set forth on pages 12 through 16 of this SPD. Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits include:

1. Termination of the Plan, or
2. Termination of Employment, or

3. Termination of Eligibility as defined on page 14 of this SPD under the heading "Eligibility Rules", or
4. For Participants continuing in the Plan on a self-payment basis, failure to remit the proper payment as required by the Plan.

Sources of Contributions to the Plan:

Contributions are made to the Fund by Employers, in accordance with the terms of the Collective Bargaining Agreement. In certain circumstances, Participants are permitted to make self-payments in case of disability and leave of absence, temporary work stoppage, or retirement, as outlined on pages 14-15.

STATEMENT OF ERISA RIGHTS

As a Participant in the Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (commonly known as ERISA). ERISA provides that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's Office or the Union office, all Plan Documents, including Collective Bargaining Agreements, insurance contracts (if any) and copies of all documents filed by the Plan with the U. S. Department of Labor at the Public Disclosure Room of the Pension and Welfare Benefit Administration, such as detailed Annual Reports (Form 5500 Series) and Plan Descriptions (if and when the Plan is required to file).

Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. 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 the Summary Annual Report.

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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for the Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an 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 present you from obtaining an insurance or welfare benefit or exercising your rights under ERISA. If your claim for an insurance or welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time frames.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of your Plan documents and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to

$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. Participants and beneficiaries may obtain, without charge, a copy of the Plan's QMCSO procedures upon written request to the Plan Administrator. 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 United States Department of Labor, or you may file suit in 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.

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 Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

DEFINITIONS

"Active Employee" — An Employee who is actively at work and reported by a Contributing Employer to the Heat and Frost Insulators and Allied Workers Local No. 47 Welfare Fund.

"Beneficiary" — The party or parties designated by an Employee as his beneficiary on the records maintained in the Fund's Office. Employees covered under this Plan may at any time change the Beneficiary, without the consent of any previously designated Beneficiary, by submitting a written request on forms furnished by or satisfactory to the Trustees. Such change shall not take effect until the fully executed form giving effect to the request is received by the Fund's Administrator.

If a Beneficiary predeceases the covered Employee, the designation shall be revoked and of no effect. In the event the Employee failed to make a valid beneficiary designation, or if the designated Beneficiary does not survive the Employee, payment will be made in a single sum to the first surviving heir in the following order of preference: The Employee's (a) widow or widower; (b) surviving children; (c) surviving parent(s); or (d) surviving brother(s) and sister(s). In the event there are no such surviving heirs, payment will be made to the Employee's executors or administrators for distribution as part of his Estate.

"Calendar Year" — January 1 through December 31 of any year.

"Child" — Any biological or adopted child of the Employee, and any stepchild who resides in the Employee's household and is dependent upon such Employee for his principal support and maintenance; provided, with respect to stepchildren, that the Employee has been appointed the stepchild's full guardian by a court having proper jurisdiction over the child.

"Claim Determination Period" or "Benefit Year" — For Medical and Major Medical Benefits and Dental Benefits, the period from January 1 through December 31.

"COBRA — Continuation Coverage" — The Consolidated Omnibus Budget Reconciliation Act ("COBRA") which requires Health and Welfare Funds to provide extended coverage to qualified beneficiaries and to maintain benefit coverage for all Employees under certain circumstances. The extended coverage will be identical to the coverage provided under the Plan to similarly-situated Participants with respect to whom the qualifying event has not occurred. The period of extended coverage is eighteen (18) months for terminations and reduced hours and thirty-six (36) months for all other qualifying events. A contribution may be required for the extended coverage, but may not exceed 102% of the actual cost of providing the coverage.

"Dependent" — The Spouse of the Employee, if not legally separated, and children to age 26.

A grandchild of an Employee with respect to whom the Employee or his spouse has been appointed full guardian for at least one (1) year may be covered as an Eligible Dependent, provided it has been established that no other insurance coverage is available to such child and the Employee is entitled to claim a Federal income tax exemption with respect to that child.

"Dependent's Benefits" — An Employee's Benefits with respect to his Dependents.

"Eligible Employee" - A person eligible for benefits under the provisions of the "Eligibility" Section of the Plan.

"Employee" - An individual who is considered to be an Employee under the terms of the Trust Agreement. The following classifications shall apply:

CLASS A = Active Employees

CLASS B = Retired Employees and Spouses of Retired Employees
Disability Retiree
Normal Retiree Age 65 or Older
Early Retiree between Age 45 and Age 65

CLASS C = Surviving Spouse or Widow

"Employer" or **"Contributing Employer" -** An Employer signatory to an Agreement with the Union requiring contributions to Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund.

"Fund" - Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund.

"HIPAA"— The Health Insurance Portability & Accountability Act

"Participant" — An Employee who has met the requirements established by the Trustees to be eligible for benefits under this Plan. A "Participant" shall also mean a Dependent of an Employee who has met the requirements established by the Trustees to be eligible for benefits under this Plan.

"Plan" — The rules, regulations and other provisions governing the administration of the Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund.

"Plan Year" or **"Accounting Year"** or **"Fiscal Year" —** The period of twelve (12) consecutive months beginning January 1 and ending December 31.

"Protected Health Information" - Information maintained by a health care provider, health plan, employer, or health care clearinghouse which relates to the past, present, or future physical or mental health or condition of an

individual **that identifies the individual** or to which there is a reasonable basis to believe the information can be used to identify an individual.

"Work-Related" and/or **"Occupational Claim" —** A claim arising out of work-related illness or injury which is generally covered by Workers' Compensation insurance and not by this Fund.

"Total Disability" — The complete inability, due to illness, injury or medical condition, to engage in any business, occupation or employment, even on a part-time basis, for which the Employee or Dependent is qualified or becomes qualified by reason of education, training or experience for pay, profit or compensation.

"Trust Agreement" — The Agreement and Declaration of Trust which established the Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund.

"Trustees" or "Board of Trustees" — The Trustees designated in the Agreement and Declaration of Trust together with their successors designated and appointed in accordance with the terms of the Agreement and Declaration of Trust.

SECTION II

INITIAL ELIGIBILITY - ACTIVE EMPLOYEES (FIRST TIME ELIGIBILITY)

All Employees working under the jurisdiction of Local No. 47 who have been employed by a Contributing Employer for six (6) consecutive months (or less) for whom contributions have been received for at least 520 hours will become eligible on the first day of the second month following the month for which contributions have been received for 520 hours. (Example: If an Employee works a total of 520 hours in January, February and March, eligibility will commence effective May 1). If authorized by Local 47, an Employee may also establish initial eligibility by working outside Local 47's jurisdiction based upon contributions received pursuant to a valid reciprocity agreement between Local 47 and the Local having jurisdiction over the territory where the work is to be performed.

CONTINUATION OF ELIGIBILITY

An Employee, once having established initial eligibility, will continue to be eligible so long as he is credited with 130 hours of contributions per month. 130 hours of contributed employment for the month will provide eligibility for the second month following the month for which the hours are reported. (Example: 130 hours of contributions for June will provide eligibility for the month of August). In the event 130 hours of employment are not reported, the Employee may continue to be eligible by drawing on the hours in his hourly reserve bank, if any.

HOURLY RESERVE BANK

The 520 hours required to establish initial eligibility will be put into an hour "bank" for purposes of continuing eligibility when the Employee fails to be credited with the minimum of 130 hours of employment and contributions in any month. All hours worked and for which contributions are received in the month will be credited to the Employee's bank, less the 130 hours to maintain eligibility. As of January 1, 2006, Employees may not accumulate more than 1,170 banked

hours at any one time, but do not lose any excess hours existing in the bank on the date of this change.

In order to utilize the hourly reserve bank, the Employee must either:

1). Be insured for twelve (12) consecutive months, or;

2). Have accumulated 1,170 hours in the hourly reserve bank.

Example

An Eligible Employee with 520 hours works 80 hours in July: 50 hours are taken from the bank to maintain eligibility for September. A balance of 470 hours is left in the bank.

In August, the Employee works and contributions are received for a total of 200 hours of employment; 130 hours are required to insure the Employee for October and 70 hours are put back in the "bank" to bring the bank to 540 hours. The bank of hours can be built to a maximum of 1,170 hours. A bank of 1,170 hours may continue eligibility for an Employee who fails to work or be credited with contributions for a period of 9 months.

Example

If the Employee does not work in September, October, November, December, January, February, March, April and May, the 1,170 hours in the bank will continue eligibility for the months of November, December, January, February, March, April, May, June and July, **if qualified to use the bank.**

In the event of the Participant's death, the hour bank will be extended to his Eligible Dependents until the bank is depleted.

TERMINATION — FOR INSUFFICIENT HOURS AND CONTRIBUTIONS

Eligibility will terminate on the last day of the month following the month in which the Employee has not been credited with 130 hours of employment

and/or 130 hours from his hour bank or 130 hours through a combination of hours worked and hours in his hour bank.

An Employee will be notified of the termination along with a self-pay notice. The termination notice shall be sent by regular mail. Unless termination is avoided through self-payments, reinstatement will only be permitted through contributions received from an Employer as a result of hours worked by the Employee.

Notice of termination under this Plan will be deemed sufficient if mailed to the Participant's last known address as shown in the Plan's records.

REINSTATEMENT OF ELIGIBILITY

If eligibility has been terminated due to insufficient hours for less than twelve (12) months, it will be reinstated on the first day of the second month following the month in which the Employee has been credited with at least 130 hours of contributions and banked hours. If eligibility has been terminated for more than twelve (12) months, the eligibility will be reinstated on the same basis as a new Employee under the Initial Eligibility provisions of this Plan. After retirement, eligibility must be continuous and may not be reinstated once lost, unless otherwise provided in this Plan.

SELF-PAYMENT FOR CONTINUATION OF ELIGIBILITY

An Employee who is totally or partially unemployed and is **registered on the out of work list at the Local Union and/or available for work in the jurisdiction of Local 47** may self-pay for lack of hours worked or because the accumulated hours in the hourly reserve bank have been depleted; however, the Employee cannot self-pay unless he is first eligible for benefits through Employer contributions.

An Employee may self-pay for continued eligibility and benefits, except weekly disability benefits, for a period of twelve (12) consecutive months. (NOTE: During periods of high unemployment, the Trustees may extend the 12-month period to 18 months).

The self-pay rate for a period of twelve (12) consecutive months shall be equal to 130 hours times the current contribution rate, adjusted by the number of hours in the hour bank to maintain the Active Employee Schedule of Benefits.

In the event an Employee does not elect to self-pay for continued eligibility but has hours remaining his/her the hour bank, those hours will be automatically allocated to enrollment in the Minimum Coverage Self Payment Program. When the remaining hours are insufficient to maintain coverage, the Employee may choose to self-pay the difference or allow coverage to terminate. If terminated, any remaining hours will be preserved in the hour bank for up to 12 months. If no further contributions are received on behalf of the Employee within that period, the hour bank will be returned to zero.

MINIMUM COVERAGE

Participants can elect the Minimum Coverage Program if coverage terminates and they do not have sufficient banked contributions or are not yet eligible to utilize their bank.

Participants electing the Minimum Coverage Self-Payment Program will be given credit towards satisfying the continuous eligibility requirement for utilization of banked contributions for each month they remit a Minimum Coverage Self-Payment.

Participants who have not elected to be covered by the Minimum Coverage Self-Payment Program, but who have sufficient hours in their hour bank to do so according to the following schedule, will be automatically enrolled and their hour bank will be used to maintain Minimum Coverage for as long as sufficient hours are available. Hours will be utilized according to the following schedule (subject to revision to reflect future increases in the actual cost of coverage):

Single Contract - 20 hours

2 Person Contract – 44 Hours

Family Contract* – 53 hours

*Family coverage will be applied automatically to a member with a family; lesser coverage may not be elected.

Participants who elect to maintain the Regular Schedule of Benefits by remitting a self-contribution equal to one hundred thirty hours (130) hours multiplied by the contribution rate, may elect to change to the Minimum Coverage Self-Payment Program at any time.

Participants can only opt back into the Regular Coverage if they re-establish eligibility via the Plan's reinstatement rules.

CONTINUATION OF ELIGIBILITY FOR DISABLED EMPLOYEES

An eligible Employee who becomes disabled and unemployed due to illness or injury either on or off the job will have his monthly eligibility continued by the Fund at no cost to the Employee, up to a maximum period of twelve (12) months for one continuous period of disability, provided they are eligible on the date the disability first began. The period of "free insurance" will commence on the first day of the month following the month in which the disability commenced. At the end of the twelve (12) month period, hours accumulated in his hour bank will be used to continue the Employee's eligibility until the hour bank has been exhausted. The Employee must then return to work for a period not less than 520 hours and contributions must be received on his behalf from a Contributing Employer for 520 hours in order to reestablish eligibility.

To qualify for this benefit, **the Employee must submit evidence of disability to the Fund Office that is satisfactory to the Trustees.**

WITHDRAWAL STATUS

An Employee who elects to be placed on Withdrawal Status as permitted under the Constitution and By-Laws of the International Association of Heat and

Frost Insulators and Allied Workers ("By-Laws") may continue to participate in this Plan, provided the following conditions are met:

1. At the time the Employee is placed on Withdrawal Status by the Union, he is an active Participant in the Plan;

2. While on Withdrawal, the Employee is employed with an Employer signatory to the collective bargaining agreement with the Union in a capacity permitted under the By-Laws, and;

3. The Employer pays into the Fund on the Employee's behalf the equivalent of not less than 40 hours of contributions per week at the current rate applicable to Active Employees.

COVERAGE FOR NON-BARGAINING UNIT MEMBERS

Participation in this Fund is also available to the non-bargaining unit employees of a Contributing Employer, as follows:

- Coverage is offered only for the medical/health care benefits outlined in the Plan; ancillary benefits such as life insurance, death benefits, disability benefits and retiree health care are not provided;
- Enrollment is generally available only to active non-bargaining unit employees under age 65. Employees over age 65 will have the option to elect the Medical Advantage Plan by paying the actual cost of coverage applicable while coverage is in effect. Where both spouses work for the same contributing employer, contributions must be submitted on behalf of both (including any active employee over age 65);
- The Hour Bank, Retiree Self-Payment and other provisions of this Plan, as determined from time-to-time by the Trustees, are not available to non-bargaining unit employees;
- The Working Spouse Rule will be enforced as to non-bargaining unit employees;

- Contributing Employers seeking to exercise this option for their non-bargaining unit employees must execute and comply with the terms of the applicable Participation Agreement, provide a list of all non-bargaining unit employees and credit coverage certificates for those employees opting out of coverage, and contribute 130 hours per month at the current hourly rate set by the Trustees for each covered non-bargaining unit employee.

RECIPROCITY WITH OTHER LOCAL UNIONS

The Trustees may elect to enter into a Reciprocal Agreement with other Local Unions in order to provide continuity of coverage for the Employees. It is the responsibility of the Employee to notify the Fund Office that he was/is employed in the jurisdiction of another Local Union and the Employee must complete proper request/authorization forms for the transfer of eligibility hours and contributions.

The Reciprocity Procedure is not automatic and it is important that the Employee notify the Fund Office immediately in the event of employment in another jurisdiction. An authorization card must be signed and filed with the Fund Office. The Trustees have executed Reciprocity Agreements with the following Locals/Welfare Funds:

Local 1 - St Louis, Missouri
Local 2 - Pittsburgh, Pennsylvania
Local 3 - Cleveland, Ohio
Local 6 - Boston, Massachusetts
Local 7 - Seattle, Washington
Local 8 – Cincinnati, Ohio
Local 10 – Little Rock, Arkansas
Local 13 – Jacksonville, Florida
Local 14 - Philadelphia, Pennsylvania
Local 17 - Chicago, Illinois
Local 18 - Indianapolis, Indiana
Local 21 - Dallas, Texas
Local 22 - Houston, Texas
Local 23 – Harrisburg, Pennsylvania
Local 24 - Washington, DC

Local 25 - Detroit, Michigan
Local 27 – Kansas, Missouri
Local 28 – Denver, Colorado
Local 30 - Syracuse, New York
Local 33 - Wallingford, Connecticut
Local 34 – Minneapolis, Minnesota
Local 37 – Evansville, Indiana
Local 38 - Wilkes-Barre, Pennsylvania
Local 39 - Omaha, Nebraska
Local 40 - Albany, New York
Local 41 – Fort Wayne, Indiana
Local 45 - Toledo, Ohio
Local 46 – Knoxville, Tennessee
Local 48 – Atlanta, Georgia
Local 50 – Columbus/Dayton, Ohio
Local 53 - New Orleans, Louisiana
Local 55 – Mobile, Alabama
Local 60 – Miami, Florida
Local 64 – Tulsa, Oklahoma
Local 66 - Amarillo, Texas
Local 67 – Tampa, Florida
Local 69 – Salt Lake City, Utah
Local 72 – Greensboro, North Carolina
Local 73 – Phoenix, Arizona
Local 75 – South Bend, Indiana
Local 78 - Birmingham, Alabama
Local 80 – Charleston, South Carolina
Local 81 - Cedar Rapids, Iowa
Local 82 - Spokane, Washington
Local 84 - Akron, Ohio
Local 85 – Norfolk/Richmond, Virginia
Local 86 – Nashville, Tennessee
Local 87 – San Antonio, Texas
Local 90 – Memphis, Tennessee
Local 92 – Columbia, North Carolina
Local 94 – Oklahoma City, Oklahoma
Local 96 – Savannah, Georgia
Local 97 - Anchorage, Alaska
Local 114 – Jackson, Mississippi
Local 133 - Fargo, North Dakota
Local 135 - Las Vegas, Nevada

RETIRED EMPLOYEES

A Participant who is part of the Bargaining Unit or an employee of the Union on the date of retirement and who meets the criteria set out below will be eligible to participate in the Plan after retirement. To obtain post-retirement coverage, the following criteria must be established:

1). The Participant must be eligible under the terms of the Plan by way of employer contributions, banked contributions or self-payments on the date of retirement, and;

2). The Participant must be receiving an Early, Normal or Disability retirement benefit from the Heat and Frost Insulators and Allied Workers Local 47 Retirement Trust Fund, or be an employee of the Union not participating in the Local 47 Retirement Trust Fund, and;

3). The Participant must have been eligible in the Plan for not less than a total of one hundred and twenty (120) months, which eligibility need not have been consecutive, and one of the following: a) at least six (6) months in each of the ten (10) years immediately preceding the date of retirement; or b) at least eighty (80) months in total during the ten (10) year period immediately preceding the date of retirement, and;

4). Payment by the Participant of monthly self-contributions at the rate set from time-to-time by the Plan's Trustees. **Any lapse in coverage resulting from the failure to make a monthly self-contribution will result in the permanent loss of eligibility.**

For purposes of calculating eligibility for post-retirement coverage, the Participant will be considered to have been eligible in the Plan during any period of time: a) spent in active military duty with any branch of the armed forces of the United States of America (up to a maximum of twenty-four (24) months); and b) on disability and receiving disability benefits through Section V of this Plan.

RETIREE CONTRIBUTION SCHEDULE

The monthly contribution will be required on the first day of the month for which the Retired Participant) has exhausted his eligibility as an Active Employee. The Retiree self-payment rates are available at the Fund Office. Retirees are categorized as follows:

Single Retiree over age 65
Retiree on Medicare, Spouse not on Medicare
Retiree and Spouse over age 65
Widow over age 65
Widow under age 65
Single Retiree under age 57
Single Retire age 57-65
Early Retiree and Spouse under age 57-65
Early Retiree and Spouse age 57-65
Early Retiree and Family under age 57
Early Retiree and Family age 57-65
Retiree not on Medicare, Spouse on Medicare
Single Disabled Retiree eligible for Medicare
Disabled Retiree eligible for Medicare w/Spouse
not eligible for Medicare
Disabled Retiree eligible for Medicare w/Spouse eligible for Medicare
Disabled Retiree w/Family

There is an additional charge of $85.00 per dependent child.

The Eligibility of a Retiree and/or Spouse must be continuous. The Retiree and/or Spouse must be eligible and apply for coverage at retirement and must maintain continuity of coverage in the Plan, except as expressly provided elsewhere in this Plan. A spouse who has been married to a Retiree for less than one (1) year as of the date of retirement is not eligible for coverage under this Plan. New dependents of a Retiree, including a new spouse, may not be added after the date of retirement (or first retirement in the case of a Retiree returning to active employment and subsequently retiring again).

If a Retiree works out of the jurisdiction of the Fund, the new employer will be primary and this Plan will be secondary. This Fund will only pay a Retiree's claim in the event there is no other coverage with any other insurance or health and welfare plan.

Return to Covered Employment — In the event an Employee has been retired for a period of not less than twelve (12) months and wishes to return to status as an Active Employee, he must 1) advise the Fund of his intentions and authorize the suspension of his pension benefits, and; 2) contribute the required Retiree self-contribution during his period of reemployment until he has been credited with at least 520 hours of contributions. Upon completion of the required hours, his eligibility will be reinstated as an Active Employee. After reinstatement of Active Employee status, his continued eligibility will be based upon the rules set forth above applicable to Active Employees. In the event the Employee is credited with less than 130 hours of contributions during the month, he must pay the difference between the Active Member rate and the hours contributed on his behalf to remain eligible as an Active Employee. Upon return to retired status, Active Employee benefits will continue until the Employee depletes his hourly reserve bank (if any), at which time the obligation to pay the Retiree self-contribution rate resumes.

A Retiree returning to Active Employee status who did not elect to continue participation in the Plan at the time of retirement may regain eligibility for coverage under the Plan if, counting only those hours worked after the return to Active Employee status, each of the conditions set forth under the "Retired Employees" section set forth above is met. Provided, however, that after an initial retirement, the Employee will be permanently ineligible for Sickness & Accident Weekly Disability Benefits and Active Member Life Insurance.

A Retired Employee who returns to work for a Contributing Employer but continues to receive a monthly benefit through the Heat and Frost Insulators and Allied Workers Local 47 Retirement Trust Fund (such as when the limitation on permitted hours has been waived) shall have hours for which contributions are received on his behalf (up to a maximum of 130 hours) credited to reduce the self-contribution payment owed to maintain health care coverage for that month.

After an Employee initially retires, he will not be eligible for the Sickness & Accident Weekly Disability Benefit or the Active Member Life Insurance.

ELIGIBILITY FOR WIDOWS & SURVIVING SPOUSES

The legal Spouse of an Eligible Employee (Active or Retired) may continue eligibility in the Plan through self-payment unless she remarries. Please contact the Fund Office for Self-Payment Rates.

Continuity of coverage must be maintained and self-payments received on the first day of the month following the date of death of the Eligible Employee. In the event of remarriage, eligibility will terminate on the first day of the month following the date of marriage. If less than thirty-six (36) months of continuous coverage has been extended under the Surviving Spouse Classification, the Surviving Spouse may continue her coverage for a combined maximum period before and after remarriage of thirty-six (36) months.

ELIGIBILITY FOR DEPENDENTS

An eligible Dependent shall mean an eligible Employee's (Active or Retired) legal Spouse and each unmarried child of the Employee to age 26, including any stepchild or adopted child who resides in the Employee's household and is dependent upon such Employee for his principal support and maintenance; provided, with respect to step-children, the Employee has been appointed the stepchild's full guardian by a court having jurisdiction over the child. In the case of coverage for a stepchild, the insurance of the natural parents will primary and secondary. If only one parent is insured, such insurance will be primary and this Plan will be secondary. In either case, this Fund will be either the secondary health care provider or the tertiary health care provider for the stepchild of the Employee.

When a claim arises, the Employee must present proof of employment for the natural parent(s), including the name, address and telephone number of the employer and the name and address of the health care provider. If it is claimed that the natural parent(s) is/are uninsured, proof satisfactory to the Trustees must be provided before coverage will be available under this Plan.

Coverage for Children born outside of Marriage - In a case where an Employee is not married to the mother of a claimed dependent child and/or was not married to the mother of the child at the time of birth, proof of paternity must be provided in the form of a registered birth certificate naming such Employee as the father, a court order establishing paternity, or an adoption order.

Disabled Child - If an unmarried child is chiefly dependent upon the Employee for support and maintenance and is incapable of self-sustaining employment by reason of physical or mental disability which commenced prior to the date such child's coverage would otherwise have terminated, coverage for such child will continue so long as such Employee's coverage remains in force. Proof of the Dependent child's incapacity must be submitted to the Trustees within thirty-one (31) days of the date coverage would have otherwise terminated.

Grandchildren/guardianship - A grandchild of an Employee with respect to whom the Employee or his spouse has been appointed full guardian for at least one (1) year may be covered as an Eligible Dependent, provided that it has been established that no other insurance coverage is available to such child and the Employee is entitled to a federal income tax exemption with respect to that child.

ACTIVE EMPLOYEES ELIGIBLE FOR MEDICARE:

The Plan will be primary and Medicare will be secondary for all Employees and their Spouses, regardless of age.

RETIREE OPT OUT PROVISIONS

Retired Participants who have other health care coverage may elect to "Opt Out" of coverage with this Fund and reinstate coverage at a later date, if the Fund continues to provide such retiree coverage. The guidelines for this Opt Out option are as follows:

- The Retired Participant ("Retiree") may elect to Opt Out of coverage at any time;
- The Retiree must complete the applicable election form in order to activate this request;
- The Retiree must exhaust his/her hour bank before the election of this option will take effect;
- At all times while the option is in effect, the Retiree must remain a member in good standing with Local 47;

An Opt-Out Fee in the amount of Ten dollars ($10.00) must be remitted on a monthly basis. The purpose of this Fee is solely for reporting, to reserve the Retiree's ability to resume coverage in the future should such coverage be available under this Plan at the time the option is exercised. The Fee is not a guarantee of future benefits, does not provide any current coverage or benefits, and does not provide monthly eligibility for the Retiree or family.

- The spouse of a Retiree who is on Medicare may separately opt out of coverage while the Retiree remains covered, in which case he or she will have the same opportunity to reinstate coverage as a Retiree;

- The option to reinstate coverage with this Fund can be exercised effective January 1 of each year, except in the case of a "qualifying event" as that term is defined under federal law;
- If the option to reinstate coverage is exercised, coverage will not be provided retroactively. Coverage will be reinstated the first day of the month following receipt of the required documentation by the Fund Office. Once reinstatement is approved, the Retiree will be responsible for monthly self-payments at the current self-payment rate for Retirees as established by the Board of Trustees.
- This option is subject to termination with a ninety (90) day prior written notice by the Board of Trustees. In the event the option is terminated, the Retiree may elect to return immediately to coverage under the Heat and Frost Insulators and Allied Workers Local 47 Welfare Fund unless the Fund no longer provides coverage for Retirees.

WORKING SPOUSE RULE

If the spouse of an Employee regularly works thirty-two (32) or more hours per week for an employer and is entitled to elect health/medical insurance as a benefit of employment, no benefits shall be payable under this Plan to the extent that coverage would have been available under the Plan of the spouse's employer if the spouse had elected the employer-sponsored insurance. The spouse of an Employee who is eligible and entitled to elect health/medical insurance **will not be covered** by this Plan for dependent coverage if they fail to enroll in the employer-sponsored plan.

A "hardship" exception to this Rule is provided if the working spouse has gross annual wages of less than $25,000. An exception is also provided if the only health care plan offered by the employer is an HMO plan, and the Employee's residence is more than 25 miles outside the HMO service area.

If a spouse works and elects coverage through his/her employer as required above, that employer's plan is primary and this Plan will be secondary for all of the spouse's medical claims**. This Plan will not pay any of the health care expenses of a spouse who does not elect his/her employer's coverage** unless the "hardship" exemption applies.

Additional terms:

- The Working Spouse Rule only applies to the spouse's claims, not claims incurred by children;
- The Rule applies to Retirees as well as active employees, but only if the retiree's spouse is still actively employed;
- The Rule does not apply to COBRA coverage (if the spouse terminates employment and declines COBRA, this Plan will pay normal benefits);
- The Rule applies only to medical and drug expenses;
- The Rule applies whether or not the spouse's employer 1) requires its employees to pay part of the premium; 2) offers an incentive to induce employees not to enroll; 3) offers strictly single-only coverage, or; 4) offers medical coverage as an option under a "cafeteria" plan;
- No reductions will apply if the spouse's claim would have been denied under the employer's plan (for example, if the claim was for a service not covered under the employer's plan);
- If covered under the employer's plan, the spouse must receive his or her medical care in accordance with that plan's rules. This Plan will not cover the amount of the employer's plan's noncompliance penalties, or any other charges incurred because of a failure to follow the other plan's rules (including the failure to use HMO providers or follow the HMO's referral procedures);
- Employees are required to provide accurate and timely information to the Fund about a spouse's employment status and benefit entitlement. The Fund office may require verification of such information from the spouse's employer.

NEW DEPENDENT/FAMILY ELIGIBILITY BENEFITS

New family members (new Spouses, stepchildren, etc.) will be eligible for benefits on the date they become Eligible Dependents as defined above.

Birth Certificates for children and Marriage Certificates for spouses are required to establish eligibility as a Dependent. In the event a claim is received without either a Birth Certificate or Marriage Certificate, the Plan Administrator is required to request and obtain such proof prior to processing the claim. In the case of stepchildren, coverage is not automatic. The Employee must have been appointed the stepchild's full guardian by a court having jurisdiction over the child. A copy of the Judgment of Divorce of the parents of the stepchild is required to establish responsibility for health care. Claims will be processed pursuant to the Coordination of Benefits Provisions herein.

MEDICARE

When you are eligible to enroll in Medicare, you must enroll in both parts A & B of Medicare and submit a copy of your Medicare Card to the Fund Office within 30 days to remain eligible under BCBSM Medicare Advantage.

If you are an Active Participant, this Plan will be primary and Medicare will be secondary for all Employees and their Spouses, regardless of age. For Retirees, Medicare Advantage will provide coverage.

For retirees on Medicare and retiree spouses on Medicare, benefits are provided through the Blue Cross Blue Shield Medicare Plus Blue Group-PPO – a Medicare Advantage PPO Plan.

BCBSM will administer both your Medicare and your Medicare Plus Blue Group-PPO. Use only your new BCBSM Medicare Plus Blue Group-PPO Card. (Put your Medicare "red, white, and blue" card away for safekeeping.)

ONE Explanation of Benefits (EOB): For each medical service rendered, you will receive only one EOB. Therefore, you will not have to compare your BCBSM and Medicare EOB's to understand how your claims and services were paid.

ONE Benefit Book: You will get only one (1) benefit book. Therefore, there is no need to compare your BCBSM and Medicare benefit books to understand your benefits.

BCBSM's Dedicated Medicare Advantage Member Serving Center: If you have questions, you can call BCBSM's Medicare Plus Blue Group-PPO customer service representatives toll-free at 1-866-684-8216, 8:30 a.m. to 5 p.m., Monday through Friday. They are specially trained to answer Medicare and the Medicare Plus Blue Group-PPO-related questions.

You will automatically be enrolled in the Medicare Plus Blue Group PPO Plan. If you do not want to participate in this new Plan, you must complete and return the Coverage Wavier Form.

IF YOU DO NOT PARTICIPATE IN THE BCBSM MEDICARE PLUS BLUE GROUP-PPO, YOU ARE NOT ELIGIBLE FOR ANY OTHER COVERAGE THROUGH THE FUND

NOTE: Please keep in mind that an individual can only be enrolled in one Medicare Advantage plan at a time. Enrolling in the Heat & Frost Insulators and Allied Workers Local 47 Medicare Plus Blue Group PPO will automatically dis-enroll you from any other Medicare Advantage health plan or Individual Part D Medicare Prescription drug plan in which you are enrolled.

Please refer to the separate Benefits-at-a-Glance for the Medicare Plus Blue Group-PPO benefits.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This Plan will recognize the eligibility of a child in accordance with a Qualified Medical Child Support Order ("QMCSO"), provided that the Order is submitted to the Trustees in accordance with the following provisions, and provided that the Order is determined by the Trustees to be a Qualified Order in accordance with ERISA. To obtain eligibility under thus section, a QMCSO must be submitted to the Trustees for approval.

A "Qualified Medical Child Support Order" is an Order issued by a court of competent jurisdiction that meets all of the following requirements:

1. The Order provides for child support, or provides for health insurance coverage, with respect to a child of a Participant.
2. The Order relates to benefits provided by the Plan.
3. The Order is issued in accordance with, and pursuant to, the domestic relations law applicable to the Participant and the child.
4. The Order clearly states the following information:
   i. The name, last known mailing address, and social security number of the Participant;
   ii. The name, address, and social security number, of each child to be covered in accordance with the Order;
   iii. A description of the type of coverage to be provided to each child identified above, or a description of the manner to be used in order to determine the type of coverage to be provided to each covered child;
   iv. The period of applicable time, and
   v. The name of the Insurance plan to which the Order will apply.
5. The Order does not require that the Plan provide any type or form of benefit, or any option, not otherwise provided under the Plan, except as required to meet the medical child support requirements of Section 1908 of the Social Security Act, as added by the Omnibus Budget Reconciliation Act of 1993. In particular, and regardless of the provisions of the Plan, a Qualified Medical Child Support Order may require that the Plan provide health insurance coverage for a Participant's child who:
   i. Was born outside marriage;
   ii. Is not claimed as a dependent on the Participant's Federal income tax return;

iii. Does not reside with the Participant; and

iv. Does not reside within any service area maintained by the Plan.

QMCSO Procedures

A Qualified Medical Child Support Order must be submitted to the Plan in order to begin coverage for the child who is made eligible under the Order. No coverage will be provided for the child prior to receipt of the QMCSO, unless the child is eligible for coverage under another provision of this Plan. The following procedure will be used in determining whether a submitted order is a QMCSO, which makes a child eligible for coverage by the Plan:

1. Upon receipt of the Order, a copy of the Order and these procedures shall be sent, using the addresses set forth in the Order, to:

   i. the Participant whose child is to be covered in accordance with the Order, and;

   ii. each child to be covered in accordance with the Order.

2. A copy of the Order shall also be provided to the administrative service provider and the legal counsel for the Plan.

3. The Order shall be placed on the agenda of the next meeting of the Trustees.

4. Following the meeting of the Trustees described in 3 above, the Participant and each child covered under the Order shall be notified regarding whether the Order has been determined to be a QMCSO.

5. If an Order is determined to be a QMCSO, then each child will be covered retroactive to the date on which the Order was received by the Plan, unless a later effective date is provided in the QMCSO.

6. If an Order is determined not to be a QMCSO, then the Participant and each child shall be notified of the reasons for such a determination.

Eligibility Under a Qualified Medical Child Support Order

If the Trustees determine that an Order is a Qualified Medical Child Support Order:

1. The Plan will enroll the child covered by the QMCSO without regard to any enrollment period which normally limits the time when a dependent may be enrolled for coverage; and
2. If the Participant does not enroll the child for dependency coverage, then the Plan will enroll the child covered by the QMCSO upon application of either the child's other parent or a State agency administering a Medicaid Program covering the child, and
3. The Plan will not discontinue coverage for the child unless:
    i. the period for insurance coverage stated in the QMCSO expires;
    ii. the Plan receives satisfactory written evidence that the Qualified Medical Child Support Order is no longer in effect;
    iii. the Plan receives satisfactory written evidence that the child is or will be enrolled in a plan with comparable health insurance coverage, which will take effect not later than the effective date of termination of coverage by the Plan;
    iv. the child ceases to be eligible for insurance coverage under the age restrictions normally applied to all children covered under the Plan;
    v. the Plan completely discontinues providing dependency coverage;
    vi. the Plan fails to receive the employer or self-payment contributions normally required to continue coverage for the Participant and his dependents under this Plan;
    vii. the Participant's employer ceases to be a contributing employer to the Plan, or;

viii. the Participant ceases to be eligible for coverage, including eligibility under the COBRA or self-payment provisions of the Plan.

Responsibility to Withhold Participant's Portion of Contributions

Each contributing Employer is responsible for withholding from an Employee's pay, and to forward to the Plan, the amount required to be contributed by the Employee to maintain coverage for the Employee and his Dependents; provided, however, that the amount withheld does not exceed the amount permitted to be withheld (1) under section 303(b) of the Consumer Credit Protection Act, or (2) under any regulations promulgated by the Secretary of Labor.

State Agencies to Be Treated the Same As Any Other Agent or Assignee

The State agency which has been assigned the rights of a child covered under a QMCSO will be treated the same as any other agent or assignee of a person covered by the Plan.

Direct Reimbursement to the Custodial Parent

The Plan will directly reimburse the custodial parent of a child covered by a QMCSO, for expenses actually incurred and covered under the Plan, regardless of whether the custodial parent is a Participant in the Plan. In accordance with this provision, the Plan will:

1. Provide such information to the custodial parent as is necessary for the child to obtain benefits through coverage by the Plan, and
2. Permit submission of claims for covered services by the custodial parent, or by the medical services provider with the custodial parent's approval, without the approval of the noncustodial parent, and
3. Make payment directly to the custodial parent, the medical services provider, or the State agency, provided that: (i) the claim is submitted in accordance with paragraph 2 and in accordance with the normal procedures of the Plan, (ii) the claim is determined to be covered under

the benefit provisions of the Plan, in accordance with the normal procedures for determining whether a claim is covered by the Plan, and (iii) the claim is subject to the normal Coordination of Benefit provisions of the Plan, which may reduce in whole, or in part, the amount of payment to be made under this Plan.

COBRA

Under federal law known as "COBRA" – the Consolidated Omnibus Budget Reconciliation Act of 1985, most employers sponsoring group health plans are required to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "qualifying events"). The following notice is intended to inform you, in a summary fashion, of your rights and obligations with respect to continuation coverage under this Plan. Both you and your spouse should take the time to read this information carefully.

If you are an employee of a contributing employer and you are covered by the Plan, you have a right to choose continuation if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an Employee covered by the Plan, you have the right to choose continuation coverage under the Plan for any of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment with a contributing employer;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

Dependent children of an employee covered under the Plan have the right to choose continuation coverage if group health coverage is lost for any of the five following reasons:

1. The death of the employee-parent;
2. The termination of the employee-parent's employment (for reasons other than gross misconduct) or a reduction in the employee-parent's hours of employment with a contributing employer;
3. The parents become divorced or legally separated;
4. The employee-parent becomes entitled to Medicare; or
5. The dependent ceases to be a "dependent child" under the terms of the Plan.

In addition, there may be a right to continuation coverage for certain eligible retirees and their spouses, surviving spouses, and dependent children if a Title 11 Bankruptcy proceeding is commenced with regard to a contributing employer. If this occurs, you should contact the Plan Administrator concerning your rights.

Children who are born to or placed for adoption with a covered employee during the period of the employee's continuation coverage are also "qualified beneficiaries" entitled to COBRA continuation coverage. Thus, once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan's rules, the child will be treated like all other COBRA qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and **not** from the date of the child's birth or placement for adoption).

Under the law, the Employee or family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the date of the event or the

date on which coverage would end under the Plan because of the event, whichever is later. Your employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, reduction in hours of employment, or Medicare entitlement. When the Plan Administrator is notified that one of these events has happened, you will in turn be notified that you have the right to choose continuation coverage. Under the law, you have 60 days from the later of the (1) date you ordinarily would have lost coverage because of one of the events described above, or (2) the date of the notice of your right to elect continuation coverage to inform the Plan Administrator that you want continuation coverage. If you do not choose continuation coverage, your group health insurance coverage under the Plan will end.

If you choose continuation coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated employees (or their family members). If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that qualified beneficiaries be afforded the opportunity to maintain continuation coverage for up to 18 months. In the case of either qualifying events, qualified beneficiaries will be afforded the opportunity to maintain continuation coverage for up to 36 months.

An 18-month period of continuation coverage may be extended for up to 11 months (for a total of up to 29 months of continuation coverage) if the qualified beneficiary has been determined to be disabled (under Title 11 or XVI of the Social Security Act) as of the date of the employee's termination or reduction in hours and if the Plan Administrator is timely notified within 60 days of such determination (and within the initial 18-month continuation coverage period). Effective as of January 1, 1997, the 11-month extension also applies if a qualified beneficiary becomes disabled at any time within the first 60 days of the 18-month continuation coverage period, provided that the Plan Administrator is timely notified of the disability, as described above. The 11-month extension

applies to all disabled qualified beneficiaries entitled to COBRA coverage as a result of the same qualifying event, subject to the above notice requirements.

Additional qualifying events can occur while continuation coverage is in effect. Such events may extend an 18- or 29-month period of continuation coverage to a period of up to 36 months, but in no event will coverage extend beyond 36 months after the initial qualifying event. You should notify the Plan Administrator immediately if a second qualifying event occurs during your continuation coverage period.

The law also provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29- or 36-month period for any of the following five reasons:

1. The Plan Sponsor no longer provides any group health coverage;
2. The premium for your continuation coverage is not timely paid (within the applicable grace period);
3. The individual becomes covered under another group health plan (as an employee or otherwise) that (a) does not contain any pre-existing condition exclusion or limitation applicable to the individual, or (b) contains a pre-existing condition exclusion or limitation, but does not apply to the individual because he or she has been credited with at least 12 months of creditable health coverage, which ended no more than 62 days before coverage under the new plan began;
4. The individual becomes entitled to Medicare; or
5. Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. You are required to notify the Plan Administrator within 30 days of any such final determination.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to

your eligibility for coverage under the Plan. The Plan reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible. Once your continuation coverage terminates for any reason, it cannot be reinstated.

Under the law, you may be required to pay up to 102 percent of the applicable premium during the 18 or 36-month period of continuation coverage. However, during the additional 11 months of continuation coverage (for disability), you may be required to pay up to 150 percent of the applicable premium.

The law also says that, at the end of the 18-, 29- or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan if one is provided under the Plan.

This notice is a summary of the law and is therefore general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstances. If you have any questions about the law, please contact the Plan Administrator, TIC International Corporation, at 6525 Centurion Drive, Lansing, MI, 48917; 1-877-244-9473. Also, if you have changed marital status, or if either you or your spouse has changed addresses, please notify the Plan Administrator immediately.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for late enrollees). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan or other source, a certificate or proof of coverage may help you obtain coverage without a pre-existing condition exclusion.

You have the right to receive a certificate of prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of

health care coverage. Check with your new plan administrator to see if your new plan excludes coverage for preexisting conditions and if you need to provide a certificate or documentation of your previous coverage. To receive a certificate, please contact the Fund Office.

HIPAA also requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which can be obtained from the Fund office.

Neither this Plan or its sponsor will use or further disclose information that is protected by HIPAA ("protected health information" or "PHI") except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any benefit or employee benefit plan.

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

If you have questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C., 20210.

SECTION III

NOTICE OF CHANGES

The Plan Administrator's Office must be notified of any change as follows:

Marriage - To add a Spouse to coverage, the marriage must be reported within 30 days. A copy of the certificate of marriage must be filed in the Fund Office.

Children - Birth Certificates are required of all Dependent Children.

Stepchildren - A copy of the court order appointing the employee as full guardian of the stepchild, plus complete information regarding the employment status, including the names and addresses of the employers and the insurance provider for the natural parent and the policy number, name and address of the insurance providers.

Births - To add a child to coverage, the birth must be reported within 30 days. A copy of the birth certificate must be filed in the Fund Office. The child will be covered from the moment of birth, as provided herein.

Adoptions - Adoption of a child must be reported within 30 days to add the child as an eligible Dependent and a copy of the legal adoption papers or court order must be filed in the Fund Office.

Change of Address - Any change of address, or name change shall be reported immediately.

Deaths - Deaths should be reported immediately. A certified copy of the Death Certificate is required.

Divorce - Divorce must be reported immediately and a copy of the Judgment of Divorce must be filed in the Fund Office. A former Spouse is not eligible for

benefits commencing on the date of the divorce, except as provided under the Continuation of Coverage (COBRA) Provision as outlined on pages 33-37. Eligible Dependent children will continue to be covered if they continue to be legal Dependents.

THE HEALTH CARE FALSE CLAIM ACT

The submission of false claims information to a health care benefits plan is a felony, under the "Health Care False Claim Act" which was passed by the Michigan legislature. Under this law, anyone who submits false claims information or conspires to do so for the purpose of obtaining benefits for themselves or someone else could be found guilty of a felony and could face imprisonment for up to ten (10) years and/or fines up to $50,000.00, depending on the section of the act which was violated.

The Health Care False Claim Act provides:

1. A person shall not make or present or cause to be made or presented to a health care corporation or health care insurer a claim for payment of health care benefits knowing the claim to be false.

2. A person shall not make or present or cause to be made or presented to a health care corporation or health care insurer a claim for payment of health care benefits which he or she knows falsely represents that the goods or services were medically necessary in accordance with professionally accepted standards. Each claim which violates this subsection shall constitute a separate offense. A health facility or agency shall not be liable under this subsection unless the health facility or agency, pursuant to a conspiracy, combination, or collusion with a physician or other provider, falsely represents the medical necessity of the particular goods or services for which the claim was made.

3. A person shall not knowingly make or cause to be made a false statement or false representation of a material fact to the health care corporation or health care insurer for use in determining rights to health care benefits. Each claim which violates this subsection shall constitute a separate violation.

4. A person who, having knowledge of the occurrence of an event affecting his or her initial on continued right to receive a health care benefit, or the continued right of any other person on whose behalf he or she has applied for or is receiving a health care benefit, shall not conceal or fail to disclose that event with intent to obtain a health care benefit to which the person or any other person is not entitled, or to obtain a health care benefit in an amount greater than that to which the person or any other person is entitled.

5. A person who violates this section is guilty of a felony punishable by imprisonment for up to ten (10) years, or by a fine of not more than $50,000.00, or both.

6. This section does not apply to statements made on an application for coverage under a certificate or policy of insurance issued by a health care insurer or coverage under a certificate issued by a health care corporation.

APPEAL PROCEDURES

Internal Appeals

If any claim for benefits filed by a Participant ("Claimant") is denied by the Fund's Plan Administrator in the exercise of authority delegated to it by the Trustees, the denial, and the reason therefore, shall be communicated to the Claimant via first class mail within the time period prescribed by law. Where appropriate, such notification of denial shall inform the Claimant of any statements, documents, papers, or information which, if submitted to the Plan Administrator by the Claimant, might reverse the denial of the claim.

The notification of denial shall also inform the Claimant of his or her right to appeal the denial by submitting a written request for review within one hundred and eighty (180) days of receiving notice that the claim was denied. Such appeal shall be addressed to the Board of Trustees at the Fund's Office.

After reviewing the factual situation involved in the disputed claims, the Board of Trustees (or a Committee appointed by the Board and authorized to act on behalf of the full Board of Trustees) shall make its decision on the appeal and

notify the Claimant of that decision. The Trustees may extend an invitation to the Claimant and/or his personal representative to appear before the Board where a personal appearance would afford the Trustees an opportunity to clarify the facts involved and render their final decision on an appeal.

Any decision rendered by the Trustees, or their authorized agent, after compliance with the foregoing conditions and appeal procedures, shall be final and binding on all parties concerned.

Appeals should be sent to the following address:

HEAT and FROST INSULATORS and ALLIED WORKERS LOCAL 47 WELFARE FUND
ATTN: APPEALS COMMITTEE
6525 Centurion Drive
Lansing, MI 48917
TOLL FREE # 1-800-323-8079
Telephone # 517-321-7502
FAX# 517-321-7508

Be sure to include your Member Identification Number and Local Union Number on all correspondence.

The Claimant may review pertinent documents relating to the denial and he may submit issues and comments in writing.

Decision on Review: A decision by the Board of Trustees will be made promptly and not later than 30 days if the appeal is for service not yet provided to the Claimant; or within 60 days if the appeal is for a service already provided. The decision on the review will be in writing and will include specific reasons for the decision.

External Review

If you are not satisfied with the decision made on your Internal Appeal, you have the right to request an external review within 60 days of the date of the internal appeal decision.

In reviewing your claim, every effort will be made by the Trustees to handle interpretations of the Plan and claims disputes in a consistent and equitable manner. The Trustees have full discretionary authority to determine eligibility for benefits under the Plan and to interpret the Plan, all Plan documents, Plan rules and procedures, and the terms of the Trust Agreement. Their decisions and interpretations will be given the maximum deference permitted by law for the exercise of such full discretionary authority and will be binding on all parties affected.

Review of an Adverse Benefit Determination

Most questions or concerns about decisions Blue Cross Blue Shield of Michigan ("BCBSM") makes on claims or requests for benefits can be resolved through a phone call to one of the BCBSM Customer Service Representatives. You can locate the phone number in the top right-hand corner of the first page of your BCBSM Explanation of Benefits statement or in the letter we send to notify you that we have not approved a request for benefits.

In addition, the Employee Retirement Income Security Act of 1974, as amended, (ERISA) claims procedure regulations protect you by providing you the opportunity to request the review of an adverse benefit determination.

An adverse benefit determination is 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 based on your eligibility to participate in the Plan. You may request review of an adverse benefit determination on a pre-service claim, an urgent care claim, or a post-service claim.

"Pre-service claim" means a claim for a benefit where your plan conditions receipt of the benefit, in whole or in part, on obtaining approval in advance of receiving medical care.

"Urgent care claim" means a claim for medical care or treatment where applying the time periods for non-urgent determinations could seriously jeopardize your life or health or your ability to regain maximum function, or in

the opinion of a physician who knows your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

A claim will be found to be one involving urgent care in one of two ways. If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, we will treat it as such. Absent a determination by your physician, we will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

"Post-service claim" means all other claims that are not "pre-service claims" or "urgent care claims".

To obtain review of an adverse benefit determination, you must follow the review procedures below. These procedures vary, depending on whether you are asking for review of a decision on a pre-service, a post-service, or an urgent care claim.

With the exception of requests for review of adverse benefit determinations involving urgent care claims, which may be made orally, all requests for review must be in writing. Normally, for all three types of claims, you must exhaust our internal review procedure before you can initiate a civil action under section 502(a) of ERISA to obtain benefits.

Review Procedure

A. Review Procedure — Post-service claims:

Under the review procedure for post-service claims, you are entitled to a two-step appeal process. BCBSM must provide you with a written determination within 30 calendar days of receipt of your written requests for review at each level. However, that 30-day timeframe may be suspended if BCBSM has not received information they have requested in writing from you or from your health care provider, for example your doctor or hospital.

The review procedure for post-service claims provides two levels of review:

1. To initiate the level 1 review, you or your authorized representative must send BCBSM a written statement explaining why you disagree with the determination. Please include in your request all documentation, records or comments you believe support your position. You must request review no later than 180 calendar days after you receive our decision on your claim for benefits. Mail your written request for review to the address found in the top righthand corner of the first page of your Explanation of Benefits statement, or to the address contained in the letter BCBSM sends you to notify you that BCBSM has not approved a benefit or service you are requesting. BCBSM will respond to your request for review in writing within 30 days, unless they have notified you in writing that they need additional information to complete the review. If you agree with their response, it becomes their final determination and the review ends.

2. If you disagree with the BCBSM response to your request for review at level 1, you may then proceed to level 2. You must request review at level 2 in writing no later than 30 calendar days after you receive the BCBSM determination at level 1. Mail your request to the Fund Office, providing all documentation, records, and comments, that you feel support your position. You will receive a written determination within 30 days of receipt of your request for review at level 2, unless you are notified in writing that additional information is needed to complete the review. The written determination at level 2 will be the final determination regarding your request for review.

3. If you disagree with the final determination, or if the determination at each level is not issued within the 30-day time frame or the review procedures for level 1 and level 2 are otherwise not complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

B. Review Procedure — Pre-service claims:

1. The review procedure for pre-service claims is identical to the review procedure for post-service claims, except that BCBSM must provide you with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a two-step process. A determination will be issued within 15 calendar days of receipt of your request for a level 1 review, and within 15 calendar days of your request for a level 2 review. You still have 30 days after receipt of the level 1 determination to file your level 2 appeal.

2. If you disagree with the final determination, or if the determination at each level is not issued within the 15-day time frame or the review procedures for level 1 and level 2 are otherwise not complied with, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

C. Review Procedure — Urgent care claims:

1. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call: (313) 225-6800.

2. BCBSM must provide you with their decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review. All necessary information, including the BCBSM decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile, or other available similarly expeditious method. If the BCBSM decision is communicated orally, they must provide you or your authorized representative with written confirmation of their decision within 2 business days.

3. If you disagree with the BCBSM final determination, if they fail to issue the determination within 72 hours or otherwise fail to comply with the review procedures, or if you otherwise believe for any reason that you have a cause for legal action relating in any

way to this Plan, the Fund, its Trustees or others, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits or seek other relief that may be available under the law. **Any such legal cause of action must be brought within three years of the date your benefit was denied *(or the date your cause of action first arose, if earlier).***

In addition to the information found above, the following requirements apply to review of pre-service, post-service, and urgent care claims.

a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal review procedure.

b. No fees or costs may be imposed as a condition to requesting review.

c. Although there are set timeframes within which you must receive the final determination on all three types of claims, you have the right to allow additional time if you wish.

d. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

e. You may submit written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination.

f. The person who reviews your adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The determination on review will be a new determination; the initial determination on your claim will not be afforded deference on review.

g. If your request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment,

including whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.

h. Upon request, the medical expert whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination.

i. On review, you will be advised of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.

J. If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion free of charge upon request.

k. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be advised and provided an explanation of the scientific or clinical judgment free of charge upon request.

l. If your health plan provides for any voluntary appeal procedures beyond the level 2 review, you will be advised of those procedures in the level 2 response.

Appeals – Disability Benefit Claims

With respect to claims for disability benefits under this Plan, the follow rules shall apply:

1. In the event of an initial denial or denial on appeal, you will be provided with a discussion of the decision and an explanation why the Plan disagrees or does not follow:
   - the opinion of your treating health care professionals and vocational professionals, or
   - the opinion of medical or vocational experts whose advice was obtained on behalf of the Plan, or
   - a disability determination concerning you made by the SSA.

2. An explanation of the scientific or clinical judgment relied upon by the Plan will be provided for denials that are based on a medical necessity, experimental treatment or similar exclusion or limit.

3. Copies of any internal plan rules relied on in making a benefit denial, or a statement that such rules do not exist if there are no such rules, will be provided.

4. Before the Plan issues a denial on appeal based on new or additional evidence or a new or additional rationale, you will be provided the evidence or rationale in advance of a denial so you may respond.

5. If more than 10% of individuals residing in your county speak the same non-English language, the Plan will provide its services in a culturally and linguistically appropriate manner. This means the Plan will a) provide language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language; b) provide, upon request, a notice in any applicable non-English language; and c) include in the English versions of all claims and appeals notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

6. The Plan will also comply with all general requirements against bias in claims decision-making.

ADMINISTRATION

Interpretation

The Plan is administered solely by the Trustees and employees or agents of the Trustees, acting for them as authorized, and the decisions of the Trustees in all matters pertaining to the administration of the Plan is final. The Trustees make adopt rules and procedures for the administration of the Plan as they shall deem necessary and reasonable.

The Trustees have discretionary authority to make any determination with respect to an individual's eligibility for participation or benefits or to construe the provisions of the Plan, policies, procedures, resolutions or directives, as amended from time to time. This discretionary authority includes, but is not be limited to, the power to construe any disputed or doubtful terms of the Plan, Policies, Procedures or Directives as amended from time to time.

Miscellaneous Provisions

The headings and subheadings in this Summary Plan Description have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

In the construction of this Summary Plan Description, the masculine shall include the feminine and the singular the plural in all cases where such meanings would be appropriate.

Amendment of the Plan

The Board of Trustees has established the Plan. The Board has the power to amend the Plan from time to time. The Trustees may require partial or full payment of the cost of providing Retirees and their Dependents benefits and may revise or adjust the Schedules of Benefits provided the Retirees and their Dependents or terminate the Retirees as an eligible Class in the event that the

claims experience and/or the financial condition of the Plan makes such action prudent, as determined in the sole discretion of the Trustees.

Termination of the Plan

In the event of termination of this Plan, benefits will cease on the date of such termination and accrued eligibility will be eliminated. Claims incurred prior to termination will be processed and paid according to the provisions of the Plan and Schedule of Benefits then in effect. There will be no extension of eligibility beyond the date of the Plan's termination.

ADDITIONAL INFORMATION

Coordination of Benefits

This Plan will always pay either regular benefits in full, or a reduced amount which, when added to the benefit payable by another Plan or Plans of Insurance, will equal the regular benefit otherwise payable under this Plan. In no event shall this Plan pay any benefit to the extent that, as a result of such payment, the Beneficiary would receive a greater overall benefit than would have been received had this Plan been the only coverage available.

Another Plan or Plans of Insurance shall NOT mean a limited risk contract such as cancer, lung and heart disease indemnity policies purchased by the Employee.

In the event that payments to a Beneficiary shall be made under this Plan for any benefit for which another Plan or Plans of Insurance, as herein defined, has primary liability, this Fund shall be subrogated to the rights of the Employee or Dependent and shall have full authority to proceed in the name of said Employee or Dependent to effect reimbursement of such payment.

A. Benefits Subject to this Provision

All of the benefits provided under this Plan are subject to this provision except any benefits providing indemnity for total disability or any accidental death, dismemberment and loss of sight benefits.

B. Definitions

1. "Plan" or "Policy" means any plan providing benefits or services for or by reason of medical or dental care or vision care or treatment, and any plan providing indemnification for total and partial disability, which benefits or services are provided by:

a. Group, blanket or franchise insurance coverage, including Blue Cross and Blue Shield, Health Maintenance and Preferred

Provider Organizations but excluding any policy of automobile insurance or motor vehicular insurance under which medical or Weekly Disability payments are made pursuant either to a "no fault" provision or by reason of liability on the part of the third party. **This Plan does not coordinate with automobile insurance because the Schedule of Benefits does not provide for and excludes automobile or motor vehicular accident injury benefits.**

Any state law purporting to regulate the benefits offered by such federally-regulated plans are preempted by ERISA. ERISA self-funded health and welfare benefit plans are governed solely by federal law, 29 USC Section 1144(a).

b. Hospital service prepayment plans, medical service prepayment plans, health maintenance organizations, or other group prepayment coverage.

c. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit plans or supplemental unemployment benefit plans;

d. Any coverage sponsored by or provided through a school or other educational institution.

The terms "Plan" and "Policy" shall include the plural of those terms. The terms "Plan" and "Policy" shall be construed separately with respect to each policy, contract, or other arrangements for benefits or services and separately with respect to (i) that portion of any such policy, contract, or other arrangement, which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and (ii) that portion which does not, with the exception of automobile insurance.

2. "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the

plans covering a person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

3. "Claim Determination Period" means a calendar year (the period of one year commencing on January 1).

C. Effect on Benefits

1. This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expense incurred as to such person during such period, the sum of (a) the benefits that would be payable under this Plan in the absence of this provision, and (b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision, would exceed such Allowable Expense.

2. As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan, in the absence of this provision, for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of (a) such reduced benefits and (b) all the benefits payable for such Allowable Expenses under all other Plans, except as provided in item (3) of this Section C, shall not exceed the total of such Allowable Expenses.

Benefits payable under another Plan include:

a. the benefits that would have been payable had claim been duly made therefore; and

b. the benefits or services that would have been payable or provided by another Plan but for the failure to seek services from a health care provider designated by another Plan.

3. If another Plan which is involved in item (2) of this Section C and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and the rule set forth in item (4) of this Section C would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

4. For the purpose of item (3) of this Section C, the rules establishing the Order of Benefit Determination and the Coordination of Benefits Rule for the Plan, effective April 1, 1985, are as follows:

a. If a person is covered as an insured or Employee under one policy and a Dependent under another, the policy or plan under which he is the insured or Employee will be primary.

b. If a person is covered under two policies or plans as a Dependent, the Policy or Plan of the policyholder of Eligible Employee whose birthday occurs earlier in the year will be primary. Annually renewable policies shall be considered to have been in effect from their initial effective date.

c. If the birthdays of the two policyholders or Eligible Employees are on the same date, the Policy or Plan which has been in effect for the longer time will be primary.

d. If one of the Policies or Plans is issued in another state which does not use birthdays for coordination of benefits and each Policy or Plan by its terms is secondary, then each Policy or Plan will be responsible for a maximum of fifty percent (50%) of their allowed expense or allowed benefit.

e. In the case of divorce and separation, the rules governing coordination of benefits as to minor Dependent children are as follows:

1) In the event of a divorce or legal separation of the parents, if the divorce judgment defines which parent has financial responsibility for the health care of the minor child (regardless of who has custody), then the Policy or Plan of the financially responsible parent is primary.

2) Absent such a provision in the divorce judgment, the Policy or Plan of the parent who has been granted custody will be the primary and the noncustodial parent will be secondary; however, if the custodial parent has remarried, then the custodial parent's Policy or Plan will be primary, the Policy or Plan of the custodial parent's new Spouse, to the extent it covers the minor children as a Dependent, will be secondary and the Policy or Plan of the noncustodial parent will be tertiary.

f. If none of these rules fit a particular case, there is a general rule that the policy which has covered the Dependent person for the longest period of time will be primary except that if one of the Policies or Plans covers the person for whom expenses are claimed as a laid off or retired person, then the policy covering the person other than as the laid off or retired person or Dependent of the laid off or retired person shall be primary if both are Michigan Policies or Plans. There can be no reduction in group benefits because of the existence of non-group insurance.

5. If the spouse of an Participant regularly works thirty-two (32) or more hours per week for an employer and is entitled to elect health/medical insurance as a benefit of employment, no benefits shall be payable under this Plan to the extent that coverage would have been available under the Plan of the spouse's employer. The spouse of a Participant who is eligible and entitled to elect health/medical insurance **will not be covered** by this Plan for dependent coverage, and coordination of benefits will not be applicable because there is no coverage. A "hardship" exception to this Rule is provided if the working spouse has gross annual wages of less than $25,000.

If a Participant and/or Beneficiary is eligible for benefits under a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or similar type of Plan, which requires that health care services be obtained only from certain designated health care providers and/or organizations, and *if such individual fails to comply with the requirements of such Policy or Plan*, then he/she shall not be eligible for benefits under this Plan. An exception is provided if the only health care plan offered by the spouse's employer is an HMO plan, and the Employee's residence is more than 25 miles outside the HMO service area.

Eligibility for coverage under this Plan is available only where a Participant and/or a Beneficiary is denied benefits under another health care plan *after complying with all its requirements for eligibility and/or coverage*.

6. The Fund will provide identical benefits to all active participating Employees regardless of Medicare coverage to which an Active Employee may otherwise be eligible; except, in the event an Employee over age 65 or a Spouse of an Employee over age 65 for whom Medicare would otherwise be secondary is determined to be an Employee of an Employer with less than twenty (20) Employees, the Employee or the Spouse of the Employee over age 65 will be referred to Medicare for processing.

7. In the event a Participant is eligible both as an Employee and a Dependent, the claim will be processed pursuant to the Coordination of Benefits provision of the Plan as though the Dependent is covered by another Plan of Insurance. There will be no duplication of coverage.

D. Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing this provision or any similar provision of another Plan, the Fund may, without the consent of or notice to any person, release to or obtain from any other insurance company, organization or person any information the Fund deems to be

necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

E. Facility of Payment

Whenever payments that should have been made under this Plan in accordance with this provision have been made under any other Plans, the Fund shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan. To the extent of such payments, the Funds shall be fully discharged from liability under this Plan.

F. Right of Recovery

Whenever payments have been made by the Fund with respect to Allowable Expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Fund shall have the right to recover such excess payments from any party.

Subrogation

With respect to any payment made under this Plan on behalf of a Participant or Dependent, the Fund shall be subrogated to all rights of recovery of the Participant or Dependent arising out of any claim or cause of action which may accrue against a third party. As a condition to receipt of such payment on their behalf, the Participant/Dependent agrees to reimburse the Fund for any benefits so paid out of monies recovered from any third party as the result of judgment, settlement or otherwise. The Participant or Dependent further agrees to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Trustees may request to facilitate the enforcement of this right of subrogation.

Workers' Compensation

Benefits will not be paid under this Plan for any illness or injury if the Employee is entitled to Workers' Compensation benefits for that illness or injury.

"Work Related" and/or "Occupational Claims" must first be filed under Workers' Compensation. In the event the claim is denied/disputed, payment for medical care will be considered by the Trustees, but only when proof (complete medical records) has been presented that the claim has been filed under Workers' Compensation, and subject to the Employee executing an assignment of his right to reimbursement for medical care necessitated by his illness or injury.

Where questions or disputes exist as to whether an illness or injury is work-related and thus covered by Workers' Compensation, the Trustees may, but are not required to, authorize voluntary payments from this Fund for Medical, Hospital and related expenses resulting from such illness or injury. In no event shall such payments be made unless a claim has first been filed with the Workers' Compensation Bureau. In the event the claim is denied or disputed, benefits may then be paid in accordance with this Plan, ***subject to reimbursement in the event workers' compensation benefits are, at a later date, received.***

Release Of Participant Records — Information regarding a Participant or the records of a Participant may be furnished or released upon receipt of an authorization properly executed by the Participant before a Notary Public or in compliance with a subpoena.

Family And Medical Leave Act Of 1993 ("FMLA")

Pursuant to the Family and Medical Leave Act of 1993 ("FMLA"), Eligible Employees are allowed to take up to twelve (12) weeks of unpaid leave each year for specified employee and family medical leave reasons.

In addition, an Eligible Employee who is the spouse, son, daughter, parent or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for a service member. This "military caregiver leave" is available during a single 12-month period during which an Eligible Employee is entitled to a combined total of 26 weeks of all types of FMLA leave.

While an Employee is on such a leave, it is the responsibility of the Employer to continue the Employee's health care coverage. In the event the Employer determines that an Employee/Participant is eligible for family and medical leave, the Fund will accept contributions for the period of medical leave.

Contributions to the Fund shall be for the hours that the Employee is on family medical leave (up to a maximum of 40 hours per week) and will be reported to the Fund at the same contribution rate required by the Collective Bargaining Agreement for hours worked***. An Employee's banked hours cannot be used to continue coverage during Family and Medical Leave.***

The Fund can, if necessary, enforce Employer contributions for family and medical leave in the same manner that payment of other contributions is enforced. In other words, during a period of an approved family medical leave, the Employer shall make contributions to the Plan at the same rate, and in the same amount, as if the Employee were continuously employed during the period of the leave.

During the duration of an Employee's FMLA leave, coverage by and benefits provided pursuant to the Plan will continue at the same level of coverage the Employee would have received if he remained actively employed.

Notice to this Fund of leave under FMLA is the Employer's responsibility.

Covered Employer: Not all Employers are Covered Employers. An Employer is a Covered Employer if the Employer employed a total of fifty (50) or more

employees on the Company's payroll for each working day during each of twenty (20) or more work weeks in the current or preceding calendar year.

The employer must count:

- Any Employee whose name appears on the payroll records.
- Full and part-time Employees.
- Employees on paid or unpaid leave of absence.

Employees on lay-off are ***not*** counted.

The Trustees have a right to verify whether an Employer is a Covered Employer before accepting contributions to continue coverage for an Employee.

Eligible Employee: An "Eligible Employee" is an Employee of a Covered Employer who:

- Has been employed by that Employer for at least twelve (12) months (need not be consecutive), and
- Has been employed by that Employer for at least 1,250 hours during the twelve (12) month period immediately preceding the commencement of approved leave, and
- Is employed by an Employer which has fifty (50) or more Employees at worksites within seventy-five (75) miles of the Employee's worksite.
- For an Employee with no fixed worksite, the worksite is the site to which he is assigned as home base, from which work is assigned, or to which he reports.
- While in all circumstances it is the Employer's responsibility to designate leave as FMLA qualifying, the Trustees have a right to verify that the Employee is an Eligible Employee under the Family and Medical Leave Act.

Eligible Leave: Leave is available in the following circumstances:

- the birth of a child and care of the newborn child;
- placement of a child with the Employee for adoption or foster care;
- care for the Employee's spouse, son, daughter, or a parent with a serious health condition;

- a serious health condition of the Employee which makes the Employee unable to perform his/her job;
- As a result of a qualifying exigency arising out of the fact that a spouse, son, daughter or parent is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

Serious Health Condition: An eligible Employee is entitled to unpaid leave if the Employee requires treatment for a "serious health condition" or the Employee needs to care for a spouse, dependent child, or parent (but not a parent-in-law) who has a "serious health condition". A "serious health condition" is defined as an illness, injury, impairment or physical or mental condition that involves:

(1) Any period of incapacity or treatment in connection with or consequent to inpatient care (i.e. an overnight stay) in a hospital or residential medical facility;

(2) Any period of incapacity requiring absence from school, work, or other regular daily activities, of more than three calendar days that also involves continuing treatment by (or supervision of) a health provider; or

(3) Continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term condition that is incurable or so serious that if not treated, would likely result in a period of incapacity of more than three calendar days; or

(4) Prenatal care.

Examples of a serious health condition include (but are not limited to): heart attacks, heart conditions requiring heart bypass or valve operations, most cancers, back conditions requiring extensive therapy or surgical procedures, strokes, severe respiratory conditions, spinal injuries, appendicitis, pneumonia, emphysema, severe arthritis, severe nervous disorders, injuries caused by serious accidents on or off the job, ongoing pregnancy, severe morning sickness, the need for prenatal care, childbirth and recovered from childbirth.

Where inpatient care is not involved, the regulations require that the absence from work, school or other regular activities be a period of more than three days in addition to requiring the continuing treatment of a health care provider.

"Continuing Treatment" by a health care provider includes two or more visits for an illness or injury to a health care provider; or two or more treatments by a health care practitioner (such as a physical therapist) on referral from a health care provider; or a single visit to a health care provider that results in the scheduling of continuing treatment under that provider's supervision.

A "health care provider" includes a doctor of medicine or osteopathy who is authorized to practice medicine or surgery by the State in which the doctor practices, any other person determined by the Secretary of Labor to be capable of providing health care services, podiatrists, dentists, clinical psychologists, optometrists, chiropractors (subject to certain limitations), nurse practitioners, nurse-midwives, and Christian Science practitioners listed with the First Church of Christ in Boston, Massachusetts.

Voluntary or cosmetic treatments (such as most treatments for orthodontia or acne) which are not medically necessary are not serious health conditions unless inpatient hospital care is required. Restorative dental surgery after an accident, or removal of cancerous growths are serious health conditions provided all other conditions of the regulations are met.

Treatment of allergies or stress may be a "serious health condition" if all other conditions of the regulations are met. Prenatal care is included in the definition; routine physical exams are excluded.

In an attempt to limit potential abuse, the Employer may require a health care provider to certify:

(1) In the case of medical leave for the Employee, that "the Employee is unable to perform the essential functions of his job";

(2) In the case of family medical leave, that the Employee is "needed to care" for the family member; or

(3) In the case of leave taken intermittently or on a reduced leave schedule, that such leave is a "medical necessity".

An Employer may request such certification before leave is granted and on a periodic basis (but not more than once every thirty (30) days). Details on how much information may be required from a health care provider for certification purposes are set forth in Section 825.306 of the Code of Federal Regulations.

In order to continue FMLA coverage under this Plan, the Trustees will require the following:

1. The Employer must make the determination; however, the Employer must notify the Fund that an Employee is or is about to be on family or medical leave.

2. The Employer must provide whatever proof or information is requested by the Fund to demonstrate that your company is a Covered Employer and the Employee involved is an Eligible Employee.

3. The Employer must contribute to the Fund for the hours during the week the Employee is on family or medical leave (up to a maximum of forty) at the current contribution rate established by the Collective Bargaining Agreement.

4. The Employer is required to provide verification materials to the Fund Office to establish that the Employee meets or continues to meet the conditions required for an eligible leave, including medical reports within ten (10) days, from the date the approval of leave is granted.

5. The Employer is required to notify the Fund when an Employee has returned from such leave or has indicated by word or action that he or she will not be returning to work for the Employer. (The latter event may be a "Qualifying Event" under COBRA.)

In the event the Employer does not provide coverage through the Fund, the Company/Employer will remain responsible for providing the same level of health care coverage for the Eligible Employee and his or her covered Dependents.

Other Provisions**:**

- Leave may be taken intermittently or on a reduced leave schedule.
- Employee must be able to return to previous position, or equivalent position, after leave.
- Group health benefits must be continued while Employee is on leave.
- Employer can require a medical certification and two (2) subsequent opinions to justify leave for a serious health condition.
- Employee is required to give Employer thirty (30) days notice for foreseeable leave.

Military Service

If you leave covered employment to enter the Armed Forces of the United States of America or other uniformed services, you may elect to continue coverage under the Plan for yourself and your eligible dependents, if any, except for Death, Accidental Death and Dismemberment and Weekly Disability Benefits, for a period which is the lesser of (1) the 18-month period beginning on the date you leave covered employment or (2) the period of your service in the services plus 90 days. If you elect to continue coverage, you will be charged the monthly COBRA premium rate, unless your period of service is less than 31 days, in which case coverage will be continued at no cost to you.

You must return to covered employment or register on the Union's Out-of-Work List within 90 days of honorable discharge from the military or within 24 months of honorable discharge if you are recovering from an illness or injury incurred during your service in the military.

Upon your return to covered employment, you will be eligible for coverage without having to reestablish eligibility. Generally, if your period of service in the military was more than 5 years, you must satisfy the initial eligibility requirements to be eligible for benefits again.

SECTION IV

LIFE INSURANCE BENEFITS

The Plan provides a life insurance benefit for **active employees only**. These benefits are insured with a life insurance company that underwrites the benefit. The life insurance benefits are summarized here; however, the general provisions and limitations outlined in the Master Policy and the Certificate of Insurance will prevail in the event of a claim. **In case of death, the Fund Office should be notified Toll Free at (1-800-323-8079) and a claim form will be mailed to the designated beneficiary.**

Immediately upon receipt of due proof of death of any eligible Employee while covered under the Plan, the insurance carrier will pay, subject to the provisions set forth below, the Amount of Life Insurance specified. All rights, privileges and benefits are governed by the provisions of the Group Life Policy.
Life Insurance benefits are payable in the following amounts:

- Participant — $25,000
- Spouse — $10,000
- Dependent Child (over 6 months) — $5,000
- Dependent Child (birth to 6 months) - $2,000

Written notice of the death must be given to the Fund Office within one (1) year of the date of death, otherwise no benefits will be payable.

Beneficiary

An Employee may designate a beneficiary or beneficiaries in the application for insurance and, subject to any legal restriction or to the rights of any irrevocably appointed beneficiary, may from time to time change the beneficiary.

An appointment or change of beneficiary must be in writing, signed by the Employee and filed with the Fund Office.

If any legally designated beneficiary predeceases the Employee, insurance monies which such beneficiary, if living, would have received under the policy shall, unless otherwise specified by the Employee and in the absence of any statutory provisions as to the disposition thereof, be payable equally to the remaining legally-designated beneficiary, or beneficiaries, who survive the Employee.

If an Employee has named two (2) or more beneficiaries but has not specified a method of sharing the insurance monies, the beneficiaries who survive the Employee shall be entitled to equal shares.

If no legally designated beneficiary survives the Employee, or if the Employee has not designated any beneficiary, such insurance monies shall, in the absence of any statutory provision as to the disposition thereof, be payable to:

1. the Employee's widow or widower, if surviving the Employee, otherwise;
2. the Employee's surviving child or children in equal shares, but if neither of them survive;
3. the Employee's surviving parent or parents in equal shares, but if neither of them survive;
4. the Employee's surviving brothers and sisters in equal shares, but if none of them survive;
5. the Employee's estate.

If any beneficiary is a minor or is otherwise incapable of giving a valid release for any payment due, insurance monies payable to such beneficiary shall be paid to his duly appointed guardian. Any such payment shall be for the sole benefit of such beneficiary and shall constitute a full discharge of the liability of the Insurance Company to the extent thereof.

TOTAL AND PERMANENT DISABILTY WAIVER OF PREMIUM BENEFIT

If an Eligible Employee becomes totally disabled prior to age 60 and while eligible, application may be made for Total and Permanent Disability Waiver of Premium Benefit. Initial written proof that disability exists and has continued uninterruptedly must be furnished to the life insurance company underwriting this benefit on their required form within one (1) year from the date of termination of the eligible Employee's eligibility but not before such disability has continued uninterrupted for at least nine (9) months. Further written proof that total disability exists and has continued uninterrupted must be furnished when and so often as may reasonably be required, but not more often than once a year after total disability has continued uninterrupted for at least two (2) years beyond the date the initial written proof was received and approved. The underwriting of this benefit shall be pursuant to the life insurance contract held by the Trustees at the time such disability commences or the death of the Employee occurs. This is not an automatic benefit. The Employee must apply for this benefit and be approved by the applicable life insurance underwriter.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFITS

The phrase "Insured Individual" as used in this benefit, means the person insured under the Policy of the Insurance Company who is eligible for individual insurance.

When accidental bodily injury which was caused directly and independently of all other causes by external, violent and accidental means occurs while the insurance is in force as to the Insured Individual (Participant or Employee) and results in any of the following losses to the Insured Individual within ninety (90) days after the date of the accident, the Insurance Company will pay in addition to any other benefit provided by the policy:

For Loss of:

Life	**The Principle Sum**
Both Hands or Both Feet Or Sight of Both Eyes	**The Principle Sum**
One Hand and One Foot	**The Principle Sum**
One Hand and Sight of One Eye	**The Principle Sum**
One Hand or One Foot	**1/2 Principle Sum**
Sight of One Eye	**1/2 Principle Sum**

"Loss" means, with regard to hands and feet, dismemberment by severance through or above wrist or ankle joints; with regard to eyes, total and permanent or irrecoverable loss of sight beyond remedy by surgical or other means.

Limitations

No indemnity shall be payable if the death or injury of the Employee results from or was in any manner or degree associated with or occasioned by:

a. Suicide or attempted suicide, while sane or insane or the intentional act of another during an altercation in which the Insured Individual participated, otherwise than as a spectator;

b. Travel or flight in or descent from any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial route or chartered flight;

c. War, or any act of war, whether declared or undeclared, or while in the Armed Forces or any country;

d. Bodily or mental infirmity, ptomaines, bacterial infections (except phylogenic infections which shall occur with and through accidental cut or wound), or by any other kind of disease;

e. Any drug, except those drugs prescribed by a physician, including narcotics and hallucinogens, or any gas or fume, taken or inhaled voluntarily; or by voluntary poisoning.

SECTION V

WEEKLY DISABILITY BENEFITS

Weekly Disability Benefits for loss of time will be paid to an **Eligible Active Employee** (refer to limitations, Item a, on the following page) who becomes wholly and continuously disabled by a non-occupational accidental bodily injury or sickness or disease not covered by Worker's Compensation that prevents him from working at his occupation, provided he is under the regular care and attendance of a legally qualified physician or surgeon. Further, such disability must occur while the Employee is eligible for benefits.

A Weekly Benefit of $300.00 per week shall be paid through the maximum period of thirty-nine (39) weeks for disability due to non-occupational accidental bodily injury or disease. The Weekly Disability Benefit shall commence with the first day of disability due to non-occupational **accidental bodily injury; first day if hospital confined, provided the loss of time exceeds seven (7) days**; eighth day due to sickness or disease.

Payment for one day of disability is 1/5th of the amount of the weekly benefit.

In determining when one disability period ends and a new period begins, all disability absences due to the same or related causes and separated by less than fourteen (14) days of active work will be considered as occurring in a single disability period. If a new disability period is due to a cause different from the causes of any prior disability, it must be separated from the prior disability by fourteen (14) days of full-time active work in order for the Employee to be eligible for payment for that absence.

It is not necessary for the Employee to be confined in a hospital or to the home to collect benefits; however, the Employee must have been seen and treated personally by a LEGALLY QUALIFIED PHYSICIAN. A Chiropractor is not considered a legally qualified physician for purposes of verification of a disability. No benefits are payable for any day during which the Employee has performed

any work, anywhere, for pay or profit or for any period during which the Employee is not under the care of a LEGALLY QUALIFIED PHYSICIAN. No benefit will be paid prior to the first medical visit or treatment.

Limitations

No benefits shall be payable under this Weekly Disability Benefit Provision:

a. To any Employee not in active status and not currently covered under this Plan. Inactive employees who have maintained eligibility through employer contributions, banked hours, self-payments or otherwise are eligible for this benefit. This benefit is not available to retired employees under any circumstances.

b. For any period of disability during which such Employee is not under the direct care of a physician. It is understood that no disability will be considered as beginning more than three (3) days prior to the first visit of or to a physician;

c. For disability due to accidental bodily injury arising out of and in the course of such Employee's employment;

d. For disability due to occupational disease, defined as a disease for which the Employee with regard to whom a claim is submitted is entitled to benefits under the applicable Workers' Compensation Law, Occupational Disease Law, or similar legislation;

e. For any disability arising as a result of an automobile accident;

f. In the event an Employee is eligible for Loss of Time Benefits by means of another Plan or Plans of Insurance for which Loss of Time Benefits are provided where such benefits are equal to the benefits provided in the Schedule of Benefits.

Payment Of Benefits

Upon compliance with the Claim Provisions, accrued benefits will be paid weekly during the period of disability and any balance thereof will be paid at the termination of the period for which they are payable, provided the required medical evidence or certification of disability by the attending physician has been submitted to the Administrator.

In the event Weekly Disability Benefits are paid to an Employee based on certification of disability by the attending physician and such Employee returns to active employment without notification to the Administrator and benefits are paid in error, such benefits must be refunded by the Employee within ten (10) days.

IT IS THE RESPONSIBILITY OF THE EMPLOYEE TO NOTIFY THE PLAN ADMINISTRATOR ON THE DATE OF RETURN TO WORK OR ACTIVE EMPLOYMENT. All claims must be filed with the Fund Office within one (1) year from the date the disability begins, otherwise no benefits will be payable.

SECTION VI

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and general limitations apply to all benefits provided by the Heat and Frost Insulators and Allied Workers' Local 47 Welfare Fund unless specifically stated otherwise in a particular benefit section.

Routine Care and Elective Procedures

Benefits under this Plan are for the treatment of sickness or accidental bodily injury when rendered by hospitals and physicians. Routine care, cosmetic surgery, diet medication or supplements, and other such treatment which is not medically necessary to correct a condition which threatens the health of an Eligible person are not eligible for Benefits from this Plan. The Trustees reserve the right to have an Eligible Person examined by a physician of their own choice and at the Fund's expense to make their determination regarding any benefit payable or eligibility rule of this Plan.

Unless otherwise required by law, treatment designed to merely improve bodily functions is not considered medically necessary or an eligible expense for benefits. Examples of treatment considered not covered (by way of illustration and not limitation) include: treatment to improve sexual dysfunctions or inadequacies (including penile prosthesis to treat impotence) and treatment to improve fertility (including, but not limited to, drug/hormone therapy, surgical procedures, artificial insemination, in vitro fertilization, embryo transfer procedures and related diagnostic testing of all types).

Medical Necessity

Benefits under this Plan are payable only for services and supplies which are considered by the Trustees to be medically necessary in view of the patient's condition and diagnosis. For example, non-emergency hospital admission and confinement over a weekend will be presumed not medically necessary and not an eligible expense incurred. Hospital admission for surgery which is generally

performed on an out-patient basis will not be considered eligible for benefits unless such admission is medically necessary due, for example, to a co-existent medical condition.

Self-Inflicted Injury or Substance Abuse

Payment will not be made for self-inflicted injury such as attempted suicide or substance abuse.

Organ Transplants

Payment will be limited to the usual, customary and reasonable fee schedule incurred as a result of any type of organ transplants, such as, but not limited to the liver, lung, heart, kidney or cornea.

Reasonable and Customary Charges

Payment will not be made by this Plan for any expense incurred or charge made, which the Trustees determine is not reasonable or customary as defined herein.

Treatment Sponsored by Governmental Units

Unless otherwise prohibited by law, payment will not be made by the Plan for expenses incurred:

1. While confined in a hospital owned or operated by the Federal Government or other government unit; or
2. For treatment by a physician employed by the Federal Government or other governmental unit; or
3. For services or supplies furnished by or at the request or direction of the Federal Government, any of its agencies, or other government unit unless the Eligible person is legally required to pay.

This exclusion will not prevent coordination of benefits with a plan specifically established by a governmental unit for its own civilian employees and their dependents.

Further, this exclusion does not apply to health care services furnished by the Federal Government to a veteran for a non-service-connected disability in accordance with 38 USC §1729.

Treatment Without Charge

Payment will not be made for confinement in any hospital or treatment by a physician when the hospital or physician makes no charge that the Eligible Person is legally required to pay or would not be charged in the absence of these benefits.

Illegal Occupation or Commission of Felony

The Trustees will not be liable for loss to which a contributing cause was the commission of or attempt to commit a felony by the person whose injury or sickness is the basis of claim, or to which a contributing cause was such person's being engaged in an illegal occupation.

Payment will not be made for confinement in any hospital or treatment by any provider otherwise eligible under this Plan when such treatment is ordered as a part of any litigation, court-ordered judgment, or penalty (including, but not limited to psychiatric evaluation or counseling and confinement, evaluation or other treatment related to alcoholism or substance abuse).

Experimental Treatment Procedures

Benefits under this Plan are for the treatment of accidental bodily injury or sickness by generally recognized medicines, surgery and other techniques or devices. Medicines, treatment techniques and devices which are not generally recognized by professional peer groups (such as the American Medical Association) or by regulatory governmental authorities (such as the Food and Drug Administration) will be considered experimental and will not be considered eligible expenses under this Plan. For the purposes of this provision, recognized treatment or medicines used in a non-routine manner (frequency or dosage) will be considered experimental.

Liability for Accidental Injuries

Benefits under this Plan are considered secondary to any other available coverage for accidental injuries, including but not limited to, any automobile insurance or common carrier's liability (such as bus or commercial airline). No payment shall be made until proof is submitted to and judged acceptable by the Trustees that a proper claim has been made for other coverage. Normal Plan benefits shall be paid if other coverage has been denied or shall be coordinated with other coverage payments, if any.

General Limitations

Benefits of this Plan **do not cover** any loss caused by, incurred for or resulting from:

1. Declared or undeclared war, or any act thereof, or military or naval services of any country;
2. Services, treatment or supplies received from a dental or medical department maintained by a mutual benefit association of this or another employee benefit plan or labor union;
3. Services, treatment or supplies, which are payable or furnished under any policy of insurance or other medical benefit plan or service plan for which the Trustees shall, directly or indirectly, have paid for all or a portion of the cost;
4. Services or treatment rendered or supplies furnished primarily for cosmetic purposes;
5. Expenses incurred for services performed or supplies furnished by other than a physician;
6. Services, treatment or supplies rendered or furnished:
    a. Before the individual concerned became an Eligible Participant; or
    b. Without the recommendation and approval of a legally qualified physician;

7. Services related to obesity, diet or weight control, including but not limited to: exercise programs, surgery, special diet or diet supplements, pre-natal vitamins, smoking cessation, amphetamines, or any form of diet medication whether or not recommended or supervised by a physician, including dietary or nutritional counseling, books, pamphlets or classes;

8. Mental counseling, physical therapy, supplies or prosthesis for sexual dysfunction or inadequacies;

9. Implantation within the human body of artificial mechanical devices designed to replace human organs other than pacemakers or similar such devices which merely assist rather than replace the function of the organ;

10. Ambulance service or transportation between cities or states (such as by ambulance, air ambulance, railroad or bus) unless judged by the Trustees as essential for treatment of a life-threatening illness or injury in excess of one hundred (100) miles;

11. Expenses incurred for services performed and supplies furnished by other than a physician;

12. Growth hormones;

13. Programs or prescription medications for the purposes of smoking cessation;

14. Expenses incurred for the purpose of reversing tubal ligations, vasectomies or other sterilization procedures;

15. Special home construction to accommodate a disabled person;

16. Education, special education, job training or work hardening whether or not given in a facility that also provides medical or psychiatric treatment beyond the first medically necessary visit. Special education or like services, regardless of: the type of education, the purpose of the education, their recommendation of the attending physician or the qualification of the individual rendering the educational services;

17. Rest cures or custodial care;

18. Speech therapy, other than charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) while eligible in the Plan and as the result of a disease or accidental injury. Speech therapy to improve speech in the absence of disease or accidental injury (such as for a learning disability or speech delay) is considered special education and is not covered;

19. Supplies or equipment for personal hygiene, comfort or convenience;

20. Services, treatment or care rendered by a member of the Eligible Member's family;

21. Treatment or services for or in connection with financial counseling;

22. Treatment or services for primal therapy, rolfing, psychodrama, megavitamin therapy, bicenergetic therapy, vision perception training, or carbon dioxide therapy;

23. Cosmetic or reconstructive surgery which:

a) is not necessary for the prompt repair of accidental bodily injury, sickness or disease which occurs while the patient is not eligible; and;

b) is not performed within two (2) years from the date of a covered loss.

24. Dietary or nutritional counseling, books, pamphlets or classes;

25. Charges incurred for any abortion procedure performed on a Dependent child except where the pregnancy is the result of rape as evidenced by a police report;

26. Charges incurred for travel, whether or not recommended by a physician.

27. Artificial insemination, invitro fertilization, or embryo transfer process.

28. Accidental injury for which a third party may be liable unless you and/or the eligible Dependent sign a Subrogation/repayment agreement in a form approved by the Trustees. You, or your Dependent, must agree that if you recover from a third party relating to your accidental injury, you will repay the Fund the benefits which had been paid, without deduction for expenses or attorney's fees.

Under the provisions of the subrogation/repayment agreement, if you or your Dependent do not prosecute a claim against a third party to recover for injuries, then you or your Dependent must agree to authorize the Fund, at its option, to bring a claim in the name of you or your Dependent against the third party, including the filing of a lawsuit in court. You or your Dependent must agree to cooperate fully with the Fund in any action which the Fund may take. You and your Dependent must not do anything, or sign anything, after a loss for which the Fund paid benefits which impairs the Fund's right to recover the benefits paid.

If you or an eligible Dependent accept a settlement or receive an award, future medical expenses for any injury or illness that had been caused by the third party are not eligible expenses under this Plan.

29. For injuries sustained due to an accident involving a motor vehicle, motorcycle, moped or off-road vehicle ("ORV"). For purposes of this exclusion, the terms "motor vehicle," "motorcycle", "moped", "ORV", "motor vehicle accident," and "motorcycle accident" shall have the same meaning as that provided in MCLA 500.3101.

30. For injuries sustained while engaging as a voluntary participant in and of the following activities: kick-boxing; contact martial arts; boxing; wall climbing; alpine skiing; snowboarding; rugby; skateboarding; tackle football; horse-related activities; contact lacrosse; hockey; gymnastics; fireworks; or any activity for which compensation is paid/awarded for participation.