MICHIGAN CARPENTERS'
HEALTH CARE FUND

SUMMARY PLAN DESCRIPTION
and
PLAN DOCUMENT

Effective January 1, 2024

www.michigancarpenters.org

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INTRODUCTION

We are the Board of Trustees of the Michigan Carpenters' Health Care Fund ("Fund"). The Trustees established the Michigan Carpenters' Health Care Plan ("Plan") in 1973.

This Summary Plan Description (SPD) summarizes Plan benefits for you and your eligible family members – medical, pharmacy, dental, vision, burial and accidental death and dismemberment benefits - as of January 1, 2024. These Plan benefits provide comprehensive healthcare coverage and help to protect you against catastrophic expenses.

This SPD replaces and supersedes any prior summary plan description issued by this Fund. It includes all Plan changes made since the last SPD was printed. This SPD, along with other Plan documents (i.e., certificates, riders and plan modifications) govern the Plan's operation.

NO BENEFITS ARE GUARANTEED

No Plan benefit is guaranteed. Among other things, we may amend, modify or eliminate any Plan benefits and/or change the Plan's eligibility rules. The benefits provided by the Fund are limited to the assets of the Fund that are available to pay for such benefits. **No participant, dependent or retiree has any vested rights to any benefit provided by the Fund, now or at any time in the future.**

SOLE AUTHORITY TO INTERPRET THE PLAN

The Fund Trustees have the sole authority and discretion to interpret all Plan documents and to make the final determinations regarding eligibility and benefits. Stated another way, no Employer, Union, Third Party Service Provider or any of their representatives, are authorized to interpret the Plan. Nor can any such person act as the Trustees' agent. You may only rely on Plan information that is in writing and signed by the Board of Trustees.

READING THIS SPD

Read this SPD carefully to understand what Plan coverage is available, who's eligible for coverage and when Plan coverage begins and ends. If you are married or have other covered dependents, you should share this SPD with them. To assist you when reading the SPD, please consult the SPD Definitions for terms and explanations pertaining to your benefits.

Finally, if you have questions about this SPD or about the Plan, please contact the Fund Office at (800) 273-5739 or (517) 321-7502.

Sincerely,

THE BOARD OF TRUSTEES
MICHIGAN CARPENTERS' HEALTH CARE FUND

SECTION 1: GENERAL PLAN INFORMATION

PLAN ADMINISTRATION

Plan Name
Michigan Carpenters' Health Care Fund

Plan Administrator
Board of Trustees
Michigan Carpenters' Health Care Fund
6525 Centurion Drive
Lansing, Michigan 48917-9275
(517) 321-7502
(800) 273-5739

Employer Identification Number
38-6058383

Plan Number
501

Plan Year
For governmental filing and reporting purposes, the official plan year for the Michigan Carpenters' Health Care Fund is September 1 through August 30.

Type of Plan
This Plan is a self-funded plan for medical, pharmacy, dental, vision, accidental death and dismemberment and burial benefits. This means that the Fund accepts full liability for the payment of claims and related expenses.

The Fund's Medicare Advantage Prescription Drug Plan is fully insured.

About the Plan
The Plan's sponsor is the Board of Trustees of the Michigan Carpenters' Health Care Fund. The settlors of the Trust establishing the Fund are the Michigan State Carpenters' Council, affiliated with the United Brotherhood of Carpenters and Joiners of America, AFL-CIO (the "Union") and the Associated General Contractors (AGC) of Michigan.

Although the Fund settlors are your Union and the employer association, the Plan is not a Union or Employer subsidiary, agent or department. It is a completely independent organization. No Union dues are used to pay for benefits or operational expenses. The benefits are funded primarily by Employer contributions.

Plan Trustees
The Fund is maintained and administered by a Board of Trustees of which labor and management are equally represented. There are six Labor Trustees and six Management Trustees on the Board. These "Plan Trustees" have the responsibility for decisions regarding the eligibility provisions, type of benefits, administrative policies, management of Fund assets and interpretation of Fund provisions. Contact information about the Plan Trustees is located in **Appendix A** of this SPD.

Type Of Administration
The administration of the Plan will be under the supervision of the Plan Administrator. The Board of Trustees is the legally designated Plan Administrator. To the fullest extent permitted by law and applicable contracts, the Plan Administrator will have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Plan Administrator will also have the discretion to determine all matters relating to interpretation and operation of the Plan and to make factual determinations. Any decisions by the Plan Administrator, or any authorized delegate, shall be final and binding and will be upheld unless the Court of competent jurisdiction determines the decision is arbitrary or capricious.

As Plan Administrator, the Board of Trustees has delegated many of the day-to-day functions to a third-party administrator, TIC International Corporation (the Fund Office), and to our benefit providers.

- The Fund Office maintains the eligibility records, accounts for employer contributions, keeps participants informed about Plan changes, pays burial and accidental death and disability benefits and performs other routine activities.
- The benefit providers process claims and perform other routine activities.

Collective Bargaining Agreements
The Fund was established and is maintained under the terms of collective bargaining agreements (CBAs). These agreements set forth the conditions under which Employers are required to contribute to the Fund and the rate of contributions and/or any other conditions for participation in the Plan. Upon written request, Employees may examine the agreements at the Fund Office or at other specified locations. Employees may request a copy of the CBAs which will be provided to them at a reasonable charge.

Source of Funding
The Plan is funded through the Trust Fund, which receives contributions made by employers at rates specified in collective bargaining agreements between the employer association and the Union, and in special participation agreements with the Fund. Contributions are held in trust by the Board of Trustees pending the payment of benefits and administrative expenses. Employees, retirees, spouses and other dependents may make payments to the Fund under certain circumstances in order to continue eligibility.

NAME AND ADDRESSES OF HEALTH CARE PROVIDERS

Medical Benefits
Independence Administrators
1900 Market Street.
Philadelphia, PA 19103
1-833-242-3330
www.ibxtpa.com

Pharmacy Benefits
EXPRESS SCRIPTS
One Express Way
St. Louis, MO 63121
800-282-2881
Express-scripts.com

Vision Benefits
VSP
P.O. Box 495918
Cincinnati, OH 45249-5918
800-877-7195
vsp.com

Dental Benefits
DELTA DENTAL
P.O. Box 9085
Farmington Hills, MI 48333-9085
800-524-0149.
www.deltadental.com

Burial and Accidental Death and Dismemberment (AD&D) Benefits
TIC INTERNATIONAL CORPORATION
6525 Centurion Drive
Lansing, MI 48917
800-273-5739 or 517-321-7502
www.tici.com

AGENT FOR SERVICE OF LEGAL PROCESS

If, for any reason, you wish to seek legal action, you may serve legal process on the Plan Administrator by delivering it to the Agent for Service of Legal Process at the following address:

Lauren Crummel
Watkins, Pawlick, Calati & Prifti, P.C.
1423 E. Twelve Mile Rd
Madison Heights, MI 48071
(248) 658-0804

Service of legal papers also may be made directly upon the Plan Administrator.

FUND OFFICE

TIC INTERNATIONAL CORPORATION
6525 Centurion Drive
Lansing, MI 48917
800-273-5739 or 517-321-7502
www.tici.com

INTERNET ACCESS

You may access your benefit information at www.michigancarpenters.org. You may use this website to view, print plan documents, forms and obtain other useful information.

In cooperation with the Fund Office, you can also view your own personal account information via a secured network called the Benefit Inquiry Site. The Benefit Inquiry Site allows you to verify that the Michigan Carpenters' Funds have accurate personal information about you and your family. In addition, you can check the Funds' records for up-to-date information regarding employer contributions made on your behalf and your pension history.

INFORMATION YOU MUST PROVIDE THE PLAN

Providing Information – Your Responsibility

Providing timely and accurate information is your responsibility. All changes in your dependents must be in writing and supported by appropriate documentation (birth certificate, marriage license, adoption papers, etc.) You must also notify the Fund Office in writing of any change in your address or a change in your burial and/or Accidental Death and Dismemberment beneficiary.

Inaccurate information or improper documents may result in processing errors or the improper use of Plan assets. If you or a dependent fail to submit requested information, make a false statement, or furnish fraudulent or incorrect information, you and/or your dependent(s) Plan benefits, including continued participation in the Plan, may be denied, suspended or discontinued temporarily or permanently by the Board of Trustees. For questions and/or assistance, please contact the Fund Office.

NOTE: The Fund Office and your local union are separate entities. Therefore, you must separately notify your local union of an address change.

Health Care Enrollment Form

The Fund Office will supply you with a Health Care Enrollment Form requiring details such as your address, list of dependents, beneficiaries, etc. You must also supply appropriate documentation (birth certificate, marriage license, etc.) along with your completed form. Failure to do so may affect timely processing of your health care benefits.

SECTION 2: ELIGIBILITY

ELIGIBLE EMPLOYEE

The Plan defines an Eligible Employee as an employee who meets the Initial Eligibility Requirements outlined below. An Eligible Employee may also be referred to as an **"**Active Employee**."** Once you meet Initial Eligibility Requirements, the Plan provides benefits for you, your Spouse and/or your Eligible Dependents.

Spouse - Your Spouse is your legal Spouse.

Dependent(s) - Your Eligible Dependent(s) include:

- Your children by birth, legal adoption or full legal guardianship.
  Note: A child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.
- Children of your Spouse while they are in the custody of and legally dependent on your Spouse and reside as members of your household.
- Children who do not reside with you but are your legal responsibility for the provision of medical care (e.g., children of divorced parents, etc.).
- Eligible recipients under a Qualified Medical Child Support Order.

Note: Eligible Dependents are covered through the end of the month the dependent turns age twenty-six (26).

Disabled Dependent(s)
Disabled dependent(s) may continue coverage beyond age twenty-six (26) if:

- The dependent child is disabled prior to age twenty-six (26) and you notify the Fund Office of the condition in writing.
- The disability is from a medically determined mental or physical condition that prevents your dependent from being self-supporting.
- The dependent child must be unmarried and dependent on you for support and care.
- A doctor's certification of disability is required.

SCHEDULE OF BENEFITS

Once an employee meets the Initial Eligibility requirements, the Plan provides for medical, pharmacy, dental, vision, burial and accidental death and dismemberment benefits.

SECTION 3: ELIGIBILITY GUIDELINES

INITIAL ELIGIBILITY REQUIREMENTS

To be "initially eligible" for benefits as an **Active Employee**, you must have a minimum of one hundred and thirty (130) hours of employer contributions within one (1) month or three hundred (300) hours within three (3) months multiplied by the current contribution rate remitted to the Fund for work performed. These initial eligibility requirements apply only when you are first establishing eligibility under the Plan or if you are re-establishing eligibility because you have been continuously ineligible under the Plan for twenty-four (24) or more consecutive months. **Only employer contributions can be counted when meeting the initial eligibility provisions. Self-payments are not permitted to establish initial eligibility.**

Initial Eligibility begins on the first day of the month following a one-month accounting period after the initial eligibility requirements have been met and will provide two (2) months of eligibility. For example, if you work for a contributing employer who remits at least one hundred and thirty (130) hours of contributions at the current contribution rate for work performed by you during the month of April, you become eligible for benefits on June 1st and remain eligible for the months of June and July. Or, if you work for a contributing employer who remits at least three hundred (300) hours at the current contribution rate for work performed by you during the months of April, May and June, you become eligible for benefits on August 1st and remain eligible for the months of August and September.

Note: If you have more than the required employer contributions remitted in the months used to satisfy the *initial* eligibility requirement, the amount in excess of the required amount for *initial* eligibility will **not** be credited to your "dollar bank" (see Continuing Eligibility for dollar bank provisions).

Note: If you meet Initial Eligibility under the *New Contractor Rule*, your Initial Eligibility begins on the first day of the month following the month for which your employer remits contributions for 130 hours at the current contribution rate. You will remain eligible for three months.

For example, if your newly organized employer remits the required contributions for the month of July 2024, you will become eligible for benefits on August 1, 2024 and will remain eligible during the months of August and September 2024. Since eligibility for the month of October 2024 is based on the contributions remitted for the month of July 2024, you would also be eligible for the month of October 2024.

Initial Eligibility for Apprentices in "Block" Training
New apprentices in the Michigan Carpenters' Apprenticeship and Training Fund "Block" Training Program have five (5) months to meet initial eligibility requirements instead of three (3) months. All other terms for meeting initial eligibility for apprentices are as outlined above.

Reciprocity
The Trustees have entered into an International Reciprocity Agreement sponsored by the United Brotherhood of Carpenters and Joiners of America, AFL-CIO as well as reciprocity agreements with other health care funds covering carpenters in the United States. Pursuant to these reciprocity agreements, contributions may be transferred from one health care fund to another upon your written request and authorization. These contributions may enable you to meet the Fund's eligibility provisions. If you work in another jurisdiction and have employer contributions made to another fund on your behalf, you should request that such contributions be transferred, via a reciprocity agreement, to this Fund. You should contact your Local Union Office or the Fund Office to see if a

reciprocity agreement exists between this Fund and such other fund and, if it does, sign the necessary request form in order to affect a transfer.

CONTINUING ELIGIBILITY REQUIREMENTS

The Fund uses a "dollar bank" eligibility system for continuing eligibility **after** you have met the Initial Eligibility Requirements. The minimum amount required each month for continuing eligibility is one-hundred and forty (140) hours times the then-current contribution rate. As long as you have an amount equal to at least one-hundred and forty (140) hours of employer contributions at the then-current rate remaining in your dollar bank that can be withdrawn, your eligibility will continue. Each full month of employer contributions provides coverage for one month.

You are also allowed to "bank" employer contributions in excess of those required for you to maintain eligibility each month. **But, you can only bank the dollar amount that is greater than one-hundred and forty (140) hours times the current contribution rate**.

As an example, assume you need $749 of employer contributions for continuing eligibility for one month and your employer contributions remitted for the month equals $856. The difference of $107 in employer contributions will be deposited in your "dollar bank" to be saved for you to use if employer contributions for a month are less than the amount required to maintain your eligibility.

Note: The maximum amount that can be accumulated in your dollar bank is eight (8) months of eligibility.

Self-Contributions

In order to be permitted to remit self-contributions, your Local Union must validate that you are unemployed but available for work within the geographic jurisdiction of the Fund.

"Short Hour"

If, you do not have **sufficient** employer contributions in your dollar bank for continuing eligibility, you can make a **"short hour"** self-contribution to maintain eligibility.

Example: Assume you have $200 in your dollar bank and your employer contributions for the month are $428 and you are required to have $749 to be eligible for the month. In this case, $200 will be withdrawn from your dollar bank and you will be billed $121 to maintain eligibility for the month ($428 + $200 + $121 = $749).

"Full Month"

If you no longer have any employer contributions in your dollar bank, you may continue your eligibility by making a **"full month"** self-contribution in accordance with the following:

- The Fund Office will attempt to notify you about three (3) weeks before the date you would lose eligibility for benefits. This notice will state the amount of self-contribution required to continue your eligibility.
- The full month self-contribution must be equal to one-hundred and forty (140) hours times the then-current contribution rate.
- **The maximum number of full-month self-contributions is twelve (12) consecutive months (this would be considered an alternative to COBRA).** You may be eligible for an additional six (6)

months of COBRA continuation coverage to maintain eligibility if you have met the twelve (12) month maximum (See Section 8 COBRA).

ELIGIBILITY CHART

The following chart shows the month(s) you will be eligible for coverage if sufficient employer contributions are received for work performed in any given month. The chart also shows the approximate due date of self-contributions if a self-contribution is required to continue coverage. This schedule with approximately the same "Due Dates" will continue on a revolving basis for subsequent months and years.

ELIGIBILITY CHART

Work Month	Eligibility Month	Self-Contribution Post Marked Date
09	12	11/20/YY
10	01	12/20/YY
11	02	01/20/YY
12	03	02/20/YY
01	04	03/20/YY
02	05	04/20/YY
03	06	05/20/YY
04	07	06/20/YY
05	08	07/20/YY
06	09	08/20/YY
07	10	09/20/YY
08	11	10/20/YY
09	12	11/20/YY

Note: At the time of loss of eligibility, you will be given the opportunity to choose between self-contributions outlined above, Minimum Coverage, or COBRA Continuation Self-Payments. (See Section 13 Minimum Coverage and Section 8 COBRA.)

Minimum Coverage Program

Active Employees who are maintaining eligibility by way of self-contributions and exhaust their dollar bank may be eligible for the Minimum Coverage program. Once you elect Minimum Coverage benefits, you will **not** be permitted to receive the schedule of benefits for an Active Employee until such time as you re-establish eligibility. You will be given credit towards the cost of the Minimum Coverage for any hours worked.

Keeping Track of Dollar Bank Contributions

You will receive a **Monthly Contribution Advice Notice** reflecting contributions received and/or money remaining in your dollar bank for each month that:

1. Employer contributions are remitted on your behalf
2. Contributions remain credited to your dollar bank
3. You are remitting a self-contribution

You should carefully monitor your Monthly Contribution Advice Notice to assure that contributions from employers have been remitted on your behalf while you are employed, that self-contributions remitted were

received, and that money in excess of that needed for eligibility purposes has been credited to your dollar bank. If a discrepancy in employer contributions is noted, it is your responsibility to promptly notify the Fund Office and your Local Union. If a discrepancy is noted in self-contributions or your dollar bank total, you should contact the Fund Office.

It is important that you keep the Fund Office informed of your current address. It is equally important you make self-contributions when due, even if you think you should be eligible by way of employer contributions. If the Fund later receives employer contributions, the Fund Office will refund your self-contribution payment as applicable.

Additional Dollar Bank Provisions
Upon retirement or other termination of employment, your dollar bank will be used to maintain your eligibility under the Active Employee schedule of benefits until your dollar bank is exhausted, subject to all other provisions of the Plan.

If you die, any remaining amount in your dollar bank will be used to continue coverage for your Spouse and/or Eligible Dependent(s), without self-contributions, under the Surviving Spouse Self-Payment Program until your dollar bank is exhausted.

ACTIVE EMPLOYEE SELF-PAYMENT PROVISIONS

- You cannot make Self-Payments if you voluntarily leave covered employment to find or take a job in another industry or you become self-employed.
- The Fund's acceptance of your self-contribution, whether "short hour" or "full month" contribution or for Minimum Coverage, is conditioned upon you becoming and/or remaining ineligible because you are currently working as a carpenter for a contributing employer but have insufficient employer contributions to remain eligible or because there is a lack of available employment as a carpenter within the jurisdiction of the Fund. Evidence that you are available for work as a carpenter within the jurisdiction of the Fund is required.
- You will be required to have employer contributions of at least one-hundred and forty (140) hours at the then-current rate for work performed in a calendar month to become eligible again if you fail to make self-contributions to maintain continuing eligibility.
- If you have been ineligible for twenty-four (24) or more consecutive months because you have not had employer contributions, made self-contributions, or a combination of both, you must satisfy **Initial Eligibility requirements** again to become eligible for coverage.
- In all cases, payment for **short hour** or **full month** contributions, or for **Minimum Coverage**, must be postmarked by the date indicated in the notice sent to you. Payment can also be made by credit card. Contact the Fund Office for assistance.
- **If you fail to remit the required self-contribution for continuing eligibility when your dollar bank is insufficient to provide you with continuing eligibility, any amount remaining in your dollar bank will be forfeited.**
- If you are *temporarily* disabled, you may be eligible to remit self-contributions to continue your coverage. Evidence of this *temporary* disability is required (See Section 5 T&PD Disability)

RETIREE, EARLY RETIREE, T&PD AND SURVIVING SPOUSE SELF-PAYMENT PROVISIONS

The method of payment for the Retiree, Early Retiree, Totally and Permanently Disabled and Surviving Spouse Self-Payment Programs is as follows:

- Payments are due in the Fund Office by the 20th day of the month preceding the month for which payment is being made. For example, the self-payment to provide coverage for the month of September is due in the Fund Office no later than August 20th.
- Self-Payments can be made by either check or money order made payable to "Michigan Carpenters' Health Care Fund." If you wish to pay by credit card, please contact the Fund Office.
- Self-payments may be deducted from your Michigan Carpenters' Pension Fund monthly benefit check if applicable. The appropriate Authorization for Deduction Form must be executed by the 20th day of the month preceding the month such deductions are to begin. Cancellation of the deductions must be made in writing at least sixty (60) days before the effective date of cancellation.
- Direct debit from a personal bank account such as a checking or savings account is also an option. The appropriate Authorization for Deduction form, available from the Fund Office, must be executed by the fifteenth (15th) day of the month preceding the month such deductions are to begin. Cancellation of the deductions must be made in writing at least sixty (60) days prior to the effective date of cancellation.
- A self-payment for up to six (6) months in advance is also an option. Note, however, upon receipt of the self-payment, the Fund Office will send only one notification to you specifying the due date and amount of your next self-payment. You must remit your next self-payment in a timely manner because no additional notifications will be sent.

NOTE: The Trustees establish the amount of the monthly self-payment and may change this amount periodically. For current self-payment rates, call the Fund Office at 800-273-5739 or 517-321-7502.

Special Eligibility Provisions
If you are a self-employed carpenter (sole proprietorship or partners) and have a signed Participation Agreement with the Fund, you may participate in the Plan and maintain coverage thereunder by remitting contributions on your behalf at the then current contribution rate. For details, you should contact the Fund Office.

Both Spouses Eligible as Employees
If you and your Spouse are each employed as a carpenter and you are each eligible as an Active employee, the Plan will coordinate health care benefits for any claims incurred by you, your Spouse and/or your dependents during the period of dual coverage.

Claims Incurred in Foreign Countries
Claims incurred in foreign countries are covered by the Plan, subject to all the limitations and exclusions of the Plan. Additional time is required to process claims submitted from foreign countries. You should contact the Independence Blue Cross customer service department or the Fund Office for further information or assistance.

Working Aged and Medicare Secondary Payer Rules
If you continue to work beyond age sixty-five (65) and you are Medicare eligible, you are considered a **"working aged"** under the Medicare Secondary Payer (MSP) rules. As a working aged, you have the option of choosing between the Plan or Medicare as your primary plan. However, if you choose Medicare as your primary plan, you are **prohibited** from receiving Plan benefits. This includes your Spouse and/or any dependents who may also be eligible for Medicare.

If you maintain Plan coverage, the Plan is primary for you, your Spouse, and/or dependent(s). If your Spouse or dependents become eligible for Medicare benefits, the Plan remains primary for the Spouse and dependents until you no longer meet the definition of an Active Employee.

If for some reason you would rather have Medicare as the primary payer, you must state this preference in writing and send it to the Fund Office. Contact the Social Security Administration at 800-772-1213 or visit the Medicare website at www.medicare.gov for questions or if you need assistance in fully understanding your options as a working aged.

SECTION 4: RETIREE PROGRAM

ELIGIBILITY

If you become a **Retiree** at age 65 or older or an **Early Retiree** (under age 65), you are eligible to continue coverage through the Plan's **Retiree Self-Payment Program** if you meet the following:

- You must be eligible by either employer contributions, self-contributions or through use of your dollar bank employer contributions on the date of retirement.
- Participation in the program must begin immediately upon termination of coverage under the Active Employee Program.
- You must be receiving monthly retirement benefits from one of the following sources:
  - The Michigan Carpenters' Pension Fund,
  - The Carpenters' Pension Trust Fund – Detroit and Vicinity
  - Social Security Administration.

If you are not receiving a monthly retirement benefit from one of the three (3) sources listed above, you may still be eligible to participate in the Retiree Self-Payment Program if you have been continuously eligible by employer contributions for the three (3) years immediately preceding your retirement. You should contact the Fund Office for assistance.

Your Spouse and/or Eligible Dependents are also eligible for continued coverage based on your eligibility.

SCHEDULE OF BENEFITS

The schedule of benefits for you, your Spouse and/or your Eligible Dependent(s) is based on the status of each family member (i.e., non-Medicare or Medicare eligible) on your retirement date as follows:

Not Eligible for Medicare
If you retire prior to age 65 (Early Retiree) and you and your family members are **not** eligible for Medicare, benefits are the **same as the schedule of benefits that was in effect for you as an Active Employee (i.e., Enhanced or Standard) except:**

- Dental benefits will remain the same if you elect to retain these benefits at the time of your retirement.
  - **Note:** At retirement, you have a **one-time** option to elect to continue dental benefits. Your self-payment will increase with this election (See Section 19 Dental Benefit).
- Burial Benefits are lower as a Retiree (See Section 20 Burial Benefits).
- Accidental Death and Dismemberment Benefits are no longer applicable.

Eligible for Medicare
If you retire prior to age sixty-five (65) and are eligible for Medicare due to a disability, or at age sixty-five (65) or later, and you and your family members are **each** eligible for Medicare, the following applies:

- You and your family members must enroll or have been enrolled in Parts A and B of Medicare in conjunction with your retirement date

- Medical benefits will be provided under the Medicare Advantage Prescription Drug Program (See Section 18 MAPD Benefits).
- Dental benefits will remain the same if you elect to retain these benefits at the time of your retirement.
  - **Note:** At retirement, you have a **one-time** option to elect to continue dental benefits. Your self-payment will increase with this election (See Section 19 Dental Benefit).
- Burial benefits are lower as a Retiree (See Section 20 Burial Benefits).
- Accidental Death and Dismemberment Benefits are no longer applicable.

Mixed Medicare/Non-Medicare

- If you retire (regardless of age) and you and your family members have a mixed status (i.e., with and without Medicare), benefits for each family member are as noted above based on their individual status.
- The one-time only option to purchase dental is applicable.

NOTE: In all cases, you must notify the Fund Office immediately if you are eligible or become eligible for Medicare and provide a copy of your Medicare card to avoid claim issues.

PROVISIONS FOR CONTINUED PARTICIPATION

You, your Spouse and/or Eligible Dependents may continue coverage under the Retiree Self-Payment Program until one of the following occurs:

- You fail to remit timely self-payments.
- You fail to pay the proper amount.
- You fail to remain a member in good standing with your Local Union.
- Termination or modification of the Retiree Self-Payment Program.

In addition to the above reasons for loss of coverage, your Spouse and/or Eligible Dependent(s) will lose coverage if:

- Your Spouse no longer meets the definition of Spouse.
- Your child(ren) no longer meets the definition of an Eligible Dependent.

See COBRA for possible continuation of benefits (Section 8 COBRA).

NOTE: If you discontinue remitting self-payments or are untimely in your self-payment, Plan coverage will terminate automatically on the first (1st) day of the month following the month for which your last payment was made. This termination of coverage is automatic. You will not receive a notification of termination. Upon termination, you, your Spouse and/or Eligible Dependents will also become ineligible to participate in other Plan self-payment programs because continuous coverage is required for eligibility.

SPECIAL NOTIFICATIONS

- If you are single and remitting self-payments and then marry, you may begin coverage for your new Spouse effective with the date of marriage provided that proof of your marriage is submitted to the

Fund Office within thirty (30) days from the date of such marriage along with the additional self-payment amount, if required. If the Fund office does not receive such notice with all required documentation within thirty (30) days of such person becoming your spouse, the spouse may be enrolled for coverage under the Plan on a prospective basis only, with coverage to begin no earlier than the date on which the Fund receives the notice and can administratively implement such request for coverage.

- If you return to work at the trade, you may continue to remit self-payments under the Plan until you satisfy the eligibility provisions of an "Active Employee." **Credit will be given for contributions remitted to the Fund that may not be sufficient to satisfy the eligibility provisions of the Plan**. You should notify the Fund Office immediately if you return to work. It is also your responsibility to notify the Fund Office **in writing** if you again retire.
- If you acquire dependent children, notification and proper documentation (birth certificate, adoption papers, legal guardianship papers, etc.) must be submitted to the Fund Office within thirty (30) days along with the additional self-payment amount, if required, for such coverage. Eligible Dependent(s) will be covered effective with the date the child meets the definition of an Eligible Dependent provided the Fund Office has received proper documentation of such status and any applicable payment. If the Fund office does not receive such notice with all required documentation within thirty (30) days of such person becoming your dependent, the dependent may be enrolled for coverage under the Plan on a prospective basis only, with coverage to begin no earlier than the date on which the Fund receives the notice and can administratively implement such request for coverage.
- Non-military service-related treatment provided by a Veterans Administration facility to participants and/or dependents *who are also covered by Medicare* is not covered by the Plan unless required by law. Medicare does not provide any payment for these services. Any charges incurred by the participant and/or dependent for such non-military service-related treatment may be the responsibility of the participant.

SECTION 5: TOTALLY & PERMANENTLY DISABLED (T&PD)

If you become totally and permanently disabled prior to age sixty-five (65), you may be eligible to continue Plan benefits for yourself, your Spouse and/or Eligible Dependents through the Totally & Permanently Disabled Self-Payment Program.

ELIGIBILITY PROVISIONS

To continue eligibility in the Plan for yourself, Spouse and/or Eligible Dependent(s) as a Totally & Permanently Disabled Participant you must be receiving monthly disability benefits from one of the following sources:

- The Michigan Carpenters' Pension Fund
- The Carpenters' Pension Trust Fund – Detroit & Vicinity
- The Social Security Administration

You must also have been eligible either by employer contributions, "short hour" or "full month" self-contributions at the date of retirement to participate in the Totally and Permanently Disabled Program. Coverage must begin immediately upon termination of coverage under the Active program.

PROVISIONS FOR CONTINUED PARTICIPATION

You may continue coverage for yourself, your Spouse and/or Eligible Dependents under the Totally & Permanently Disabled Self-Payment Program until one of the following occurs:

- You are no longer Totally and Permanently Disabled.
- You fail to remit timely self-payments
- You fail to pay the proper amount
- You fail to remain a member in good-standing with the Local Union
- Termination or modification of the Totally & Permanently Disabled Self-Payment Program

In addition to the above reasons for loss of eligibility, your Spouse and/or Eligible Dependent(s) will lose coverage if:

- Your Spouse no longer meets the definition of Spouse
- Your child(ren) no longer meet the definition of an Eligible Dependent

See COBRA for possible continuation of benefits (See Section 8 COBRA).

NOTE: If you discontinue remitting self-payments or are untimely in your self-payment, Plan coverage will terminate automatically on the first (1st) day of the month following the month for which your last payment was made. This termination of coverage is automatic. You will not receive a notification of termination. Upon termination, you, your Spouse and/or Eligible Dependents will also become ineligible to participate in other Plan self-payment programs because continuous coverage is required for eligibility.

SPECIAL PROVISIONS

- Your continued disability status is subject to review at least once every two (2) years. The Fund Office will contact you and you will be required to submit documentation to substantiate your continuing disability status.
- If you return to work, you will be required to remit self-payments under the Active Employee Self-Payment Program **until such time that you satisfy the eligibility provisions of an Active Employee**. It is your responsibility to notify the Fund Office in writing if you return to work so that a review of your status can be completed. It is also your responsibility to notify the Fund Office in writing if you again retire.
- If you are single and remitting self-payments and then marry, you may begin coverage for your new Spouse effective with the date of marriage provided that proof of your marriage is submitted to the Fund Office within thirty (30) days from the date of such marriage along with the additional self-payment amount if required. If the Fund office does not receive such notice with all required documentation within thirty (30) days of such person becoming your spouse, the spouse may be enrolled for coverage under the Plan on a prospective basis only, with coverage to begin no earlier than the date on which the Fund receives the notice and can administratively implement such request for coverage.
- If you acquire dependent children, notification and proper documentation (birth certificate, adoption papers, legal guardianship papers, etc.) must be submitted to the Fund Office within thirty (30) days along with the additional self-payment amount, if required, for such coverage. Eligible Dependent(s) will be covered effective with the date the child satisfies the definition of an Eligible Dependent provided the Fund Office has received proper documentation of such status. If the Fund office does not receive such notice with all required documentation within thirty (30) days of such person becoming your dependent, the dependent may be enrolled for coverage under the Plan on a prospective basis only, with coverage to begin no earlier than the date on which the Fund receives the notice and can administratively implement such request for coverage.
- Non-military service-related treatment provided by a Veterans Administration facility to participants and/or dependents who are also covered by Medicare is not covered by the Plan unless required by law. Medicare does not provide any payment for these services. Any charges incurred by the participant and/or dependent for such non-military service related treatment will be the responsibility of the participant.

Note: Currently a lower self-payment rate has been established for the first six (6) months for which self-payments are required. This provision is subject to change as determined by the Board of Trustees. Additionally, the amount of self-payments is determined by the Trustees and may be changed from time to time. You should contact the Fund Office for information.

BENEFIT ELIGIBILITY

If you are not eligible for Medicare at the time of your disability and the Social Security Administration ultimately determines that you have been disabled for a period of time that qualifies you for Medicare benefits (generally this is following twenty-four (24) consecutive months of disability), you must apply for disability benefits from Social Security **and** enroll in both Parts A and B of Medicare. You must also provide the Fund Office with a copy of your Social Security Award and your Medicare card as soon as possible.

If your Spouse and/or Eligible Dependent(s) are eligible for Medicare at the time you qualify for the Totally and Permanently Disabled Self-Payment Program, you must notify the Fund Office of such in conjunction with your application for continued eligibility in the Plan. If your Spouse and/or Eligible Dependent(s) subsequently become eligible for Medicare, immediate enrollment in Medicare Parts A and B of Medicare is required along with providing a copy of their Medicare card to the Fund Office.

SCHEDULE OF BENEFITS

The schedule of benefits for you, your Spouse and/or your Eligible Dependent(s) is based on the status of each family member (i.e., non-Medicare or Medicare eligible) on the date you become eligible under the Totally & Permanently Disabled Self-Payment Program.

If you are enrolled in the Enhanced Plan at the time of your disability, you will remain in that plan. You are no longer required to obtain a physical.

If you are enrolled in the Standard Plan at the time of your disability, you will automatically be enrolled in the Enhanced Plan. A physical will not be required.

If you or a qualified family member is eligible for Medicare at the time of your disability, benefits will be provided under the Supplement to Medicare program. You should contact the Fund Office if this situation is applicable.

Note: See Section 14 for details regarding the Enhanced and Standard Plans.

Not Eligible for Medicare

The schedule of benefits for you, your Spouse and/or Eligible Dependents is the same as the schedule of benefits in effect for an Active Employee **except:**

- You may remain in the Enhanced Plan without obtaining a physical.
- Dental benefits will remain the same if you elect to retain these benefits at the time of your disability. **Note:** At the time of your disability, you have a **one-time** option to elect to continue dental benefits. Your self-payment will increase with this election (See Section 19 Dental Benefits).
- Burial Benefits are lower (See Section 20 Burial Benefits).
- Accidental Death and Dismemberment Benefits are no longer applicable.

Eligible for Medicare

If you, your Spouse and/or Eligible Dependent(s) are eligible for Medicare the following applies:

- You and your family members must enroll or have been enrolled in Parts A and B of Medicare.
- Medical care will be provided under the Medicare Advantage Prescription Drug Program (See Section 18 MAPD Benefits).
- The BCBSM Prescription drug program is no longer applicable.
- Dental benefits will remain the same if you elect to retain these benefits at the time of your disability. **Note:** At the time of your disability, you have a **one-time** option to elect to continue dental benefits. Your self-payment will increase with this election.
- Burial benefits are lower (See Section 20 Burial Benefits).
- Accidental Death and Dismemberment Benefits are no longer applicable.

Mixed Medicare/Non-Medicare
If at the time you qualify for the Totally and Permanently Disabled Self-Payment Program and you and your family members have a mixed status (i.e., with and without Medicare), benefits for each family member are as noted above based on their non-Medicare/Medicare status.

NOTE: In all cases, you must notify the Fund Office of your Medicare status and provide a copy of your Medicare card.

SECTION 6: SURVIVING SPOUSE SELF-PAYMENT PROGRAM

ELIGIBILITY

The Surviving Spouse and/or Eligible Dependent(s) of a deceased Active Employee or Retiree are eligible for continued coverage under the Surviving Spouse Self-Payment Program if:

- The deceased Active Employee/Retiree and the Surviving Spouse and Eligible Dependent(s) were covered under the Plan on the date of the Employee's/Retiree's death.

Benefits will be the same **as were in effect prior to the death** of the Active Employee or Retiree/Early Retiree **except**:

- Surviving Spouses and/or Eligible Dependents who are **not** Medicare eligible and enrolled in the Standard Plan will automatically be enrolled in the Enhanced Plan. (See Section 14).
- Burial benefits are not applicable to the Surviving Spouse and Eligible Dependent(s).
- Accidental death and disability benefits are not applicable to the Surviving Spouse and Eligible Dependent(s).
- A Surviving Spouse of an **Active Employee** will have a **one-time option** to continue or terminate dental benefits. The self-payment is lower if dental benefits are excluded. **Once an election is made, this election cannot be changed.**
- A Surviving Spouse of a **Retiree** will be permitted to continue dental benefits provided the required payment is submitted.

MEDICARE ELIGIBLE

A Surviving Spouse and/or Eligible Dependent who becomes eligible for Medicare while making payments under the Surviving Spouse Self-Payment program, must **enroll in Medicare Parts A and B effective with the Medicare eligibility date**. Notification must be made immediately to the Fund Office. A copy of a Medicare card is also required.

Effective with enrollment in Medicare, benefits for medical and prescription drugs will be provided under the MAPD Program (See Section 17). There is no change to dental benefits if these benefits were previously elected and the required payment is submitted.

SPECIAL PROVISIONS

If the deceased Active Employee has remaining contributions in his/her "dollar bank," self-payments are not required from a Surviving Spouse and/or Eligible Dependent(s) until the "dollar bank" contributions are not sufficient to cover the required payment.

Once coverage is elected under the Surviving Spouse Self-Payment Program, continuous coverage must be maintained through self-payments. If coverage is terminated for any reason, the Surviving Spouse and/or Eligible

Dependents will not be permitted to make self-payments at any future time or under any self-payment Plan provisions, except COBRA.

Note: Currently a lower self-payment rate has been established for the first six (6) months for which self-payments are required for a non-Medicare Surviving Spouse and/or eligible dependents. This provision is subject to change as determined by the Board of Trustees. Additionally, the amount of self-payments is determined by the Trustees and may be changed from time to time. You should contact the Fund Office for information.

TERMINATION OF COVERAGE

Coverage for the Surviving Spouse and Eligible Dependents will terminate on the first day of the month following one of these events:

- Remarriage of the Surviving Spouse
- Failure to remit a self-payment in the correct amount by the specified due date
- Termination or modification of the Surviving Spouse Self-Payment program
- The dependent child fails to meet the definition of an Eligible Dependent as defined in the Plan

NOTE: Eligible Dependents who lose coverage due to any of the above provisions may be eligible for benefits through COBRA. See Section 8 COBRA Coverage.

SECTION 7: CONTINUATION OF COVERAGE - LEAVE PROVISIONS

CONTINUATION OF COVERAGE UNDER FMLA

A contributing Employer which is a "covered employer" as that term is defined by the Family Medical Leave Act ("FMLA") is required to notify the Fund when an eligible employee has been granted family or medical leave, in accordance with the terms and conditions established by the Board of Trustees. Both the Employer and the Employee are required to provide the notices, information and documentation as may be required by the Board of Trustees and by law. The Fund will continue coverage during the leave for which an Employee is eligible under the provisions of the FMLA provided the Employer remits the required contributions and fully complies with all requirements established by the Board of Trustees. If you have questions, contact your Employer and/or the Fund Office.

CONTINUATION OF COVERAGE UNDER USERRA

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), if you leave Covered Employment to enter service in the armed forces, or other uniformed services of the United States, the Dollar Bank, if any, will be frozen, and you may elect to continue your health coverage under the Plan, for a period which is the lesser of:

- The twenty-four (24) month period beginning on the last day of Covered Employment; or
- The day the Employee fails to apply for or return to Covered Employment.

If you elect to continue coverage, you will be charged the monthly COBRA premium rate, unless your period of service is less than thirty-one (31) days, in which case coverage shall be provided at no additional cost.

You must return to Covered Employment or register on the Union's out-of-work list within ninety (90) days of your discharge under honorable conditions from the uniformed services or within twenty-four (24) months of discharge if you are recovering from an illness or injury incurred during or aggravated by your service. Upon return to Covered Employment or registration on the Union's out-of-work list, your Dollar Bank, if any, shall be unfrozen. You shall be eligible for coverage without having to meet initial eligibility requirements. You will also need to submit copies of your induction and discharge papers to the Fund Office.

SECTION 8: COBRA CONTINUATION COVERAGE

This section is intended to explain to you, your Spouse and your Eligible Dependents, in a summary fashion, about *rights and obligations* under the health care continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act, or "COBRA." You, and your eligible family members should take time to read this section carefully.

DEFINITIONS

COBRA Premium - The COBRA premium (i.e., the cost to you) is determined annually.

Continuation Coverage - The coverage available to you, your Spouse and/or your Eligible Dependents in the event you lose eligibility due to a Qualifying Event. If you elect Continuation Coverage, the Plan must provide coverage which, as of the time such coverage is provided, is identical to the coverage provided for other similarly situated beneficiaries for basic hospital, medical, and surgical benefits.

Qualified Beneficiary - An individual who is covered under the Plan on the day before a Qualifying Event, as well as a newborn child or child placed for adoption with you during the period of Continuation Coverage. Qualified Beneficiaries are you, your Spouse and/or your dependent children.

Qualifying Event - An event that causes you and/or one or more eligible family members to lose coverage under the Plan. The specific events which are Qualifying Events for you, your Spouse and/or your children are explained in detail in the following sections. Depending on the Qualifying Event, Continuation Coverage is available for up to eighteen (18), twenty-nine (29) or thirty-six (36) months.

COBRA COVERAGE ELECTION

Your Right To Elect Continuation Coverage
You, as a Qualified Beneficiary, have the right to choose health care Continuation Coverage if you lose eligibility for coverage under the Plan:

- Due to a reduction in the amount of employer contributions remitted; or
- Termination of employment for any reason, unless termination is due to gross misconduct on your part; or
- Start of military service if you perform military duty for thirty-one (31) or more days.

Each of those circumstances is what is known as a "Qualifying Event" for you, as an employee. These Qualifying Events entitle you and/or your family to elect up to eighteen (18) months of Continuation Coverage.

The Trustees, through the Fund Office, determine when a Qualifying Event occurs as a result of a reduction of employer contributions or a termination of employment based on information included on submitted employer contribution forms. The Fund Office will determine when the Qualifying Event has occurred within one hundred twenty (120) days following receipt of the employer contribution form. The Fund Office will mail a COBRA election notice within sixty (60) days after it has determined that you or a Qualified Beneficiary has lost eligibility for coverage. You have sixty (60) days from the date you receive the election notice to elect Continuation Coverage. If you do not make an election for coverage within sixty (60) days, you no longer have a right to elect to receive Continuation Coverage.

If you qualify for Continuation Coverage under COBRA but do not elect such coverage for your entire family, your Spouse and/or dependent children are still entitled to elect Continuation Coverage for themselves as long as their election is made within the same election period in which you qualify.

Your Spouse's Right to Elect Continuation Coverage
Spouses of employees covered under the Plan, as Qualified Beneficiaries, have the right to choose Continuation Coverage for themselves if they lose their group health care coverage under the Plan for any of the following reasons:

- Termination of your employment (for reasons other than gross misconduct), or a reduction in the hours worked by you which results in your losing eligibility under the Fund; or
- Your death; or
- Divorce or legal separation from you; or
- You become entitled to Medicare and are not eligible to continue coverage for your Spouse under another portion of the Plan or choose not to continue such coverage.

These reasons are known as Qualifying Events for your Spouse. The first Qualifying Event entitles your Spouse to elect up to eighteen (18) months of Continuation Coverage. The other Qualifying Events entitle your Spouse to elect up to thirty-six (36) months of Continuation Coverage.

Your Dependent Children's Right to Elect Continuation Coverage
Your dependent children covered under the Plan, as Qualified Beneficiaries, have the right to elect Continuation Coverage if they lose their eligibility for coverage under the Plan for any of the following reasons:

- Termination of covered Employee's employment (for reasons other than gross misconduct) or a reduction in the number of hours worked by the parent who is the covered Employee under the Plan
- Death of the parent, who is the covered Employee under the Plan
- Divorce or legal separation of the parents – at least one of whom remains covered under the Plan
- You become entitled to Medicare and either are not eligible to continue coverage for the children or choose not to continue such coverage
- The child or children cease to satisfy the Plan's definition of a "dependent child."

These reasons are known as Qualifying Events for your dependent children. The first Qualifying Event entitles your dependent children to elect up to eighteen (18) months of Continuation Coverage. The other Qualifying Events entitle your dependent children to elect up to thirty-six (36) months of Continuation Coverage.

A newborn or adopted child will automatically be extended COBRA coverage if the parents already have COBRA coverage. But, this may involve an increase in the COBRA premium charged. A newborn child or an adopted child (or the child's custodian or guardian) has a right, separate from his or her parents, to elect Continuation Coverage for up to eighteen (18) or thirty-six (36) months, depending on the Qualifying Event, even if the child's parent(s) do not elect Continuation Coverage.

Continuation Coverage for Disabled Persons
If you, as a covered employee, your Spouse, or any dependent children, as Qualified Beneficiaries, qualify for Social Security disability benefits at the time of a Qualifying Event that entitles the Qualified Beneficiary to elect eighteen (18) months of Continuation Coverage (or any time during the first sixty (60) days after you lose

coverage due to a Qualifying Event), you may purchase up to an additional eleven (11) months of Continuation Coverage (or a total of up to twenty-nine (29) months).

This additional Continuation Coverage may be purchased not only for the disabled person, but also for other family members who are not disabled (subject to the payment of the applicable premium).

To obtain this additional Continuation Coverage, the Qualified Beneficiary must be determined eligible for Social Security disability benefits before the end of the eighteen (18) month Continuation Coverage period and must notify the Fund Office during the eighteen (18) month period and within sixty (60) days after the Social Security Administration awards Social Security benefits to the disabled person.

The Fund is permitted to charge a higher premium (up to one-hundred fifty percent (150%) of the regular COBRA premium) for up to eleven (11) additional months of Continuation Coverage available to disabled persons and their families. The higher premium applies to the disabled person and to other non-disabled family members who opt for this additional COBRA coverage.

Eligibility for extended Continuation Coverage because of disability ends the first day of the month that is more than thirty (30) days after the date that the once disabled person is determined by the Social Security Administration to be no longer disabled. Federal law requires a disabled person to notify the Fund within thirty (30) days of a final Social Security Administration determination that he or she is no longer disabled.

Employee Obligations to Notify the Fund Office of a Qualifying Event
Under COBRA, you or a family member must notify the Fund Office within sixty (60) days about a divorce, legal separation, or a child losing dependent status under the Plan. If such an event is not reported to the Fund Office within sixty (60) days after it occurs, Continuation Coverage will not be permitted.

Your surviving Spouse (or dependent child) should contact the Fund Office immediately after your death. This assures that Continuation Coverage is offered to your surviving Spouse and children at the earliest possible date.

The law requires the COBRA election notice to be sent to the last known address on file at the Fund Office. If the election notice is sent to the wrong address due to your failure to notify the Fund Office about a change in address, the sixty (60) day time limit will not be extended and you may lose the opportunity to elect COBRA Continuation Coverage.

You are also required to notify the Fund Office if you or any family members are covered under another group health care plan at the time you received a COBRA election notice (*e.g.,* if you are covered as a dependent under your Spouse's plan) or, if at any time you or a family member later become(s) covered under another group health care plan, including Medicare.

Second Qualifying Events
The following rules concerning the occurrence of a second Qualifying Event only apply if the original Qualifying Event was termination of the employee's employment (for reasons other than gross misconduct) or reduction in the number of hours worked by the employee. If a second Qualifying Event should occur during the eighteen (18) months of coverage available as a result of the first Qualifying Event [or, up to twenty- nine (29) months if the eleven (11) month extension due to disability applies], then you may purchase additional Continuation Coverage for up to a total of thirty-six (36) months. An example of a second Qualifying Event would be:

- Death of the employee if he or she is a covered employee
- Divorce or legal separation of the employee and his/her Spouse
- If a covered employee becomes enrolled in Medicare (Part A, Part B or both)
- For dependent children, the dependent child ceases to satisfy the Plan's definition of a "dependent child." (The rules for second qualifying events also apply to newborn or adopted children.)

This thirty-six (36) months total of Continuation Coverage available when a second Qualifying Event occurs includes the number of months you have already been covered under Continuation Coverage because of the first Qualifying Event. The thirty-six (36) month total is not in addition to any months of Continuation Coverage you have already had because of the first Qualifying Event. The Fund Office must be notified within sixty (60) days of the second Qualifying Event or the additional extended coverage will not be allowed.

For your reference, below is a table that summarizes COBRA Qualifying Events and the length of coverage available, including any extensions for which you may qualify:

	Maximum Continuation Period		
Qualifying Event	**Employee**	**Spouse**	**Child**
Reduction in work hours	18 months	18 months	18 months
Termination (other than for misconduct)	18 months	18 months	18 months
You're determined to be disabled by the SSA	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your Spouse divorce	N/A	36 months	36 months
Your child no longer qualifies as a dependent	N/A	N/A	36 months

Proof of Insurability is Not Necessary to Elect Continuation Coverage
You and your family members do not have to show that you are insurable to purchase Continuation Coverage. But, you must make the required self-payment(s) for such coverage in accordance with specific due dates. The amount(s) and the due date(s) will be shown on the COBRA election notice.

Procedure for Obtaining Continuation Coverage
Once the Fund Office knows that an event has occurred which qualifies you or other family members for Continuation Coverage, the Fund Office will attempt to notify you or your family member of their rights to elect Continuation Coverage.

Once you receive this election notice, you will have sixty (60) days after the date on the election notice within which to notify the Fund Office whether or not you want the Continuation Coverage. If you do not elect the coverage within the sixty (60) day time period, your right to continue your group health care coverage will end.

Termination of Continuation Coverage
The law provides that Continuation Coverage may be cancelled by the Fund for any of the following reasons:

- The Fund no longer provides group health care coverage to any Employees
- The required self-payment for Continuation Coverage is not paid on time
- The person remitting Continuation Coverage payments becomes covered under another group health care plan, after the Qualifying Event,
- The person remitting Continuation Coverage payments becomes entitled to Medicare

Although your Continuation Coverage may be canceled as soon as you are covered by Medicare, a Spouse or a dependent child receiving Continuation Coverage at that time may continue purchasing such coverage for up to eighteen (18) or thirty-six (36) months minus any months of Continuation Coverage received immediately prior to your coverage under Medicare. This option applies only if a Spouse or a dependent child is not covered by Medicare.

SECTION 9: COORDINATION OF BENEFITS, SUBROGATION, NO FAULT AUTO INSURANCE

COORDINATION OF BENEFITS (COB)

COB is how health care carriers coordinate benefits when you are covered by more than one group health care plan. Under COB, carriers work together to make sure you receive the maximum benefits available under your health care plans. Your Blue Cross Blue Shield health care plan requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans.

COB ensures that the level of payment, when added to the benefits payable under another group plan, will cover up to one-hundred percent (100%) of the eligible expenses as determined between the carriers. In other words, COB can reduce or eliminate out-of-pocket expenses for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for care.

How COB Works

If you are covered by more than one group plan, COB guidelines (explained below) determine which carrier pays for covered services first.

- Your primary plan is the carrier that is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.
- Your secondary plan is the carrier that is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by the carriers.

Guidelines To Determine Primary Vs. Secondary Plan

Contract Holder vs. Dependent Coverage

The plan that covers the patient as the employee (subscriber or contract holder) is primary and pays before a plan that covers the patient as a dependent.

Contract Holder (Multiple Contracts)

If you are the contract holder of more than one health care plan, your primary plan is the one on which you are an active member (such as an employee), and your secondary plan is the one of which you are an inactive member (such as a retiree).

Dependents (The "Birthday Rule")

If a child is covered under both their mother's and father's plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.

Children of Divorced or Separated Parents

For children of divorced or separated Spouses, benefits are determined in the following order unless a court order places financial responsibility on one parent:

- Plan of the custodial parent.
- Plan of the custodial parent's new Spouse (if remarried).
- Plan of the non-custodial parent.
- Plan of non-custodial parent's new Spouse.

If the primary plan cannot be determined by using the guidelines above, then the "birthday rule" will be used to determine primary liability. However, if a court decree, such as a judgment of divorce, states that one parent is financially responsible for the health care expenses of the child, and the plan has been advised of that legal responsibility, then that plan is primary for the child and the plan of the other parent would be secondary. If a court decree states that both parents are responsible for providing health coverage, then the two plans would be of the same priority level and the rules as stated above would apply.

Updating COB Information – Your Responsibility
It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, **notify the Fund Office immediately.** Independence Administrators may periodically ask you to update your COB information. Please help Independence Administrators serve you better by responding to requests for COB information quickly.

Both Spouses Eligible as Employees
If both you and your Spouse are employed as a Carpenter and each is eligible for Plan benefits through the Fund, the Fund will coordinate benefits between your two Plans for you, your Spouse and your Eligible Dependents.

SUBROGATION
Your medical plan includes a provision called "Subrogation." If you file a lawsuit or an insurance claim with another carrier, or if there is a settlement with another carrier for which your medical plan had paid for services incurred for which the other carrier is deemed responsible, subrogation allows this Fund and/or Independence Administrators to hold the other carrier responsible for payment of medical expenses related to the injury. Under the terms of your Plan, the Fund and/or Independence Administrators may also recover excess payments, if any, which become due to you, your dependent or beneficiary.

NO-FAULT AUTOMOBILE/MOTORCYCLE INSURANCE AND INDEPENDENCE ADMINISTRATORS' COVERAGE

If you or an Eligible Dependent are involved in an automobile accident, Independence Administrators will not pay for services related to an injury which is a direct or indirect result of any motor vehicle accident. This applies whether or not you have no-fault automobile insurance.

The Plan is secondary for a motorcycle accident whether or not you have purchased motorcycle insurance and whether or not you were wearing a motorcycle helmet. It is important that you discuss this with your automobile/motorcycle insurance agent and/or company. **See Limitations and Exclusions under Medical Benefits for a detailed description.**

SECTION 10: PRIVACY OF HEALTH INFORMATION

A Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the privacy of your personal health information be protected.

The Plan's Privacy Notice, distributed to all Plan participants and dependents, explains what information is considered "Protected Health Information (PHI)." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information. This Notice is effective as of January 1, 2018. If you have any questions, contact the Privacy Officer at the Michigan Carpenters' Health Care Fund, 6525 Centurion Drive, Lansing, Michigan 48917-9275, or (517) 321-7502, (800) 273-5739, or fax (517) 321-7508, or e-mail to privacyofficer@tici.com.

PRIVACY NOTICE

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research

- Comply with the law
- Respond to organ and tissue donation request and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask Us to Correct Health and Claims Records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request Confidential Communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask Us to Limit What We Use or Share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a List of Those with Whom We've Shared Information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a Copy of This Privacy Notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose Someone to Act for You

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a Complaint if You Feel Your Rights Are Violated

- You can complain if you feel we have violated your rights by contacting Privacy Officer at the Michigan Carpenters' Health Care Fund, 6525 Centurion Drive, Lansing, Michigan 48917-9275 or (517) 321-7502, (800) 273-5739 or fax (517) 321-7508 or privacyofficer@tici.com
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

- We typically use or share your health information in the following ways:
- Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
  Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run Our Organization
We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

- Example: We use health information about you to develop better services for you.

Pay for Your Health Services
We can use and disclose your health information as we pay for your health services.

- Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer Your Plan
We may disclose your health information to your health plan sponsor for plan administration.

- Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with Public Health and Safety Issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do Research
We can use or share your information for health research.

Comply with the Law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director upon the death of an individual.

Address Workers' Compensation, Law Enforcement, and Other Government Requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services.

Respond to Lawsuits and Legal Actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

SECTION 11: FEDERAL MANDATED NOTICES

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)

Under MHPAEA, group health plans generally may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans to ensure that financial requirements (such as deductibles, coinsurance and/or copayments), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans to ensure parity with respect to nonquantitative treatment limitations (such as medical management standards).

NEWBORNS AND MOTHERS HEALTH PROTECTION

Your health plan may not, under Federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, the mother's or the newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than forty-eight (48) hours or ninety-six (96) hours as applicable. In any case, no pre-authorization from your health plan or the group health insurance insurer is needed for a stay of up to forty-eight (48) hours or ninety-six (96) hours.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The medical options provide benefits related to breast reconstruction in compliance with the Women's Health and Cancer Rights Act of 1998. This Federal law states that group health plans provide medical and surgical benefits for mastectomy and must provide certain additional benefits related to breast reconstruction.

If you (or a covered dependent) are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the medical plans will provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of mastectomy, including lymphedemas.

Benefits will be provided as they would for any other surgical expense.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Under federal law, the Fund must recognize qualified medical child support orders (QMCSO) mandating continuation of health care coverage for certain dependent children. A QMCSO is a court order that recognizes the right of an alternate recipient (child) to receive benefits under the Plan. A QMCSO may not require the Plan to provide a type or form of benefit not otherwise provided to children of eligible participants or retirees. A QMCSO is usually issued in a divorce or a paternity case in which you are ordered by the court to continue to provide medical support for your child or children, but it may also be in the form of a National Medical Support Notice (NMSN) issued by the Friend of the Court.

The Fund Office or legal counsel for the Fund will determine whether a document is a QMCSO. If the document is determined to be a QMCSO, the Fund will notify you and the possible alternate recipient (or custodial parent or issuing agency, as appropriate). If the document is determined not to be a QMCSO, the Fund will send a letter describing the reason for that determination. Payment of benefits made by the Plan pursuant to a QMCSO may be made to the alternate recipient's custodial parent or legal guardian, and notices and explanations of benefits relating to the alternate recipient will be sent to the custodian parent or legal guardian.

FEDERAL NO SURPRISES ACT – YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Effective January 1, 2022, you cannot be balance billed when you receive emergency care or are treated at a nonparticipating provider at a participating hospital or ambulatory center.

Generally, balance billing is when you receive services from a provider or facility, and you may owe certain out-of-pocket costs for the difference between what the Plan agrees to pay, and the full amount charged for the service if the provider or health care facility does not participate with this Plan.

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is the Plan's in-network cost-sharing amount (such as deductibles, copayments and coinsurance). You **cannot** be balance billed for these emergency services.

This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain Services At An In-network Hospital Or Ambulatory Surgical Center

When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is the Plan's in-network cost-sharing amount.

This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections. You are never required to give up your protections from balance billing.

If you believe you have been incorrectly billed, contact the No Surprises Help Desk at (800) 985-3059.

SECTION 12: MEDICAL BENEFITS – INDEPENDENCE ADMINISTRATORS

ADMINISTRATION

Your medical and pharmacy benefits are administered through Independence Administrators. The following is intended as an easy-to-read summary of benefits and provides only a general overview. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on the Independence Administrators approved amount, less any deductible, coinsurance and/or copayment that may be required. For a detailed description of benefits, please see the applicable Independence Administrators certificates, riders and plan modifications (called the Plan Documents). If there is a discrepancy between this benefit summary and the Plan Documents, the Plan Documents will control.

ENHANCED/STANDARD PLANS FOR MEDICAL BENEFITS

The E*nhanced and Standard Plans* (ES Plan) applies to everyone except members enrolled in the MAPD or Minimum Coverage programs.

The medical and prescription drug benefit level for the Enhanced and Standard Plans are identical. There are, however, differences in deductibles, coinsurance and copayments between the two Plans; i.e., the Enhanced Plan has **lower** out-of-pocket costs vs. the Standard Plan. Details of each plan are provided in Section 14.

Requirements for the Enhanced Plan
To be eligible for enrollment or to remain enrolled in the *Enhanced Plan,* Active Employees and non-Medicare Retirees must obtain and submit proof of a physical to the Fund Office by December 15th of each year. Failure to obtain a physical and submit proof of such each year, **or failure to submit proof of a physical by December 15th each year**, **will result in automatic enrollment in the Standard Plan as of January 1 of the following year for the entire calendar year.** Only the Active Employee/non-Medicare Retiree is required to obtain a physical each year. Enrollment in the Enhanced Plan will continue as long as you timely provide proof of your physical.

Initial Eligibility and Enrollment for the Enhanced Plan vs. the Standard Plan
Upon meeting Initial Eligibility requirements for Plan benefits, you will be enrolled in the *Enhanced Plan* for the year in which you have become eligible. You **must,** however, obtain a physical and provide proof of your physical to the Fund Office by December 15th of the year you became eligible in order to remain enrolled in the Enhanced Plan for the following year. If you do not meet the required terms, you (and your family members) will be transferred to the Standard Plan effective January 1 of the following year for the entire calendar year.

Please Note: If you meet the Initial Eligibility requirements in October, November or December of any calendar year, you will not be required to obtain a physical by December 15th to remain in the Enhanced Plan for the following calendar year.

Example: You meet the Initial Eligibility requirements in October 2023 and are enrolled in the Enhanced Plan. You are not required to obtain a physical by December 15, 2023 to remain eligible for the Enhanced Plan during calendar year 2024. On or before December 15, 2024, you must obtain and submit your physical to remain in the Enhanced Plan during calendar year 2025.

Interim Loss of Eligibility and Reinstatement
If you become ineligible for Plan benefits due to loss of eligibility (i.e., you no longer have employer contributions and/or do not continue benefits through "short hour" or "full month" self-contributions) for an intermittent period of time and are subsequently eligible to be reinstated in the same calendar year, you will be enrolled in the same plan in which you were previously enrolled for the remainder of the calendar year.

Example: You are enrolled in Enhanced Plan from January through March, you lose coverage for April and May, you become eligible again in August -- you will be re-enrolled in the Enhanced Plan for the remainder of the year as long as you maintain eligibility. To remain in the Enhanced Plan for the following year, you must obtain and provide proof of a physical by December 15th of the current year.

If, however, you have an intermittent loss of coverage from the Enhanced Plan during the year but do not qualify for reinstatement until the following year, you must meet the requirement of obtaining and submitting proof of a physical by December 15th during the year of your loss of coverage to be re-enrolled in the Enhanced Plan in the following year.

Example: You are enrolled in the Enhanced Plan from January through September, you lose coverage for the months of October and November, you become eligible again for the month of February of the following year – you must obtain and provide proof of a physical by December 15th of the year you lost coverage to be eligible for re-enrollment in the Enhanced Plan in February.

Definition of "Physical"
A physical is a normal, routine physical exam performed by a physician. For female employees, an annual gynecological exam satisfies the physical requirement. Note that generally you do not have to pay for a physical since it is a covered benefit under both the Enhanced and Standard Plans.

Proving that You had a Physical
There are two ways to prove you had a physical:

- Use the Fund's "Physical Verification Form." Your doctor simply completes and signs the form for you to submit to the Fund Office. A copy can be obtained by calling the Fund Office.
- Submit a copy of your Independence Administrators "Explanation of Benefits" (EOB) form reflecting your physical. Your EOB will show the date of service.

If you are unsure that the Fund Office has received notification of your physical, contact the Fund Office immediately.

Note: The Fund *does not* see or receive your medical information. The Fund Office only requires confirmation that you have had a physical.

If You are Disabled
If you are disabled and enrolled through the Totally and Permanently Disabled Participant Self-payment program, you will remain eligible for the *Enhanced Plan* without obtaining a physical. You are considered disabled for purposes of qualifying for the *Enhanced Plan* if you received both a Social Security Disability Award *and* are collecting pension benefits under the Michigan Carpenters' Pension Fund.

If You are a Surviving Spouse
Non-Medicare surviving Spouses and eligible dependents are automatically eligible for the Enhanced Plan**.** Spouses and/or dependents who are eligible for Medicare will have benefits under the Supplement to Medicare program. You should contact the Fund Office for assistance.

PREAUTHORIZATION FOR SELECT SERVICES

Services listed in this summary of benefits are covered when provided in accordance with Independence Administrators policies and, when required, are preauthorized or approved by Independence Administrators. The following services require your provider to obtain approval before receiving these services – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, select outpatient surgeries or procedures, inpatient mental health care, inpatient substance abuse treatment, residential psychiatric facilities, rehabilitation therapy and applied behavioral analyses. Detailed information can be found at www.ibxtpa.com

PREAUTHORIZATION FOR SPECIALTY PHARMACEUTICALS

Select specialty pharmaceuticals may require preauthorization when received in locations such as a physician office, clinic, outpatient facility or through a home health care provider. Specialty pharmaceuticals are biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer. Independence Administrators determines which specific drug claims are payable. Contact Independence Administrators for a comprehensive list of specialty drugs by calling the number on the back of your Independence Administrators ID card.

WORK RELATED INJURIES

Coverage is excludable for services that are a work or occupational related injury or illness.

YOUR INDEPENDENCE ADMINISTRATORS PROGRAM

The medical program administered by Independence Administrators.

IN-NETWORK VS. OUT-OF-NETWORK PROVIDERS

In-Network Providers
Providers who have contracted with local Blue Cross Blue Shield companies (National BlueCard PPO) PPO program are termed "**In-network**" or "**Participating**" PPO providers. In other words, these providers are part of the National BlueCard PPO network. If you use the services of a PPO network provider, you will be responsible only for deductibles, coinsurance and/or copayments as applicable for approved services.

Out-of-Network Providers
Providers who have not contracted with Independence Blue Cross' PPO program are considered either "**Out-of-network**" or "**Non-participating**" providers.. **Providers who are not contracted with the local Blue Cross Blue Shield company are considered "Non-participating" providers. "Non-participating"** providers may bill you for applicable deductibles, coinsurance and/or copayments **and** they can also bill you for balances that are greater than the allowable amount. These balances could be substantial.

Note: Approved services received from a provider for which there is no National BlueCard PPO network are covered at the "**In-network**" benefit level.

Services received at a <u>non-participating</u> facility, clinic or freestanding facility other than emergency services are not covered.

GENE THERAPY

The Fund elects to cover gene therapy, effective September 1, 2022, in accordance with the following definition and details.

Definition:
The Plan covers medically necessary, non-experimental, and FDA-approved Gene therapy treatments under its Medical Benefits subject to the deductible and 20% co-insurance.

Gene therapy is the modification, alteration or manipulation of cells to produce a therapeutic effect or to treat diseases by replacing, repairing or reconstructing the defective genetic material. Chimeric Antigen Receptor T cells, commonly known as CAR T-cells are cells that are genetically engineered, modified or reprogrammed in a laboratory.

For Gene Therapy to be covered, the following conditions apply:

1. The Fund will provide coverage for FDA-approved, medically necessary gene therapies, subject to a deductible, coinsurance and or/copay.

2. Gene therapy services must be pre-certified in accordance with the Pre-Certification requirements of the Independence Administrators.

3. Gene therapy will be subject to case/medical management.

4. Gene therapy treatment is covered under Medical Benefits and not under Prescription Drug Benefits. No cost for gene therapy are payable under the Prescription Drug Benefit.

5. Non-human, investigational or experimental gene therapies are not covered under the Plan.

6. If services are subsequently determined to be not medically necessary, there will be no benefit available.

7. Gene therapy will be covered if administered by an in-network provider.

SECTION 13: MINIMUM COVERAGE PLAN

Disclosure of Grandfathered Status

The Fund believes that the Minimum Coverage Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Minimum Coverage Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 800-273-5739. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Please refer to the Benefits at a Glance document attached at the end of the SPD for a detailed description of coverages, limitations, deductibles and copays available under the Minimum Coverage Plan.

SECTION 14: LIMITATIONS AND EXCLUSIONS FOR ENHANCED, STANDARD, AND MINIMUM COVERAGE PLANS

Note: The limitations and exclusions listed below are not all inclusive and are subject to your certificates, riders and plan modifications.

NO-FAULT AUTO INSURANCE, MOTORCYCLE INSURANCE AND INDEPENDENCE ADMINISTRATORS COVERAGE

Automobiles/Motor Vehicles

The Fund does not provide for any coverage for Motor Vehicle related accidents or incidents. The Plan totally and completely excludes coverage for any claim arising out of an auto or other vehicular related accident or incident. "Vehicle" includes all usual forms of transportation on public highways such as vans, pickup trucks, etc. To be certain that you have health care coverage if you have an automobile/vehicular accident or incident, you should check with your automobile insurance agent and/or insurance carrier to make sure that you are covered under your automobile policy "first and completely" for any claim arising out of an automobile/vehicular related accident or incident.

Motorcycles

The Plan is **secondary** to motorcycle insurance when services are provided to treat an injury or condition that is a result of a motorcycle accident (that is not a motor vehicle accident) when the member carries motorcycle insurance, regardless of whether a helmet was worn by the driver and/or passenger.

If motorcycle insurance has not been purchased, benefits will not be covered for an injury or condition of a member/passenger who rides without a helmet and is injured in a non-motor vehicle accident for the first $20,000 of expenses. In other words, the $20,000 amount will become your deductible for which you will be responsible.

If motorcycle insurance has not been purchased and a helmet is being worn when injured, benefits will be provided under the Plan's provisions.

Payment for services to any provider made prior to discovery by Independence Administrators or the Fund that the services arose as a result of the member's injury in a motorcycle accident that is not a motor vehicle accident for which insurance is carried or required to be carried will be recovered from the provider(s).

SECTION 15: PRESCRIPTION DRUG BENEFITS –ENHANCED AND STANDARD PLANS

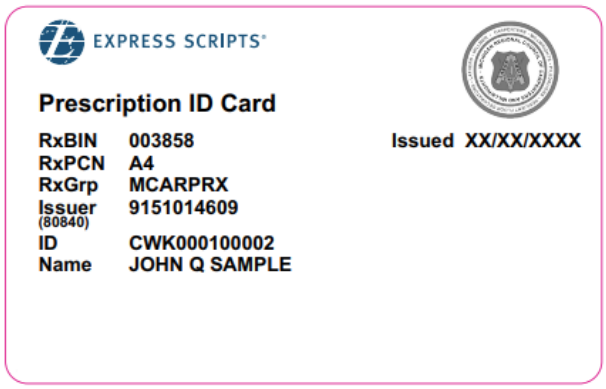
Prescription drug benefits under the Plan are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. You will receive coverage under the Plan through the self-funded arrangement with Express Scripts. Please refer to the Benefits at a Glance document attached at the end of the SPD for a detailed description of deductibles and copays.

You can have your prescriptions filled at a network or non-network pharmacy. The choice is always yours. Remember that when your prescriptions are filled through a non-network pharmacy, you have higher out-of-pocket costs.

You will receive prescription drug benefits as described in this summary only if you are eligible for coverage under the Enhanced and Standard Plans. Also, unless stated otherwise, your dependent(s) will receive the same coverage, services, etc. that you receive.

EXPRESS SCRIPTS®

Express Scripts® is an independent company providing pharmacy benefit services for Participants and Eligible Dependents enrolled in the prescription drug program. Your Express Scripts ID card identifies that you have a prescription drug program.



Ninety (90) Day Mail Order and Retail Prescription Drug Program
In addition to a thirty (30) day supply for a prescription, your plan allows for a ninety (90) day supply through either your Express-Scripts ninety (90) day retail pharmacy program or ninety (90) day mail order program for **non-specialty** drugs (see additional information on **specialty** drugs below.) Your physician **must** write your prescription for ninety (90) days.

Specialty Pharmaceutical Drugs

Select specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration and monitoring. Most "**In-network**" retail pharmacies can dispense specialty drugs. You should, however, check with your local pharmacy for availability and assistance.

Use Accredo to fill specialty medications that treat complex conditions like multiple sclerosis, hepatitis C and cancer. Through Accredo, you'll have 24/7 access to specialty-trained pharmacists and nurses who understand your condition. Call Accredo at 800-803-2523 to get started.

Express Scripts will **not** pay for more than a thirty (30) day supply of a covered prescription drug that is defined as a "**specialty pharmaceutical drug**" even if the drug is obtained from a ninety (90) day retail network pharmacy or mail-order provider. Express Scripts may make exceptions if a member requires more than a thirty (30) day supply.

Express Scripts also reserves the right to limit the quantity for certain select specialty drugs to no more than a fifteen (15) day supply for an initial fill. Any applicable copayment/coinsurance will be reduced by one-half (1/2) for a prescription that has been reduced to a fifteen (15) day supply. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable copayment/coinsurance requirement for a thirty (30) day supply.

Accredo Specialty is also available to assist for **mail order** prescriptions for **specialty pharmaceutical drugs**. If you have questions, or require assistance, call Walgreens Specialty Pharmacy customer service at **800-803-2523**.

Controlled Substance Prescription Drugs
Express Scripts may limit the first four fills of a select controlled substance prescription drug (such as hydromorphone, oxycodone, etc.) to a seven (7) day supply. You will be responsible for your applicable copayment/coinsurance or the cost of the prescription drug, whichever is lower, for the seven (7) day supply. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable copayment/coinsurance requirement for a thirty (30) day prescription.

Note: Express Scripts will not pay for prescription drugs obtained from an out-of-network mail order provider, including internet providers.

COVERED SERVICES AND COST SHARING REQUIREMENTS – ENHANCED AND STANDARD PLANS

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

- Any difference between the Maximum Allowable Cost and the BCBSM approved amount for a covered brand name drug that is your responsibility. If you request a

brand-name medication when a generic equivalent is available you will be responsible for your brand co-payment plus the difference in price between the brand-name medication and its generic equivalent.

- The twenty-five percent (25%) member liability for covered drugs obtained from an out-of-network pharmacy
- Costs for prescription drugs that are not a covered benefit.
- Certain Specialty Prescription Drugs if you do not follow the Specialty Prescription Drug Copay Assistance Benefit programs described below.

Specialty Prescription Drug Copay Assistance Benefit

Certain specialty prescription drugs on the formulary have been classified as non-essential health benefits (NEHBs) and the cost of such NEHB specialty prescription drugs will not be applied toward satisfying any applicable deductible and/or out-of-pocket maximum. This list will change from time to time.

If you are prescribed one of these NEHB specialty prescription drugs, you will be contacted by Save On SP, LLC (SaveOnSP) to participate in the plan's copay assistance benefit. Once you enroll in the available manufacturer copay assistance program, and you provide SaveOnSP with consent to monitor your pharmacy account, your out-of-pocket cost share will be reduced to $0. In the event you fail to enroll in the applicable manufacturer copay assistance program, and/or you do not provide consent to SaveOnSP to monitor your pharmacy account, you will be responsible for the full required coinsurance for the NEHB specialty prescription drug without such payment applying to any applicable deductible or the out-of-pocket maximum.

SECTION 16: BLUE VISION COVERAGE

Vision services are provided by Vision Service Plan (VSP). VSP is the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services members. To find a VSP Provider, call **1-800-877-7195** or log on to the VSP Website at www.vsp.com.

PLAN COVERED SERVICES (This is a Discount Only Program.)

Eye Exam	**VSP Network Provider**	**Non-VSP Provider**
Complete Eye Exam by an Ophthalmologist or Optometrist	20% discount off a thorough eye exam	No discount available
Lenses and Frames	**VSP Network Provider**	**Non-VSP Provider**
Standard Lenses and Standard Frames	20% discount off unlimited complete pairs of prescription glasses and non-prescription sunglasses **Note:** The discounts are valid through any VSP Provider within twelve (12) months of the last covered eye exam.	No discount available
Lens Options	20% discount off all lens options	No discount available

Contact Lenses	**VSP Network Provider**	**Non-VSP Provider**
Contact Lens Evaluation and Fitting	15% discount contact lens services, excluding materials	No discount available

Laser Vision Care Program	**VSP Network Provider**	**Non-VSP Provider**
Laser Surgery including PRK, LASIK, and Custom Lasik **Note: Custom Lasik coverage is only available using wave front technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Laser Vision Care Discounts are only available from VSP-contracted facilities.**	Discounts average 15% or 5% if the laser center is offering a promotional price	No discount available

SECTION 17: MAPD Benefits

The Medicare Plus Blue Group PPO is a Medicare Advantage Prescription Drug (MAPD) program. The MAPD program is a fully insured benefit administered by BCBSM and offered by the Fund. This MAPD Section is not a Medicare document. This MAPD Section is a summary of your medical and prescription drug benefits. A complete list of services can be found in your **Evidence of Coverage booklet and Benefits Summary Chart** which is sent to you by BCBSM. The Evidence of Coverage booklet and Benefit Summary Chart are incorporated by reference as part of this Plan. If you do not have a current Evidence of Coverage, please contact Medicare Advantage PPO Plan Member Services. For help or information, please call Member Services at 1-866-684-8216, from 8:30 a.m. to 5:00 p.m., Monday through Friday, Eastern time (Calls to this number are free). TTY users should call 711.

Enrollment in both Parts A and B of Medicare is mandatory to be enrolled in the MAPD Program.

Important Information: As long as you maintain enrollment in the Michigan Carpenters' Health Care Fund MAPD program, it is imperative that you do not enroll in another Medicare Advantage program. Enrollment in any other Medicare Advantage program will result in immediate termination of your Michigan Carpenters' Health Care Fund MAPD program.

A. Medical Benefits

MEDICARE PLUS BLUE GROUP PPO (MAPD) – Medical and Prescription Drug Benefits

This benefits chart for medical, prescription drug and hearing care benefits is a part of your Evidence of Coverage (EOC) that you receive directly from BCBSM. If there is a conflict in the language, the Evidence of Coverage booklet and Benefits Summary Chart controls.

This chart lists the services Medicare Plus Blue Group PPO (MAPD) covers and what you may be required to pay out-of-pocket. The prescription drug formulary (drug list) is BCBSM's **Comprehensive Enhanced Formulary.**

Type of maximum	In-network and Out-of-network
Annual deductible	$250
Coinsurance Amount	4% of the approved amount for select services. 50% for private duty nursing

Type of maximum	In-network and Out-of-network
Copayment Amount	$30 copayment for office visits, special services, psychiatric services and urgent care $90 Emergency Department/Room care
Part A and B combined benefit Out-of-Pocket maximum except as noted below. **Note:** Part A and B coinsurance and copayment amounts apply to the Annual Out-of-Pocket (OOP) Maximum with the following exceptions: -Private duty nursing cost sharing -For individuals who have elected hospice benefits, Medicare cost-sharing amounts resulting from Medicare's payment of services not related to the terminal condition	$5,000 per individual per calendar year

B. Prescription Drug Benefits

IMPORTANT PRESCRIPTION DRUG INFORMATION

Prescription drug coverage under this MAPD benefit plan satisfies the requirement for Part D prescription drug benefits under Medicare. It is imperative that you do not enroll in another Medicare Part D Prescription Drug Program. If you do enroll in any other Medicare Part D prescription drug plan, your MAPD coverage through this Fund will be immediately terminated.

BCBSM Network:
BCBSM has a network of Preferred and Standard pharmacies. You must generally use these pharmacies to fill your prescriptions for covered Part D drugs. Note that copayments are lower for prescription drugs if you use a Preferred pharmacy as outlined below. You can access BCBSM's pharmacy directory at www.bcbsm.com/pharmaciesmedicare. You can also call the number on the back of your BCBSM Drug ID card for assistance or to request a copy of BCBSM's Pharmacy Directory or Pharmacy Locator if you live outside of Michigan.

BCBSM Formulary:
You can see the complete plan formulary (drug list) for Part D prescription drugs and any applicable restrictions by accessing BCBSM's website at www.bcbsm.com/formularymedicare.

For detailed information about your prescription drug coverage, reference the **Evidence of Coverage (EOC)** booklet and the Benefits Summary Chart you received from BCBSM or sign into BCBSM's Member Secured Services at www.bcbsm.com.

Note: This prescription drug plan includes prior authorization, step therapy and quantity limit restrictions for certain drugs.

Benefits, copayments and/or coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Covered Services and Copayments	Up to a 90-Day Supply	Preferred Retail and Preferred Mail-order Pharmacies	Standard Retail and Standard Mail-order Pharmacies
Tier 1	Preferred Generic Drugs	$20	$25
Tier 2	Generic Drugs	$20	$25
Tier 3	Preferred Brand Name Drug	$45	$50
Tier 4	Non-preferred Drugs	$75	$80
Tier 5	Specialty Drugs	$90	$100

Note: If your covered drug costs less than the copayment amount listed above, you will pay the lower price for the drug. In other words, you pay either the full price of the drug or the copayment amount, whichever is less.

For assistance with claims, billing, or general questions, please contact MAPD Customer Service. Customer Service also has free language interpreter services available for non-English speakers.

Important BCBSM Contact Information:

- BCBSM Customer Service (866) 684-8216
- TTY 711 (Dial for assistance)
- FAX (866) 624-1090
- Address Blue Cross Blue Shield of Michigan
  Customer Service Inquiry Dept.
  Mail Code X521
  600 E. Lafayette Blvd.
  Detroit, MI 48226-2998
- Website www.bcbsm.com/medicare

SECTION 18: MEDICARE PLUS BLUE GROUP PPO (MAPD) ENROLLEES CLAIMS AND APPEAL PROCESS FOR MEDICAL AND PHARMACY BENEFITS

A. General Information

If your medical claim or prescription benefit is denied by BCBSM, you should first call the BCBSM appropriate number listed below. Most issues can be resolved through a phone call.

An appeal is a formal way of asking BCBSM to review and change a coverage decision BCBSM has made. If you decide to file an appeal, you should reference **"Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)"** of your Evidence of Coverage booklet for a detailed description of steps to take.

To contact Medicare Plus Blue Group PPO (MAPD) customer service for a **Medical Appeal**:

- BCBSM Customer Service (**866) 684-8216**
- TTY 711 (Dial for assistance)
- FAX (877) 348-2251
- Write Blue Cross Blue Shield of Michigan
  Grievances and Appeals Department
  P.O. Box 2627
  Detroit, MI 48231-2627
- Website www.bcbsm.com/medicare

To contact Medicare Plus Blue Group PPO (MAPD) customer service for a **Part D Prescription Drug Appea**l:

- BCBSM Customer Service **866-684-8216**
- TTY 711 (Dial for assistance)
- FAX (866) 601-4428
- Write Blue Cross Blue Shield of Michigan
  Pharmacy Help Desk
  P.O. Box 807
  Southfield, MI 48307
- Website www.bcbsm.com/complaintsmedicare

APPEAL PROCESS

You can appeal a coverage decision, that is when BCBSM decides what is covered for you and how much will be paid. In some instances, a service or drug is not covered or no longer covered by Medicare. There is a required two-level appeal process. If you need a quick response, you may request a "fast appeal".

SECTION 19: DENTAL BENEFITS – DELTA DENTAL

Dental benefits under the Plan are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. The Fund has engaged Delta Dental PPO (Point-of-Service) to administer your dental benefits.

Through Delta Dental PPO (Point-of-Service) you have access to two of the nation's largest networks of participating providers: Delta Dental PPO and Delta Dental Premier network. Delta Dental PPO and Delta Dental Premier dentists will submit claims for you, charge you only for your copayment, if any, request no balance billing above the contracted fee. Non-participating providers may require you to submit your own claims, charge you the full cost of a procedure, and may ask for full, up-front payment.

You are not required to go to a Delta Dental participating provider to receive benefits under the Plan, and the Fund's arrangement with this dental PPO is not an endorsement or recommendation of any of the Delta Dental-participating providers by the Fund. The Fund Office can provide you with a directory to find a participating provider near you, or you can contact Delta Dental to find out if your dentist is a Delta Dental participating provider. For a complete list of services covered by Delta Dental, copayments, annual maximums and exclusions, see the Delta Dental PPO Benefits at a Glance at the end of this SPD.

DENTAL BENEFIT PLAN OUTLINE

Your plan is a Delta Dental PPO plan. The percentages below will be applied to the lesser of the dentist's submitted fee and Delta Dental's allowance for each service. Delta Dental's allowance may vary by the dentist's network participation.

Control Plan
Delta Dental of Michigan

Benefit Year
January 1 through December 31

Group Number
5370/0001/0002/0003/1001

COVERED SERVICES	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Brush Biopsy – to detect oral cancer	100%	100%	100%
Diagnostic and Preventive Services – includes exams, cleanings, fluoride and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crowns	70%	70%	70%
Endodontic Services – root canals	70%	70%	70%
Periodontic Services – to treat gum disease	70%	70%	70%
Oral Surgery Services – extractions and dental surgery	70%	70%	70%
Basic Services – miscellaneous services	70%	70%	70%
Relines and Repairs – to bridges and dentures	70%	70%	70%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services – includes bridges and dentures	50%	50%	50%

*****When services are received from a **non-participating** dentist, the percentage in the column indicates the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for the difference.

ANNUAL SERVICE MAXIMUMS AND GUIDELINES

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Bitewing X-rays are payable twice per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Space maintainers are payable once per area per lifetime for individuals up to age 19.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first permanent molars up to age nine and second permanent molars up to age 19. The surface must be free from decay and restorations.
- Composite resin (white) restorations are covered services on posterior teeth.

- Veneers are payable on incisors, cuspids and bicuspids once per tooth per five-year period when necessary due to fracture or decay.
- Porcelain and resin facings on crowns are covered services on posterior teeth.
- Root canal treatment is payable once per tooth per twelve-month period.
- Tissue conditioning is payable once in any three-year period.
- Occlusal guards are covered services once per twelve-month period. Five limited occlusal adjustments are covered services in any five-year period.
- Tissue conditioning for partials and dentures are payable once per thirty-six months.
- Fillings – permanent (adult) teeth are eligible for replacement once per twenty-four months.
- Fillings – primary (baby) teeth are eligible for replacement once per twelve-months.
- Orthodontics (braces) and related services are not covered services.
- Implants and related services are not covered.

Maximum Annual Benefit Limit
$1,000 per person per Benefit year (January – December) for services under Class I, II and III.

Deductible
$50 deductible per person total per benefit year, limited to a maximum deductible of $100 per family per benefit year. The deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, x-rays and sealants.

Waiting Period
As defined by the Plan's eligibility requirements.

Eligibility
As determined by eligibility guidelines per the Plan benefits. Group designations as noted above are: Active – 0001; Pre-65 Retiree – 0002; Post-65 Retiree – 0003; COBRA – 1001.

Dependent Children Eligibility
Eligible dependent children are covered through the end of the month they turn age twenty-six (26).

Coordination of Benefits (COB)
If you and your Spouse are both eligible under this Plan, you may be enrolled as both a Subscriber on your own application card and as a Dependent on your Spouse's application card. Your dependent children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage. See Coordination of Benefits for additional rules.

Termination of Benefits
Benefits will cease on the last day of the month in which eligibility no longer meets Plan requirements.

SECTION 20: BURIAL BENEFITS & ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

BURIAL BENEFITS

Active Employee Burial Benefits
Burial benefits are payable to the Beneficiary upon the death of an eligible Active Employee or the Spouse of an Active Employee according to the following schedule:

- Active Employee.....$4,000
- Spouse.....$1,000

Retiree Burial Benefits
Burial benefits are payable to the Beneficiary upon the death of a Retired Employee or the Spouse of a Retired Employee according to the following schedule:

- Retired Employee $1,000
- Spouse $1,000

The Retired Employee must have met the following requirements at the time of death for burial benefits to be payable:

- The Retiree must have been eligible under the Active Program in five (5) of the ten (10) years immediately preceding the date of retirement
- The Retiree must have been receiving monthly benefits from one of the following:
  - The Michigan Carpenters' Pension Fund
  - The Carpenters' Pension Trust Fund – Detroit & Vicinity
  - The Social Security Administration (SSA)
- The Retiree must have remained a member in good standing with the local union. (Note: The local union checks the Retiree's status upon retirement and once each year thereafter to assure eligibility.)
- If retirement was **effective on or after September 1, 1986**, the Retiree must have been eligible by self-payments under one of the following:
  - the Early Retiree Self-Payment Program,
  - the Totally and Permanently Disabled Participant Self-Payment Program
  - the Supplement to Medicare Program

  on the date of death for burial benefits to be payable.
- If retirement was **prior to September 1, 1986** and the Retiree was receiving a monthly benefit from the Michigan Carpenters' Pension Fund, a $1,000 burial benefit may be applicable. You should contact the Fund Office for assistance.

For the Retiree to be eligible for the burial benefit for a Spouse, the following must have been met:

- Self-payments must have been made covering the Spouse at the time of the Spouse's death under one of the following:
  - The Retiree Self-Payment Program
  - The Totally and Permanently Disabled Participant Self-Payment Program
  - The Supplement to Medicare Program

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Active Employees Only
The Plan will pay benefits for losses if an Active Employee satisfies the following:

- Experiences a bodily injury caused solely through external, violent or accidental means, on or off the job
- Is eligible by either employer contributions or active self-contributions
- Shall directly and independently of all other causes result in any of the following losses, within 90 days after the accident, described in the following Schedule.

The following Accidental Death and Dismemberment benefit shall be paid within 90 days after the incident or accident.

Further, this benefit is paid in addition to any other benefits that may be payable by the Plan and is not subject to coordination of benefits rules.

Loss of:

.....Life	$5,000
.....Both hands or both feet	$5,000
.....One hand and one foot	$5,000
One hand or one foot &	
..... Entire sight of one eye	$5,000
.....One hand or one foot	$2,500
..... Entire sight of one eye	$2,500
..... Entire sight of both eyes	$5,000

With reference to hand or foot, "loss" means complete severance through or above the wrist or ankle joint and with reference to eye, means the irrecoverable loss of the entire sight of the eye. Benefits will not be paid for more than one (1) of the losses (the greatest) sustained by the Covered Employee as the result of any one (1) accident.

Required Information
In order to assure that correct information is available at the Fund Office for appropriate payment of benefits, the following applies:

- A Participant Data Card must be completed. The data card is used to designate a beneficiary.
- Benefits in case of death will be paid to the Beneficiary designated on the latest Participant Data Card on file in the Fund Office on the date of death, all other benefits

will be paid to the Active Employee. If a Beneficiary has not been designated, the following will apply:

- In the event the Active Employee has not filed a Participant Data Card, benefits will be paid to the surviving legal Spouse
- If the deceased Active Employee is not survived by a Spouse, benefits will be paid, equally, to surviving children
- If deceased Active Employee is not survived by either a Spouse or children, benefits will be paid to surviving parents
- If the deceased Active Employee is not survived by a Spouse, children or parents, benefits will be paid to the estate of the deceased or any individual determined by the Board of Trustees to be equitably entitled to receive the Burial Benefits.

Special Provisions

- A written claim for benefits must be made within one (1) year from the date of death
- Benefits may be assigned, by the designated beneficiary, directly to the funeral home
- Assignment of benefits by any individual(s) other than the designated beneficiary will not be honored
- Burial benefits and/or Accidental Death and Dismemberment benefits are not payable if the death or injury is a result of a felonious activity, aggravated assault or suicide

Beneficiary

As used herein, "Beneficiary" means the person or person(s) designated to receive any benefits upon the death of an Eligible Employee, Retiree or the legal Spouse of such Eligible Employee or Retiree. The designation of a Beneficiary shall be initially made by the Employee when he completes a Participant Data Card with the Fund Office.

Any Employee may thereafter designate a Beneficiary or change his designated Beneficiary at any time, without consent or knowledge of the Beneficiary, by filing with the Fund Office a new, completed Participant Data Card. A change of Beneficiary will be effective upon receipt in the Fund Office, prior to the Employee's or Retirees' death of the newly completed Participant Data Card.

Employees who are no longer married should be certain to change their Participant Data Card. Otherwise, a benefit could be paid to an unintended person such as a former Spouse.

SECTION 21: CLAIMS APPLICATIONS, LIMITS AND APPEALS

Applying for Benefits and Time Limit for Claims

Eligibility Determinations

Your eligibility for benefits is determined by the Fund Office based on receipt of hours/contributions, self-payments and all other relevant factors required to become eligible. Your dependent eligibility is determined by the Fund Office based on information provided on forms available from the Fund's administrative office and supporting documentation.

Claims for Medical, Hospital, Surgical, Prescription Drug Benefits, Dental Benefits and Vision Benefits, Burial Benefits, and Accidental Death and Dismemberment Benefits

Independence Administrators is responsible for the processing and determination of all claims for Medical, Hospital and Surgical Benefits.

Express Scripts is responsible for the processing and determination of all Prescription Drug Benefits.

Delta Dental is responsible for the processing and determination of all Dental Benefits covered by group coverage agreements and other contracts issued by it.

VSP is responsible for the processing and determination of all Vision Benefits covered by group coverage agreements and other contracts issued by it.

The Fund Office is responsible for the processing and determination of all Burial Benefits and Accidental Death and Dismemberment Benefits.

Claim forms for Burial Benefits and Accidental Death and Dismemberment Benefits are available at the Fund Office. All such forms and supporting documentation must be submitted within one (1) year from the date of the individual's death or injury.

If processing of a claim cannot be completed because of missing information, the Fund Office will notify you and advise of the specific reason why the processing of the claim cannot be completed and what information is necessary to permit the processing of the claim to continue. It is your responsibility to gather this information and submit it within the required time period. If a claim for benefits under this Plan is completely or partially denied by the Fund Office for any reason, you will be notified with the specific reason for denial within the time periods required by applicable regulations. In unusual circumstances, additional time will be required to process the claim, in which case you will be notified when additional time is needed.

If you disagree with a determination made by the Fund Office, you must appeal directly to the Board of Trustees and comply with the Board's claims appeal process.

Claim forms for benefits that **are** processed and/or covered by the Fund's policies of insurance, group enrollments, coverage agreements, administrative services agreements or other

documentation with or from its service provider(s) other than the Fund Office are available from those organizations and all such forms and supporting documentation must be submitted to those organizations and in conformity with the requirements of those organizations, including all time limits and proofs. The Fund has no liability for any claim determination made by its service providers.

Claim forms for medical, hospital, surgical and prescription drug benefits are available from Independence Administrators, and all such forms and supporting documentation must be submitted **within 12 months from the date the service was provided.** If you disagree with a determination made by Independence Administrators, you must appeal directly to Independence Administrators and comply with Independence Administrators' claims appeal process.

Claim forms for dental benefits are available from Delta Dental, and all such forms and supporting documentation must be submitted **within 24 months from the date the service was provided.** If you disagree with a determination made by Delta Dental, you must appeal directly to Delta Dental and comply with Delta Dental's claims appeal process.

Claim forms for vision benefits are available from VSP, and all such forms and supporting documentation must be submitted **within 12 months from the date the service was provided.** If you disagrees with a determination made by VSP, you must appeal directly to VSP and comply with VSP's claims appeal process.

Any claim form or other material submitted by or on behalf of any claimant that contains a material alteration or forged or false information, including signatures, will be rejected. The Board of Trustees reserves the right to forward such matters to appropriate law enforcement agencies for whatever action deemed appropriate. This will not limit the right of the Fund to recover any loses it suffers as a result of such material in any manner, including civil litigation.

Any action in law or equity brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to this Plan shall be barred unless the complaint is filed ***within three years*** after the right of action therefor accrues, unless a shorter period is established by applicable statute, regulation or case law.

Denial of Claims

If your claim is denied by the Fund Office or another Fund service provider, you will be informed of the reason for the denial on the "Explanation of Benefits" you receive. If the denial is due to missing information or a missing signature, you should supply the information directly to the service provider. If the denial is due to any other reason and you believe that the claim should have been covered, you should follow the procedure set out below for appealing a denial of your benefit claim.

Appealing a Denial of Your Benefit Claim

Every effort is made to process your claims promptly and correctly. If your claim for benefits is denied in whole or in part, the Fund Office or another Fund service provider will notify you of the denial in writing. To appeal the denial or payment, you must follow these steps:

Appeals Regarding Eligibility Determinations, Burial Benefits and Accidental Death and Dismemberment Benefits

You may appeal a denial of a claim related to an eligibility determination or a claim for Burial Benefits and/or Accidental Death and Dismemberment Benefit by writing out the reasons for your disagreement and the facts on which you rely for your claim to benefits and mailing your appeal within 180 days of the notice of denial to the Board of Trustees, Michigan Carpenters' Health Care Fund, 6525 Centurion Drive, Lansing, MI 48917 . No special form is required. Just be sure that what you have written explains your position as clearly as you can state it. You have the right to appoint someone else (such as a lawyer) to prepare and submit your appeal to the Fund. Make sure your name, the last four digits of your social security number, trade and name of the claimant (such as your spouse) are included to avoid delays in processing your appeal.

The claimant or the claimant's authorized representative on the claimant's behalf, will have the opportunity to review pertinent documents and other information relevant to the claim free of charge if you submit a written request. Reasonable access to, and copies of, relevant information will be provided upon request. Whether information or a document is "relevant" is determined in accordance with ERISA Regulation §2560.503-1(m)(8), 29 CFR 2560.503-1(m)(8).

When a claimant's appeal is received, it will be reviewed "de novo" (meaning "anew" and without deferring to the initial denial of your claim) and additional materials and information you submit with the appeal, if any, will also be reviewed.

The claimant, or the claimant's representative, may submit issues, comments, additional legal arguments and new information in writing consideration in the appeal. The review of the appeal will take into account all materials and information received from before the review and decision on your appeal, whether or not that information was previously submitted or considered in the initial determination on the claim.

The Board of Trustees will respond to appeals of denials of claims regarding eligibility in the following timeframes: no later than 72 hours after receiving an appeal of a denial of a pre-service urgent care claim, no later than 30 days after receiving an appeal of a pre-service non-urgent care claim, and no later than five days after the Board of Trustees' first regularly scheduled meeting following receipt of your appeal of a post-service care claim, unless your appeal is filed less than 30 days prior to such meeting, in which case it will be reviewed at the subsequent Board of Trustees' meeting.

If, due to special circumstances, the Board of Trustees requires additional time to review an appeal of a claim for post-service care, the claimant will be notified in writing of the special circumstances

and when a determination will be made. The Board of Trustees will communicate its decision and the reasons for the decision in writing within five days after it makes its decision on your appeal.

The claimant may request a personal appearance before the Board of Trustees, which the Board of Trustees has the discretion to permit or deny, based on whether it concludes that a personal appearance would help the Board to reach its conclusion. Such a request must be made in writing. The claimant may designate someone of his choice to represent him or her at such an appearance at his/her own expense.

You will be notified, in writing, of the Board of Trustees' decision with respect to your appeal, including (if your appeal is denied) the reasons and specific references to Plan documents upon which the Board of Trustees' decision was based.

The Board of Trustees has the sole and exclusive authority and discretion to interpret and to apply the rules of the Plan, the Trust and other rules and regulations of the Fund. Under the law, this authority means that the Board of Trustees' decision shall be upheld unless the Court finds that it was arbitrary and capricious. Please note that under the Plan, no action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of these under or relating to the Plan is barred unless the complaint is filed within *three years* after the right of action accrues, unless a shorter time period is established by applicable statute, regulation or case law. You should seek legal advice with respect to these requirements.

Appeals Regarding Claims for Medical, Surgical, Hospital, Prescription Drug, Dental or Vision Expense Benefits

If a Fund's service provider(s) other than the Fund Office denies a claim for Medical, Surgical, Hospital, Prescription Drug, Dental and/or Vision Expense Benefits, in whole or in part for reasons other than ineligibility of the claimant, the claimant may appeal the denial in the manner set forth in the Fund's policies of insurance, group enrollments, coverage agreements, administrative services agreements or other documentation with or from its service provider(s), which are incorporated by reference as if printed verbatim herein.

Most questions or concerns about decisions a service provider makes on claims or requests for benefits can be resolved through a phone call to their Customer Service Representatives. You can locate the phone number on your Explanation of Benefits statement, in the letter you receive notifying you that your claim has not been approved.

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 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 Fund. You should request review of adverse benefit determinations by a service provider on a pre-service claim, an urgent care claim, or a post-service

claim directly to that service provider, except denials based on your eligibility to participate in the Fund, in which case you should direct your request for review to the Fund Office.

"Pre-service claim" means a claim for a benefit where your plan conditions receipt of the benefit, in completely 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, the service provider will treat it as such. Absent a determination by your physician, the service provider 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 of the service provider that will be included in the letter denying you claim. A summary of the claims procedures is also included at the end of this SPD. 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. Normally, for all three types of claims, you must exhaust the service providers' internal

review procedure before you can initiate a civil action under section 502(a) of ERISA to obtain benefits.

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 and submitted to:

(1) Medical, Hospital, Surgical Benefit claims – Independence Administrators at:
Independence Administrators
Appeals Department
PO Box 21974
Eagan, MN 55121
Phone: 1-888-234-2393
Fax: 215-761-0956

(2) Prescription Drug Benefit claims – Express Scripts at:
CLINICAL APPEALS DEPARTMENT EXPRESS SCRIPTS
PO BOX 66588 ST. LOUIS, MO 63166-6588
Telephone: 800-753-285
Fax: 877-852-4070

(3) Dental Benefit claims – Delta Dental of Michigan

Reconsideration: If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your dentist may contact Delta Dental's Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly.

You may do this by calling the toll-free number, 800-524-0149. You may also mail your inquiry to the Customer Service Department, P.O. Box 9089, Farmington Hills, Michigan 48333-9089.

Form Claims Appeal Procedure: If you receive notice of Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received the Adverse Benefit Determination. To request a formal review of your Claim, send your request in writing to: Dental Director, Delta Dental, P.O. Box 30416, Lansing, Michigan 48909-7916.

Please include your name, address, the Enrollee's Member ID, the reason you believe your Claim was wrongly denied, and any other information you believe supports your Claim.

(4) Vision Benefit claims – Vision Services Plan at 800-877-7195 or vsp.com

If a claim for Medical, Surgical, Hospital, Prescription Drug, Dental or Vision Expense Benefits is denied based on the claimant's ineligibility for benefits under the Plan at the relevant

time, the claimant may appeal the ineligibility determination to the Board of Trustees, which appeal will be determined in accordance with all applicable and effective laws and regulations.

CIRCUMSTANCES THAT CAN RESULT IN DENIAL OF OR LOSS OF BENEFITS

The Board of Trustees or its representatives have the authority to deny payment for claims, and the reasons for denial may include one or more of the following:

- The person receiving the benefit was not eligible for any benefits, or for the particular benefit, on the day the expense was incurred. This includes a former spouse or any person no longer eligible as a dependent when an expense was incurred.

- The claim was not received by the Fund within the applicable claims period from the date the expense was incurred.

- The expense was for services not medically necessary, not covered by the Fund or the expense was not actually incurred.

- The person for whom the claim was filed already received the maximum benefit for the type of benefit; for example, a lifetime maximum, a calendar year maximum, etc.

- The person for whom the claim was filed had not yet satisfied any required deductible imposed by the Fund.

- The person for whom the claim was filed (or another person on their behalf) failed to sign the Fund's subrogation agreement, failed to cooperate with the Fund's right of reimbursement or failed to remit the Fund's reimbursable amount from a recovery, including a partial recovery (in which case, future claims will be denied up to the amount of the Fund's reimbursable amount).

- Another entity was primarily responsible for paying benefits (see the Fund's rules on coordination of benefits).

- The benefit or the Fund was terminated.

The above list does not list every reason a claim may be denied. It is only representative of the types of circumstances that might lead to a denial of a claim. If you have questions about a claim denial, contact the Fund Office.

EXCLUSIONS AND GENERAL LIMITATIONS

In addition to the exclusions and limitations listed above and except as may be provided for under the terms of the Fund's Plan, the Plan shall not provide benefits for the following:

The Fund will NOT provide care and services not covered as medically necessary or appropriate under the Independence Administrators' Medical Policy.

The Fund will NOT provide for treatment of injuries sustained in a motor vehicle accident or other motor vehicle licensed to be on the road or complications resulting from such injuries or accident, as stated above.

The Fund will NOT provide for loss or expense from sickness, or disease that entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law, or as a result of any accidental bodily injury, which arises out of or in the course of employment for pay or profit.

The Fund will NOT provide for care and services available at no cost in veteran's, marine or other hospital, facility, or institution owned or operated by or on behalf of any national government, its agencies or a political subdivision thereof, unless a charge is imposed and an itemized bill for services is submitted, or for care obtainable without cost from governmental agencies.

The Fund will NOT provide for treatment of a condition caused by military action or war or determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

The Fund will NOT provide for care and services payable by government-sponsored health care programs such as Medicare or TRICARE, except as provided under the Plan's contract with BCBSM Medicare Advantage Group PPO Plan.

The Fund will NOT provide for payment to the extent that such payment is prohibited by any law of the jurisdiction where the covered person resides at the time the expenses are incurred.

The Fund will NOT provide for services that the covered person is not legally required to pay, that would not be charged if no coverage existed, for which a charge is not customarily made, for services available without cost, or for any nonresident tax levied by a community hospital.

The Fund will NOT provide for any procedure, care or treatment for which the medical necessity cannot be proven to the satisfaction of the Plan, except allergy treatments and reconstruction after mastectomy.

The Fund will NOT provide for services outside the scope of the license of the institution or practitioner rendering the services.

The Fund will NOT provide for custodial care, rest therapy, education, training, or bed and board while confined to an institution that is primarily a school or other institution for training, a place of rest, or a place for the aged.

The Fund will NOT provide for services for treatment of an illness or injury due to declared or undeclared war or any act thereof, active participation in a riot, the commission of or attempted commission of an assault or felony, or engagement in any unlawful act.

The Fund will NOT provide for services and supplies that are not medically necessary according to accepted standards of medical practice, including cosmetic surgery solely for improving appearance, except that coverage will be provided for 1) reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast for symmetrical appearance and prostheses and physical complications in all stages of mastectomy; 2) to correct a condition resulting from a congenital anomaly; or 3) to correct a condition resulting from an accident (excluding auto/vehicular accidents).

The Fund will NOT provide for drugs, devices, medical treatments or procedures that are experimental or investigative, including organ transplants, except as required by section 2709 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act. The terms "experimental" or "investigative" mean medical practices, procedures, treatment, services, drugs, or supplies that are considered experimental or investigational by, or not approved by, the Food and Drug Administration or the Department of Health and Human Services.

The Fund will NOT provide for expense incurred for in-vitro fertilization or artificial insemination.

The Fund will NOT provide for reversing sterilization.

The Fund will NOT provide for pre-employment, pre-marital, school or sports examination provided by non-network providers.

The Fund will NOT provide for routine treatment or services primarily for weight loss or control, unless necessitated as the direct result of a specifically identifiable and diagnosed condition or disease etiology, except bariatric surgery, which is covered as set forth in the attached Exhibits.

The Fund will NOT provide for acupuncture, hypnotism or any goal-oriented behavior modification type therapy.

The Fund will NOT provide for air conditioners, purifiers, humidifiers, dehumidifiers, whirlpool, heating pads, hot water bottles, waterbeds, bandages and support garments, rubber gloves, treadmills, exercise equipment, lift chairs, and other equipment that does not constitute medically necessary durable medical equipment, even if prescribed by a physician.

The Fund will NOT provide for expenses incurred or resulting from self-inflicted injuries, unless the injuries resulted from a medical condition such as depression.

The Fund will NOT provide for travel or transportation by other than professional ground ambulance.

The Fund will NOT provide for services in connection with speech therapy, unless the speech therapy follows Hospital confinement for an accident (except for accidents that are work or auto/

vehicular related), or stroke, cancer or heart-related problem, or is the result of diagnoses of Childhood Apraxia of Speech (CAS) or Autism Spectrum Disorder (ASD).

The Fund will NOT provide for care or treatment rendered by a member of the covered person's family or by a person normally residing in the covered person's home.

The Fund will NOT provide for hospital admissions, medical services and supplies provided prior to the effective date of coverage or after the coverage termination date.

The Fund will NOT provide for treatment of temporal mandibular jaw disorders ("TMJ"), however, diagnosis of TMJ may be covered through the Dental Benefit.

The Fund will NOT provide for the use of a private room. If used, the average semi-private room rate of that hospital will be paid, except private room accommodations required by the hospital for treatment in quarantine purposes and not for the comfort of the patient.

The Fund will NOT provide for charges for hospital rooms in excess of the hospital's regular charges.

The Fund will NOT provide for services and/or supplies for personal comfort items such as, television, telephones, lotion, powder, transportation within hospital, guest trays or other non-essential personal items and services, including take-home prescription drugs and supplies, etc.

The Fund will NOT provide for services and/or supplies for recreational or educational therapy, massage therapy, or some forms of non-medical self-care or self-help training.

The Fund will NOT provide for nutritional and dietary supplements.

The Fund will NOT provide for psychiatric services after determination that a condition will not respond to treatment.

The Fund will NOT provide for psychological tests for guidance or counseling for vocational purposes.

The Fund will NOT provide for drugs that require a prescription by state law, but not Federal law.

The Fund will NOT provide for administration of drugs or any drug consumed at the time and place of the prescription order.

The Fund will NOT provide for refills not authorized by a physician.

The Fund will NOT provide for more than a one-month supply of prescription drugs (except for specified maintenance drugs that are covered for 90 days).

The Fund will NOT provide for refills dispensed after one year from the date of the original order.

The Fund will NOT provide for drugs dispensed for cosmetic purposes.

The Fund will NOT provide for non-prescription (over-the-counter) drugs.

Note: The above list is not a complete list of items not covered by the Plan. An item that does not appear as an exclusion is not automatically covered as a benefit.

SECTION 22: MISCELLANEOUS PLAN PROVISIONS

THE TRUSTEES INTERPRET THE PLAN

Under the Fund's Trust Agreement, and the Plan's terms, the Board of Trustees have the sole authority to interpret the Trust Agreement and the Plan, and to make final determinations regarding any benefit application and to interpret the Plan and any administrative rules adopted by the Trustees (except to the extent this authority has been delegated to the Fund Office and other providers). The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan.

If a decision of the Trustees is challenged in court, it is the intention of the parties to the Trust, and the Plan documents so provide, that such decision is to be upheld unless the Court determines the decision is arbitrary or capricious. Any interpretation of the Plan's provisions rests solely with the Board of Trustees.

Benefits under this Plan will be paid only if the Trustees decide, in their discretion, that the applicant is entitled to them. As stated earlier in this SPD, **no Employer or Union**, nor any representative of any Employer or Union, is authorized to interpret this Plan on behalf of the Board nor can an Employer or Union act as an agent of the Board of Trustees.

The Board of Trustees has authorized the Administrative Manager and the Fund Office staff to handle routine requests from participants regarding eligibility rules, benefits, and claims procedures. But, if there are any questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for a final determination.

PLAN AMENDMENTS

The Fund Trustees have the legal right to change the Plan, subject to any applicable collective bargaining agreement.

The Fund Trustees hope to maintain the Plan's present level of benefits and to improve upon them, if possible. But, the Fund Trustees must protect the Plan's financial soundness at all times. This duty requires changes from time to time.

Changes in the Plan may also be required to preserve the Fund's tax-exempt status under IRS rules and regulations. These IRS rules and regulations may change. So, the Fund Trustees may have to change Plan provisions to retain the Trust's tax-exempt status and to comply with changes in the law.

Finally, the Fund Trustees have the authority to amend the Plan's terms, change or eliminate benefits (with or without notice).

PLAN TERMINATION

Although the Fund Trustees do not foresee that the Plan will be terminated, the Trust Agreement provides that termination may occur when:

- The Trustees determine that the Trust Fund assets are not adequate to carry out the purpose for which the Fund is intended;
- There is no longer a collective bargaining agreement or other written agreement in effect that requires Employer contributions to be made to the Fund and negotiations for extension thereof have ceased.

The Trustees are obligated to use the Trust Assets for payment of expenses incurred up to the date of termination and expenses related to the termination as their first priority. Full benefits may not be paid if the Fund's liabilities are more than its assets, and benefit payments will be limited to the funds available. The Board of Trustees will not be liable for the adequacy or inadequacy of such funds. If there are any assets remaining after payment of Fund liabilities, those assets will be used for purposes determined by the Board of Trustees according to the Trust Agreement .

Upon written request, you may examine the agreement at the Fund Office or other specified location or you may request a copy of the agreement, which will be provided for a reasonable charge.

LIMITATION ON ASSIGNMENT

Your rights and benefits under the Plan cannot be assigned, sold, or transferred to anyone else except under limited circumstances (*e.g.*, Qualified Medical Child Support Order or assignment to your health provider).

TAX EXEMPT STATUS

The IRS has classified the Fund as an IRC Section 501(c)(9) VEBA Trust. This means that the Employers' contributions to the Trust are tax deductible.

Also, in most cases, the benefits paid on your behalf are not taxable as personal income. Similarly, the investment earnings on Plan assets are not taxed because they are specifically set aside for the purpose of providing benefits to participants.

Obviously, such tax exemption has advantages that work to the benefit of both Employers and Employees. It means that money which otherwise might be payable as taxes can be used to purchase health-care benefits and to cover the Plan's administrative expenses.

The Fund Trustees understand these advantages and will take whatever steps are necessary to keep your Plan "qualified" as an IRS tax-exempt trust.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To determine the applicability of and to implement the terms of this Plan or the similar terms of any other plan, the Fund may, without consent or notice to any covered person, release to or obtain from any insurance company or other organization or individual, any information, with respect to any covered person, which the Fund deems to be necessary for such purposes. Any covered person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

FUTURE OF THE PLAN

The Fund Trustees reserve the right to change or end any of the Plan's benefits (or discontinue the Plan) at any time. The Fund Trustees' decision to change or end any of the Plan's benefits (or to discontinue the Plan) may be due to changes in the Federal or State laws governing benefits, the requirements of the Internal Revenue Code or ERISA, the provisions of a contract or a policy involving an insurance company, or for any other reason. The benefits provided by the Fund are limited to the assets of the Fund that are available to pay for such benefits. **No participant, dependent or retiree has any vested rights to any benefit provided by the Fund, now or at any time in the future**.

SECTION 23: YOUR ERISA RIGHTS

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT

As a Plan participant, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as at a worksite, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series), if any, and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event, and if your Plan, because of the size and nature of your employer, is subject to the COBRA regulations. 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the 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 or any other person, may fire you or otherwise

discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 24: NONDISCRIMINATION POLICY

The Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Fund provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Fund Office.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax or e-mail or obtain assistance from the Health Care department Manager at the following:

Michigan Carpenters' Health Care Fund,
Fund Office - Health Care Department Manager,
6525 Centurion Drive,
Lansing, Michigan 48917
Phone: 800-273-5739;
Fax: 517-321-7508
E-mail: HCDmanager@tici.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at www.ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

APPENDIX A - BOARD OF TRUSTEES

MICHIGAN CARPENTERS' HEALTH CARE FUND

EMPLOYER TRUSTEES

Damian Hill (**S)** (517) 371-1550 (517) 371-1131 Fax dhill@agcmichigan.org	AGC of Michigan 2323 North Larch	Lansing, MI 48906
William Hendrick III (989) 781-8116 (989) 781-9512 Fax trace@rchendrick.com	2885 S. Graham Road	Saginaw, MI 48609
John Kersaan (616) 669-5611 ext. 216 (616) 669-3466 F jwkersaan@grandriverconstruction.com	Grand River Construction Inc. 5025 40th Avenue	Hudsonville, MI 49426-9401
James Malenich (810) 733-1313 (810) 733-7883 Fax jmalenich@fesslerbowman.com	Fessler & Bowman, Inc. 4099 Eagle's Nest Ct.	Flushing, MI 48433-2492
Bob Spence (989) 752-0400 (989) 752-8769 Fax bobspence@spencebrothers.com	Spence Brothers 203 S. Washington Ave Suite 360	Saginaw, MI 48601
Nick Rowley nrowley@christmanconstructors.com	Christman Constructors 324 East South St.	Lansing, MI 48910

EMPLOYEE TRUSTEES

Thomas Lutz (C) (734) 637-3917 Tom.lutz@hammer9.com	11687 American Ave Suite 200	Detroit, MI 48204
Michael Barnwell Mike.barnwell@hammer9.com	11687 American Ave Suite 200	Detroit, MI 48204
Brian Kerrigan (906) 228-2913 (906) 789-1962 Fax Brian.kerrigan@hammer9.com	370 US Highway 41 East Suite B	Negaunee, MI 49866
Chad Miller (616) 837-1200 (877) 974-2538 Toll Free (616) 837-1500 Fax chad.miller@hammer9.com	Carpenters' Local No. 525 500 Reno Drive, PO Box 457 49348	Wayland, MI
Jason Reed (989) 753-1487 (989) 753-1791 Fax Jason.reed@hammer9.com	Carpenters Local 202 PO Box 467	Grayling, MI 49787
Vince Dawe (616) 837-1200 Vince.Dawe@hammer9.com	500 Reno Drive	Wayland, MI 49348