Service Employees' International Union

SEIU LOCAL 1

SEIU MICHIGAN HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

SEIU MICHIGAN HEALTH AND WELFARE FUND
SPD
for
PARTICIPATING MEMBERS AND DEPENDENTS
AS OF APRIL 1, 2020

SEIU MICHIGAN HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

As of April 1, 2020

Contents

SEIU MICHIGAN HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

IMPORTANT NOTICE

This summary plan description booklet describes the Plan in effect on April 1, 2020.
If you have questions about the Plan or your rights under the Plan, contact the Fund Office.

One word of caution:
NO ONE HAS THE AUTHORITY TO SPEAK FOR THE BOARD OF TRUSTEES IN EXPLAINING THE ELIGIBILITY RULES OR BENEFITS OF THE FUND, EXCEPT THE FULL BOARD OF TRUSTEES.

IN CASE OF CONFLICT, THE PLAN (WHICH INCORPORATES THE FUND'S INSURANCE AND OTHER CONTRACTS WITH ITS SERVICE PROVIDERS), NOT THIS SUMMARY, WILL GOVERN.

SEIU MICHIGAN HEALTH AND WELFARE FUND

IMPORTANT ADDRESSES AND PHONE NUMBERS

BOARD OF TRUSTEES

Union Trustees

Ken Munz
SEIU Local 1
2211 E. Jefferson, 3rd Fl.
Detroit, MI 48207

Max Gerboc
SEIU Local 1
2211 E. Jefferson, 3rd Fl.
Detroit, MI 48207

Employer Trustees

John Aska
GDI Integrated Facility Services
24300 Southfield Rd., Suite 220
Southfield, MI 48075

John Tamas
GDI Integrated Facility Services
24300 Southfield Rd., Suite 220
Southfield, MI 48075

THE BOARD OF TRUSTEES IS THE LEGAL PLAN ADMINISTRATOR

ADMINISTRATIVE MANAGER / FUND OFFICE
TIC International Corporation
30700 Telegraph Road, Suite 2400
Bingham Farms, Michigan 48025
(248) 645-6550

OFFICE HOURS:
Monday through Friday
8:15 a.m. to 4:30 p.m.

MEDICAL BENEFITS ADMINISTRATOR
Benefit Administrative Systems, LLC
17475 Jovanna Drive, Suite 1D
Homewood, Illinois 60430
(877) 685-0805
www.bashealth.com

MEDICAL BENEFITS NETWORK PROVIDER
Cigna OAP Network (PPO)
877-625-0205
www.myCigna.com

PRESCRIPTION DRUG BENEFITS ADMINISTRATOR
EHIM
26711 Northwestern Highway, Suite 400
Southfield, Michigan 48033
(800) 311-3446
www.ehimrx.com

DENTAL BENEFITS ADMINISTRATOR
A.D.N Administrators
P.O. Box 610
Southfield, Michigan 48037
(248) 901-3705
https://www.adndental.com

VISION BENEFITS PROVIDER
EyeMed Vision Care
EyeMed Vision Central
4000 Luxottica Place
Cincinnati, OH 45040
www.eyemed.com

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
LIFE INSURANCE BENEFITS
Mutual of Omaha Insurance Company / United of Omaha Life Insurance Company
Group Life Claims Mutual of Omaha Plaza
Omaha, Nebraska 68175-0001
Phone Toll Free (800) 775-8805
Fax number: (402) 997-1835

SHORT-TERM DISABILITY BENEFITS
Mutual of Omaha Insurance Company / United of Omaha Life Insurance Company
Group Insurance Claims Management
Mutual of Omaha Plaza
Omaha, Nebraska 68175-0001
Phone Toll Free (800) 877-5176
Fax number: (402) 997-1865
Email: newdisabilityclaim@mutualofomaha.com
http://www.mutualofomaha.com

AGENT DESIGNATED FOR SERVICE OF LEGAL PROCESS
Legal Counsel, Joseph Pawlick, Esq.
Watkins, Pawlick, Calati & Prifti, PC
1423 East Twelve Mile Road
Madison Heights, Michigan 48071

Legal process may also be served on any Trustee or the Plan Administrator.

INTRODUCTION

To All Participants and Dependents:

The Board of Trustees is pleased to provide you with this summary description of the **SEIU Michigan Health and Welfare Fund**, as in effect on April 1, 2020. If you have questions about the Plan or your rights thereunder, contact the Administrative Manager / Fund Office.

As you read through this booklet, keep in mind that it is an effort to summarize and simplify the principal provisions of the Fund's coverage and eligibility rules. The full terms and conditions governing coverage and eligibility are stated in the formal documents governing the terms of the Fund's coverage and eligibility rules, which include the Trust Agreement, Collective Bargaining Agreements, Participant Agreements, Certificates and Riders that form the basis of coverage with service providers and other contracts entered into by the Fund (together, "the Plan"). The benefits as outlined in this Summary are effective only if you are eligible for coverage and remain eligible according to the provisions of the Plan.

This Summary is not intended to cover every detail of the Plan or every situation that might occur. We have tried to make the Summary accurate and complete, but it is not a substitute for the Plan itself. It does not describe Plan changes that occurred after the book was printed. If there is any conflict or difference between the Summary in this booklet and the Plan, the Plan will govern.

Previous changes to the Plan were communicated to you in the form of announcements and notices. This booklet incorporates all of those changes. Accordingly, this booklet supersedes and replaces all prior summaries, booklets and changes that have been previously communicated to you.

We expect you to use your benefits when you or one of your dependents is ill or injured. It is important that you do not abuse the Plan. Money paid from the Plan, like any other expense, is an operating cost. In short, we trust you will treat the Plan's money as if it were your own.

The Board of Trustees reserves the right, at any time, to modify, amend or terminate any existing or future benefit or condition of eligibility or self-payment or any other term or condition of the Fund.

You should read this material carefully and keep it for reference. It will help you to understand how the Plan works, what rights and benefits it provides for you and your family, and how to obtain those benefits. We hope the benefits available through the Fund will serve your needs and those of your family.

Board of Trustees

Ken Munz	**John Aska**
Max Gerboc	**John Tamas**

April, 2020

GENERAL INFORMATION

THE FUND IS TAX EXEMPT

The Fund is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the employer's contributions to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefits paid on your behalf are not tax deductible and are not part of your personal income.

Obviously, such tax exemption works to the benefit of both employer and employee. In effect, it means that money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses.

TYPE OF ADMINISTRATION

The Board of Trustees of the SEIU Michigan Health and Welfare Fund is the Plan Administrator and Plan Sponsor and is responsible for overall Plan administration. There are two Trustees appointed by the Union and two Trustees appointed by the employers.

Although the Board of Trustees is the legal Plan Administrator, it has engaged the firm of TIC International Corporation ("TIC") as the Administrative Manager / Fund Office to operate the program on a day-to-day basis.

The Board of Trustees has also engaged a third-party administrator called Benefit Administrative Systems LLC ("BAS") to process self-funded claims for medical benefits through the Cigna OAP Network (PPO).

The Board of Trustees has also engaged EHIM to process self-funded claims for prescription drugs and A.D.N. Administrators to process self-funded dental claims.

Finally the Board of Trustees has purchased insurance through EyeMed to for vision benefits and Mutual of Omaha Insurance Company / United of Omaha Life Insurance Company for accidental death and dismemberment, short term disability, and life insurance benefits.

UNION

Service Employees International Union ("SEIU") Local No. 1

EMPLOYERS

You may contact the Fund Office at any time for information on which employers participate in the Fund and whether an employer is a participating employer.

NAMED FIDUCIARY

A Named Fiduciary is the person or persons who have the authority to control and manage the operation and administration of the Fund. The Named Fiduciary for the Fund is the Board of Trustees of the SEIU Michigan Health and Welfare Fund. With respect to processing certain

claims like medical, prescription drug, and dental benefits, the Board of Trustees has delegated responsibility to certain service providers. The service provider's fiduciary claims administrator responsibilities extend only to the full and fair review of claims and administrative appeals as set forth in ERISA §503 and applicable regulations. Any determination or interpretation made by the service providers pursuant to their claim determination authority is binding on the participant or beneficiary and the Fund unless it is demonstrated that the determination or interpretation was arbitrary and capricious.

PLAN NAME

The SEIU Michigan Health and Welfare Fund Plan and Trust Agreement.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Fund has been assigned an Employer Identification Number by the Internal Revenue Service. It is 38-6061083. The Plan Number is 501.

TYPE OF PLAN

The Plan is an employee welfare benefit plan providing hospitalization, medical, prescription drug, dental, vision, short-term disability, death, and accidental death and dismemberment benefits. The Plan is subject to the Employee Retirement Income Security Act of 1974, as amended, usually referred to as ERISA. As a participant in the SEIU Michigan Health and Welfare Fund, you are entitled to certain rights and protections under ERISA, as described in the ERISA RIGHTS section of this Summary.

PLAN MODIFICATION, AMENDMENT AND TERMINATION

The Board of Trustees may modify, amend or terminate the Plan at any time in its sole discretion. Amendments or modifications that affect participants will be communicated to participants in writing. Such amendments or modifications may have the effect of limiting, expanding or eliminating any benefit or changing the conditions, eligibility or co-payment required for any benefit. In the event of termination, any remaining assets of the Fund (after all obligations are met) will be distributed in a manner which, in the opinion of the Board of Trustees, best accomplishes the purposes of the Fund.

COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to collective bargaining agreements. A copy of such collective bargaining agreement(s) may be obtained upon written request to the Administrative Manager/ Fund Office, which may make a reasonable charge for copying. Copies are also available for examination by participants and beneficiaries at the Administrative Manager / Fund Office.

SOURCE OF PLAN CONTRIBUTIONS

The Plan is funded through the Trust Fund, which receives contributions made by employers and employees at rates specified in collective bargaining agreements between the Employers and the Union, and special participation agreements with the Fund. Contributions are held in trust by the

Board of Trustees pending the payment of benefits and reasonable administrative expenses. Employees, spouses and other dependents may make payments to the Fund under certain circumstances in order to continue eligibility. Any participant, surviving spouse, or beneficiary may receive, upon written request to the Fund Office, information about whether a particular employer is contributing to the Fund and, if so, the employer's address.

WELFARE TRUST ASSETS AND RESERVES

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to eligible participants and beneficiaries, and defraying reasonable administrative expenses.

The life insurance, accidental death and dismemberment, and short-term disability benefits are provided through insurance contracts with the Mutual of Omaha Insurance Company / United of Omaha Life Insurance Company (policy numbers 7000GM-C-EZ-2001 (life insurance benefits), GLUG-AKAW (accidental death and dismemberment benefits), and 7000GM-MU-EZ-2001 (short-term disability benefits)). The vision benefits are provided through insurance contracts with EyeMed (policy numberVC-97).

All other benefits, including medical, hospitalization, surgical, prescription drug and dental, are paid directly from the Trust and are considered "self-funded" (i.e., not covered through an insurance policy). Although Cigna provides access to its network of health care providers, it does not insure coverage. The Fund is responsible for the payment of these claims, changes in Plan benefits, and enrollment.

PLAN YEAR

The Fund operates on a July 1 to June 30 fiscal year. The fiscal year is used for Fund accounting and for filing annual reports required by the Internal Revenue Service and the U.S. Department of Labor. The "benefit year" or claim determination period for benefits is the calendar year, January 1 to December 31.

ELIGIBILITY AND BENEFITS

The Plan's eligibility rules with respect to participation and benefits are generally described in this Summary.

The Board of Trustees may change the eligibility rules and/or benefit provision of the Plan at any time. 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 right to any benefit provided by the Fund, now or any time in the future.

SUMMARY PLAN DESCRIPTION

The Summary Plan Description is this booklet.

IMPORTANT NOTICE – TIME LIMIT FOR FILING LAWSUITS

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. In addition, under the Plan, any such action must be brought in the United States District Court where the Plan is administered.

Your rights with respect to any insurance company are governed by the rules, regulations and laws governing the insurance company.

You should seek legal advice regarding these limitations.

If you have any questions about the Health Fund's Plan, you should contact the Administrative Manager / Fund Office or the Board of Trustees.

Your rights under federal law as a participant in this program are the same as they are in respect to other fringe benefit programs. You are urged to read the ERISA RIGHTS section of this booklet.

TRUSTEE AUTHORITY

The Board of Trustees has full authority to increase, reduce or eliminate benefits and to change the eligibility rules and other provisions of the Plan at any time. However, the Board of Trustees intends that the Plan terms, including those relating to coverage and benefits, are legally enforceable while they are in effect.

Notices of any changes or deletions of the information in this book will be provided to each participant within the time required by any applicable regulations, but some changes may take effect before you are notified of a change. Before incurring any non-emergency expense, you should contact the Administrative Manager / Fund Office to confirm your current entitlement to coverage.

This book is intended to give you an accurate summary of the benefits and provisions of the Fund's Plan. It does not describe Plan changes that occurred after the book was printed. The Plan and the Agreement and Declaration of Trust, which you can read at the Fund Office or other specified locations, contain a detailed description of the rules, regulations, benefits, and provisions of the Fund. If any discrepancy exists between this book and the Plan documents (including any insurance contracts entered into by the Fund), the provisions of the Plan documents will govern.

Only the full Board of Trustees, or its delegate, is authorized and has the discretion to interpret the Plan and the benefits described in this Summary (except that the companies that provide insured benefits have full authority with respect to their policies, certificates and riders). The interpretation of the Board of Trustees, or its delegate, with respect to matters within its authority is final and binding on all persons dealing with the Fund or claiming a benefit from the Fund. If

a decision of the Board of Trustees, or its delegate, is challenged in court, that decision will be upheld, under current law, unless it is determined by the court to have been arbitrary and capricious. No agent, representative, officer or other person from the Union or the Employers has the authority to speak for the Board of Trustees or to act contrary to the written terms of the governing Plan documents.

If you have questions about your eligibility or a claim, contact the Administrative Manager / Fund Office. Matters that are not clear, or which need interpretation, will be referred to the Board of Trustees.

DOING YOUR PART

As a participant with the Fund, you have certain responsibilities in order to protect your eligibility and receive your benefits.

Read this book. You and your spouse should take the time to read this benefit booklet, and all the other documents enclosed with it, and familiarize yourselves with the eligibility and benefit rules.

Keep the Fund Office informed about you. One of your most important responsibilities is to make certain that the Administrative Manager / Fund Office always has current and accurate information about you and your dependents. Failure to make certain that the Fund Office always has current and accurate information about you and your dependents can result in loss of COBRA rights, missed notices from the Fund Office, transfer of responsibility for medical expenses from the Fund to you, and your being legally liable for expenses the Fund paid which the Fund should not have paid.

You must complete an Enrollment Form immediately and return it to the Administrative Manager / Fund Office if you are a new participant.

To avoid delays and loss of coverage or rights for you or your dependents, the Fund Office must be notified of the following events as set out below as soon as possible:

> **Marriage** – To add a spouse to your coverage, your marriage must be reported to the Fund Office. If you report your marriage **within 30 days** of its occurrence, your spouse will be covered from the date of marriage – if your marriage is reported later, your new spouse's coverage may be delayed. A copy of the certificate of marriage must be filed with the Fund Office. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the date on which it receives the enrollment notice and all documentation.
>
> **Births** – To add a newborn as an eligible dependent, the child's birth must be reported to the Fund Office. If you report your child's birth **within 30 days** of its occurrence, your child will be covered from birth – if the birth is reported later, the Fund is not obligated to provide coverage effective any earlier than the date on which it receives the enrollment notice and all documentation. A copy of the birth certificate must be filed with the Fund Office. Upon review, further evidence of parentage may be required.

Adoptions, Stepchildren and Foster Children – To add a child as an eligible dependent, the event [adoption (for adopted children), marriage (for stepchildren) or placement (for foster children)] must be reported **within 30 days** of its occurrence, and one or more of the following must be filed with the Fund Office: 1) a copy of the legal adoption or Court Order placing the child in your home for adoption or foster care; 2) certificate of marriage to the child's parent, proof of the child's birth and proof that adoption proceedings have commenced. The child will be covered from the moment of adoption, placement, or marriage to the child's parent, if the event is reported **within 30 days** of its occurrence. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the date on which it receives the enrollment notice and all documentation.

Change of address or name – Any change of address, or name change, must be reported immediately, in writing, signed by you, to the Administrative Office / Fund Office. Please visit the website or call the Fund Office if your name or address has changed.

Deaths – Deaths must be reported immediately to the Fund Office. A copy of the death certificate is required in order for benefits to be payable to a beneficiary.

Divorce – Divorce must be reported immediately and a complete copy of the Judgment of Divorce, and any amendments to the Judgment, must be filed with the Fund Office. If the Fund pays benefits for a former spouse because you did not notify the Fund of you divorce, you are personally liable to the Fund for any benefits or premium payments issued on behalf of your former spouse.

Birthdays – You must inform the Fund Office immediately when your dependent child attains the age of 26.

Other coverage – Notice of other coverage must be reported to the Fund Office **within 30 days** of the date you or your dependent(s) obtain such coverage.

You should also tell the Administrative Office / Fund Office if:

- You are unable to work due to accident or illness;
- Your sickness or disability has terminated;
- Your employment with a contributing employer has terminated;
- You have applied for family or medical leave from your employer;
- A court has entered a qualified medical child support order directing that health care coverage be provided for your child(ren) through the Fund;
- You or your dependent(s) are eligible for or have received benefits under another health care plan, insurance contract, program or statute; or

- You or your dependent(s) enter the military or other uniformed services of the United States.

Follow the proper procedures for receiving benefits, filing claims and submitting appeals. Review the information on claims processing in this Summary. When in doubt, before incurring any non-emergency expense, ask the Fund Office about claims processing and benefits.

Carry your cards. You should have a Cigna/BAS Identification Card, an EHIM Identification Card, an A.D.N Identification Card, and an EyeMed Identification Card. Be certain to carry these cards, and show the applicable one when you receive medical care, get a prescription, or receive dental or vision care.

Keep copies of all bills and EOBs. It is important that you keep any bills and Explanations of Benefits ("EOBs") that you receive. These can be valuable in any claim or appeal you may make, and, possibly, as your only record of benefits and care you have received.

Keep notices you receive from the Fund. After the publication of this Summary, you will receive notices of any changes as they occur. You should keep those together with this Summary booklet so that you will have a complete record of the Fund's communications to you regarding your benefits.

Identify yourself. When you write to the Administrative Manager / Fund Office, please be sure to include your name, the last four digits of your Social Security number or the alternative identification number assigned to you by the Fund Office and your employer in your letter. If you call, please be sure to have your Social Security number or the alternative identification number handy. Please note that due to privacy concerns, the Fund Office will not release your protected health information to your spouse or dependents unless you have a signed authorization form on file with the Fund Office. This form is available on the website.

Notify the Fund Office when you or one of your dependents becomes eligible for Social Security benefits and/or Medicare coverage. You must sign up for Medicare Parts A, B and D, and send a copy of the Social Security Award letter and/or the Medicare Card to the Fund Office immediately.

Protect your and your dependents' COBRA rights. Your surviving, separated or divorced spouse, and/or your children who no longer qualify as eligible dependents **must** notify the Fund Office **within 60 days** of the date on which the event occurred that resulted in their loss of eligibility if they want to be permitted to continue their coverage under the Fund through self-payments under COBRA. If the Fund does not receive notice within the 60-day period, they will **lose** their right to continue coverage through self-payments under COBRA.

ADMINISTRATIVE RESPONSIBILITIES

The Plan Administrator, as a legal matter, is the Fund's Board of Trustees. However, the Board of Trustees has divided the day-to-day operations of the Fund into six areas of responsibility, and has delegated them to the Fund Office and to some of the Fund's other service providers.

Administrative Manager / Fund Office Functions

The Administrative Manager / Fund Office is responsible for the following:

- Day-to-day details of running the Fund, including financial and record-keeping functions for the Fund
- All matters pertaining to *eligibility*
- Processing self-payments.
- Forwarding claims for the following benefits to the insurers:
  - Disability Benefits
  - Accidental Death and Dismemberment
  - Life Insurance
- Reviewing and presenting appeals to the Board of Trustees

BAS/Cigna Functions

The Fund has engaged BAS to administer, adjudicate and pay all medical, hospital, and surgical claims through the Cigna OAP Network (PPO). BAS also determines all appeals concerning claims it pays.

EHIM Functions

The Fund has a contract with EHIM to administer and pay all outpatient prescription drug benefits. It also determines all appeals concerning the claims it pays.

A.D.N. Administrators Functions

The Fund has engaged A.D.N. Administrators to administer and pay all dental claims. It also determines all appeals concerning the claims it pays.

EyeMed Functions

The Fund has an insurance contract with EyeMed to administer and pay all vision claims in accordance with its schedule of benefits. It also determines all appeals concerning the benefits it provides.

Mutual of Omaha Functions

The Fund has insurance contracts with Mutual of Omaha to administer and pay all accidental death and dismemberment benefits, short-term disability benefits, and life insurance benefits. It also determines all appeals concerning the benefits it provides.

FREE CHOICE OF PROVIDER

You may choose any health care provider you wish to provide your health care. However, the amount of benefits paid by the Fund, if any, may vary widely and may be severely limited based

on the provider you choose and the provider's participation in a preferred provider organization (i.e., the Cigna OAP Network) utilized by the Fund.

DISCHARGE OF LIABILITY

Any payment made by the Fund in accordance with the Plan will fully discharge the Fund's liability to the extent of the payment.

YOUR EXPLANATION OF BENEFITS (EOB)

Each month BAS processes medical claims for you or you or your dependents, you will receive an Explanation of Benefit Payments statement, or EOB. This statement is not a bill. At the top of the EOB, you will find a BAS Customer Service phone numbers and an address to use for inquiries.

An EOB is a record of paid or rejected claims. It also lists any amounts applied to deductibles and/or copays. All health insurance carriers will accept the EOB statement to process any available benefits for coordination of benefits. They can be used to keep track of medical expenses for tax purposes.

> Note: It is very important for your provider and the Fund Office to have your correct mailing address. In most cases, your EOB will be mailed to the address that is on the system. However, if a payment is being sent directly to you, the address that is on the claim form will be used for mailing purposes.

About your EOB. Briefly the EOB tells you:

- The family member who received services
- The date services were provided ("claims processed from...to...")
- "Summary of Balances" includes the provider(s) of the services, details about charges and payments, including the amount saved by using PPO network providers
- "Summary of Deductibles and Copayments" provides your deductible and copay requirements as well as a total of all deductibles and copays paid to date
- "Helpful Information" includes messages and reminders
- "Detail on Services" summarizes the payment and shows your balance

If you see an error, contact your provider first. If your provider cannot correct the error, call the customer service number on your EOB.

PAYMENT OF BENEFITS TO A PERSONAL REPRESENTATIVE

If a person is not mentally, physically, or otherwise able to handle his or her business affairs, the Fund will pay benefits to the legally appointed guardian or conservator or person holding the power of attorney if the Fund is provided with all necessary documentation.

ELIGIBILITY AND COVERAGE

INITIAL ELIGIBILITY REQUIREMENTS

If you are employed by an employer that is signatory to a collective bargaining agreement that requires it to make contributions to the Fund on your behalf, you will be eligible for benefits from the Fund when your employer makes the required contributions. Depending on your employer, there may be a delay between when your employment starts and when your employer is obligated to remit contributions on your behalf under the terms of the collective bargaining agreement covering you.

In order to become a Participant, you must complete and submit to the Fund an Enrollment Form on a form prescribed by the Fund, and accompanied by such documentation as the Fund shall require. If the collective bargaining agreement covering you requires you to make an employee contribution, you will also need to complete and submit to your employer a written and signed authorization form, authorizing your employer to deduct and remit to the Fund the required contribution amount from your payroll checks.

CONTINUING ELIGIBILITY REQUIREMENTS

1. Continuation by Working

Once you have established initial eligibility as set out above, you will continue to be eligible for benefits if you remain in active continuous employment with a participating employer, and the Fund receives all contributions on your behalf that are required by the terms of the collective bargaining agreement covering you.

2. Continuation Without Working

If your coverage is lost for certain specified reasons, you may continue your coverage under the terms of COBRA Continuation Coverage, discussed in detail below.

3. Special Enrollment Rights

a. **Eligible But Not Enrolled Dependents.** If you do not enroll one or more of your eligible dependents (such as a child or spouse) at the time of your initial eligibility, or when you acquire that dependent if later, because they have other health insurance coverage, you must provide **written** notice of this to the Fund **within 30 days** of your initial eligibility (or when you acquire that dependent if later) that you are declining coverage from this Fund for the dependent. The

written notice must include complete information regarding the dependent for whom you are declining coverage from this Fund, including his or her name, date of birth, relationship to you, and the source and provider of the other coverage.

If all of this information is provided to the Fund within the required time limits, you may later enroll that eligible dependent(s) if they later lose that other coverage *provided* that the enrollment is made **within 30 days** of the loss of other coverage. The Fund will require proof of the other coverage and its termination date for re-enrollment.

b. Additional Special Enrollment Rights. If you or your dependent(s) is eligible for coverage under the Plan but are not enrolled, you may enroll for coverage under the Plan for yourself or your dependent if either:

(i) you or your dependent is covered under a Medicaid plan or State CHIP, coverage of you or your dependent under such Medicaid plan or State CHIP is terminated as a result of loss of eligibility for the Medicaid plan or State CHIP, and you request coverage under this Plan **no later than 60 days** after the date you or your dependent's coverage under such Medicaid plan or State CHIP terminates; or

(ii) you or your dependent becomes eligible for assistance under a Medicaid plan or State CHIP (including under any waiver or demonstration project conducted under or in relation to those plans), and you request coverage under this Plan **no later than 60 days** after the date you or your dependent is determined to be eligible for such assistance.

TERMINATION OF ELIGIBILITY

Your coverage under the Plan shall immediately terminate on the earliest of the following dates:

- The date you are no longer eligible for coverage under the terms of the collective bargaining agreement covering you;
- The date the Fund is notified that your covered employment terminated (note that your coverage may be terminated retroactively in some circumstances if the Fund is not timely notified that your covered employment terminated);
- The date the Plan does not receive all required contributions on your behalf;
- The date the Plan terminates; or
- The date you are inducted into the Armed Forces.

ELIGIBILITY OF DEPENDENTS (Applies Only Where The Collective Bargaining Agreement Includes Dependent Coverage)

If the collective bargaining agreement covering you includes dependent coverage, coverage of your dependents generally begins and terminates when your coverage begins and terminates. However, several special rules apply, as set out below. In addition, dependents are **never** eligible for accidental death and dismemberment benefits, life insurance benefits, and short-term

disability benefits.

Status as a dependent hereunder shall require such documentation as the Fund may require from time to time, including, but not limited to, Federal income tax records, adoption records, physician's statements, birth certificates, marriage certificates, qualified medical child support orders and judgments of divorce or orders for separate maintenance. In the event that the required documentation is not filed and a claim is received, the Fund Office is required to request **and** obtain such proof **before** the claim can be processed.

1. Coverage of Spouses

If the collective bargaining agreement covering you includes dependent coverage of spouses, your legal spouse is eligible for coverage from the Fund when you are eligible.

You must complete an Enrollment Form with all required information **within 30 days** of your becoming eligible, listing your spouse, in order for coverage for your spouse to be retroactive to the date of your eligibility. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice.

Coverage for a spouse ends immediately upon your divorce or legal separation. You MUST report a divorce or legal separation to the Fund Office immediately and provide the Fund Office with a complete copy of the judgment or decree of divorce, or order of separate maintenance. By enrolling a spouse for coverage with the Fund, you are agreeing that you will be *personally liable to the Fund* for any premiums or benefits for services rendered after your divorce or legal separation that the Fund pays on behalf of your spouse or former spouse before you notify the Fund of such divorce or legal separation, whether or not you are still covered when the Fund discovers the divorce or legal separation or when the Fund issues its demand for repayment or at any time of reference. Therefore, it is in your best interest to notify the Fund immediately if you are divorced or legally separated from your spouse.

2. Coverage of Children

If the collective bargaining agreement covering you includes dependent coverage of children, your biological and adopted children (including children placed for adoption), foster children and stepchildren are eligible for coverage from the Fund until the last day of the calendar month in which they reach age 26, regardless of their marital status or availability for other coverage. However, the spouses of your children and the children of your children are not eligible for coverage from the Fund.

You must complete an Enrollment Form with all required information **within 30 days** of your becoming eligible, listing your dependent(s), in order for coverage for your dependent(s) to be retroactive to the date of your eligibility. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice.

Coverage for stepchildren ends immediately upon your divorce from their parent. You MUST report a divorce to the Fund Office immediately and provide the Fund Office with a complete copy of the judgment or decree of divorce. If the Fund pays premiums or benefits for services rendered to your former stepchildren after the date of your divorce from their parent because you did not timely provide a copy of the judgment or decree of divorce, you are personally liable to the Fund for any amounts the Fund pays in benefits for services rendered to or on behalf of your former stepchildren after the date of the entry of the judgment or decree of divorce but prior to notification to the Fund of the divorce, regardless of whether or not you continue to be eligible for benefits at the time the Fund discovers the divorce.

No child is considered a dependent under the Plan after the end of the calendar month in which the child attains the age of 26 years.

The Fund will also cover a child who is named as an alternate recipient of the employee under a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is a judgment, decree or order (including a court-approved settlement agreement), entered by a court or agency, that requires a group health care plan to provide coverage to a participant=s child or children. When the Fund receives such an order, judgment, decree or court-approved settlement agreement regarding health care coverage, the Fund Office will make the initial determination of whether that document meets the Fund's requirements for a QMCSO. If the document is determined to be a QMCSO, the Fund will notify the parties. If the document is determined not to be a QMCSO, the Fund will send a letter describing the reason for that determination.

3. Enrollment of New Dependents

If the collective bargaining agreement covering you includes dependent coverage, you may enroll your dependents at the time of your initial eligibility under the Plan.

You may enroll a new dependent (a new spouse or a new child) for coverage under the Plan **within 30 days** of the date that person becomes your dependent by giving written notice to the Fund Office and including but not limited to copies of the birth certificate or other proof of dependent status, such as an order of filiation, an adoption order, marriage certificates or a QMCSO. Eligibility for new dependents begins no sooner than 30 days prior to when notice is received, so it is to your benefit to provide notice to the Fund Office as quickly as possible. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice.

If you do not enroll a dependent for coverage at the time of your initial eligibility, or when you acquire the dependent if later, because they have coverage under another health plan and you provide written notice to the Fund **within 30 days** of your initial eligibility that you are declining coverage from this Fund for the dependent due to the availability of other coverage, you may enroll such dependent if they later lose that other coverage, *provided* that the enrollment is made within 30 days of the loss of the other coverage. The Fund will require proof of the other coverage and its termination date for re-enrollment.

4. Re-enrollment of Previously Disenrolled Dependent Children

You may elect to disenroll an otherwise eligible dependent child for any reason. If you later seek to re-enroll that dependent child, then the dependent child shall be eligible for coverage as soon as administratively feasible, but not before the first day of the month following the month within which the election is received by the Fund Office.

5. Termination of Dependent Eligibility

Coverage of your dependent will terminate on the date you cease to be eligible as set out above, or when any of the following events occur:

a. Termination of Coverage for Spouses

Your spouse's coverage ends immediately upon his or her divorce or legal separation from you. Both you and your former spouse have an independent obligation to notify the Fund **immediately** upon your divorce or legal separation. **If you delay providing notice of your divorce or legal separation to the Fund for any reason and the Fund pays premiums or benefits on behalf of your ineligible spouse or former spouse, you will be personally liable to the Fund for any amounts paid by the Fund.** The Fund reserves the right to recover that amount from you, your spouse or former spouse, and/or both of you. It also reserves the right to recover through litigation, termination of your participation in the Fund, offsetting that amount from any future benefits payable to you, and any other lawful means.

Any coverage for a spouse or former spouse after the date of entry by the court of a judgment of divorce or legal separation is available only under the terms of COBRA continuation coverage. If the Fund Office is not notified of a divorce or legal separation within 60 days of the date of its entry, the Fund has no obligation to offer COBRA coverage. See pages 24-26 for details on COBRA continuation coverage.

If earlier, a spouse's coverage also ends on the earliest of the date the spouse enters the Armed Forces of any country, or upon the elimination of coverage of spouses under the Plan.

b. Termination of Coverage for Children

Children who qualify as your dependents under this Plan will be eligible for benefits until the last day of the month in which they reach age 26. If prior to that date, coverage for children will terminate on the earliest of the following:

- The date you elect to disenroll the child;
- The date the child becomes eligible for benefits from the Fund as a participant in his/her own right. However, the child may be covered as a child under the Fund after losing eligibility as a participant if his parent is eligible for coverage, subject to all child coverage requirements;
- For stepchildren only, the date you are divorced from the stepchild's parent;
- The date the child enters the Armed Forces of any country; or
- The elimination of coverage of children under the Plan.

COBRA CONTINUATION COVERAGE

Introduction

This section of the Summary contains important information about your right to COBRA continuation coverage under the Plan, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA continuation coverage is a temporary extension of coverage under the Plan. COBRA continuation coverage does not include accidental death and dismemberment benefits, life insurance benefits, or short-term disability benefits. The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you or they would otherwise lose group health coverage. This is only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under Federal law, you should contact the Fund Office.

The Board of Trustees has delegated the day-to-day responsibilities for the administration of COBRA continuation coverage to the Fund Office. Both the Board of Trustees and the Fund Office can be contacted at 30700 Telegraph Road, Suite 2400, Bingham Farms, Michigan 48025.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred.

You Must Give Notice of Some Qualifying Events.

You must notify the Fund Office within 60 days after the following qualifying events: divorce or legal separation of the participant and spouse or a dependent child's losing eligibility for coverage as a dependent child. The Plan may require that you provide evidence that a qualifying event has occurred, such as a complete copy of the Judgment of Divorce or a birth certificate. You must provide this notice to: Board of Trustees, SEIU Michigan Health and Welfare Fund, 30700 Telegraph Road, Suite 2400, Bingham Farms, Michigan 48025, (248) 645-6550. ***Failure to comply with these rules will result in the permanent loss of COBRA rights.***

How is COBRA continuation coverage provided?

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying

events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must make sure that the Fund Office is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary will be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary is required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option will be described in the COBRA notice you will receive if you became eligible for COBRA.

When and how must payment for COBRA continuation coverage be made?

If you elect continuation coverage, you do not have to send any payment with the Election Form. **However, you must make your first payment for continuation coverage not later than 45 days after the date of your election**. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Fund Office to confirm the correct amount of your first payment.

After you make your first payment for continuation coverage, you will be required to make monthly payments for each subsequent month of coverage. The amount due for each coverage

month for each qualified beneficiary will be provided in the Election Notice. Each monthly payment for continuation coverage is due on or before the first day of the month of coverage. The Plan does not send out notices for payments.

Although monthly payments are due by the first day of the coverage month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. If you pay the monthly payment later than the first day of the coverage month, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that coverage month, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to the Fund Office at 30700 Telegraph Road, Suite 2400, Bingham Farms, Michigan 48025.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation

coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Fund Office know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Plan contact information

SEIU Michigan Health and Welfare Fund
30700 Telegraph Road, Suite 2400
Bingham Farms, Michigan 48025
(248) 645-6550

FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act of 1993 ("FMLA"), a Federal law, provides for up to 12 weeks of unpaid, job protected leave for certain family and medical reasons and up to 26 weeks if the leave is to care for a family member who is recovering from a serious illness or injury sustained in the line of duty during military service that has rendered the person unfit to perform military service. You are eligible for such leave if you have worked for your employer for at least 12 months **and** for at least 1,250 hours in the 12 months before the leave starts, and if your

employer is covered by FMLA and has at least 50 employees within 75 miles of where you work.

This Summary is not intended to be a complete description of FMLA – you should go to the U.S. Department of Labor's website on this topic (http://www.dol.gov/whd/fmla) for more details.

Whether you are eligible for family or medical leave is determined by your employer, not the Fund. Both you and your employer are required to notify the Fund if you take family or medical leave and to provide certain other information as required by the Board of Trustees. The Fund will continue coverage during the period of your family or medical leave, provided that your employer makes contributions to the Fund at the same rate and in the same amount as if you were continuously employed during the period of your leave, and fully complies with all requirements established by the Board of Trustees.

ELIGIBILITY WHEN ENTERING MILITARY OR UNIFORMED SERVICE

If you enter the uniformed services of the United States ("Service") while you are eligible for benefits under the Plan, you may elect to continue coverage for all benefits under the Plan, except accidental death and dismemberment benefits, life insurance benefits, and short-term disability benefits, for a period which is the lesser of:

- The 24-month period beginning on the date on which your absence begins; or
- The period of your Service plus 90 days.

Continuation of coverage hereunder requires that you pay a monthly amount equal to the Fund's current COBRA coverage rate unless your period of service is for less than 31 days, in which case you will receive coverage at no cost to you.

It is your responsibility under Federal law to notify the Fund when you are called to Service.

As long as you return to covered employment within 90 days of your discharge under honorable conditions from the Service (or within 24 months if you are recovering from an illness or injury incurred during or aggravated by your Service), you will not be required to satisfy the Plan's initial eligibility rules. However, if the period of your Service exceeds five years, you must satisfy the initial eligibility requirements irrespective of when you return to work.

These rules can be complicated. Therefore, please notify the Fund **immediately** when you enter your Service and **immediately** upon your discharge to take advantage of your rights under the law.

BENEFITS

The Fund provides a wide variety of benefits, not all of which are available to all participants. Benefits vary based on the collective bargaining agreement covering the participant to which his/her employer is bound. In order to make this Summary useful to the greatest number of participants, it is impractical to list all available benefits.

Together with this Summary, you should have received from the Fund Office materials from the

medical, prescription drug, dental, vision, life insurance, accidental death and dismemberment, and short-term disability administrators applicable to your plan of benefits (a booklet called the "Insurance Benefit Guide"), setting forth each of the following:

1. any cost sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which participants and beneficiaries are responsible;

2. any annual, lifetime, or frequency limits on benefits;

3. the extent to which preventive services are covered;

4. whether, and under what circumstances, existing and new drugs are covered;

5. whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;

6. provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services;

7. any conditions or limits on the selection of primary care providers or providers of specialty medical care;

8. any conditions or limits applicable to obtaining emergency medical care; and

9. any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service.

Important: If you did not receive the latest Insurance Benefit Guide booklet when you receive this Summary, contact the Fund Office immediately as they are an integral part of this Summary.

You may always contact the Fund Office for information about the benefits package which your employer and the Union has arranged to provide to you through the Fund, and the most current information will be provided to you without charge.

CLAIMS APPLICATIONS AND LIMITS

1. Applying for Benefits:

Medical/Hospital/Surgical Benefits (BAS/Cigna),
Prescription Drug Benefits (EHIM),
Dental Benefits (A.D.N. Administrators),
Vision Benefits (EyeMed)

Claim forms are generally **not** required for medical, prescription drug, dental, or vision benefits if provided in-network. All claims for these benefits must be in conformity with the requirements of the applicable service provider, including all time limits and proofs. Claim

determinations are made by BAS (medical), EHIM (prescription drug), A.D.N. Administrator (dental), or EyeMed (vision). If you disagree with a determination made by any of these service providers, you must appeal directly to the respective service provider and comply with its claims appeal process. Claims for medical, prescription drug, dental, or vision services should be submitted by you or your provider directly to BAS, EHIM, A.D.N. Administrator, or EyeMed, as applicable.

Claims for medical benefits must be submitted to BAS within one year from the date of service.

Claims for prescription drug benefits must be submitted to EHIM within one year from the date of service.

Claims for dental benefits must be submitted to A.D.N. Administrators within one year from the date of service.

Claims for vision benefits must be submitted to EyeMed within 180 days from the date of service for in-network providers and 15 months from the date of service for out-of-network providers.

2. Applying for Benefits:

Accidental Death and Dismemberment Benefits (Mutual of Omaha)
Life Insurance Benefits (Mutual of Omaha)
Short-Term Disability Benefits (Mutual of Omaha)

Claim forms for accidental death and dismemberment benefits, life insurance benefits, and short-term disability benefits are available from the Fund Office, and all such forms and supporting documentation must be submitted within the following time periods established by this Plan for such benefits.

Claims received by the Fund Office for accidental death and dismemberment benefits, life insurance benefits, and short-term disability benefits are submitted to Mutual of Omaha, the insurance company with which the Fund has policies for these benefits. Mutual of Omaha is solely and exclusively responsible for all determinations with respect to those claims, and the Fund has no liability or responsibility for those determinations. If you disagree with a determination made by Mutual of Omaha, you must appeal directly to Mutual of Omaha and comply with its claims appeal process.

If processing of a claim cannot be completed because of missing information, the Fund Office will attempt to notify you or the person filing the claim, and advise as to 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 the responsibility of the person filing the claim to gather this information and submit it within the required time period.

- **Accidental death and dismemberment benefit** claims must be submitted **within one year** from the loss or death.

- **Life insurance benefit** claims must be submitted **within one year** from the eligible individual's death.

- **Short-term disability benefit** claims must be submitted **within one year** from the onset of the disability.

Late proof may be accepted only if, under the particular circumstances, it was furnished as soon as was reasonably possible, and, in any event except in the absence of the claimant's legal capacity, within two years after the time it was otherwise required.

3. Denial of Claims

The Board of Trustees or its representatives and the Fund's service providers as delegates 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 services were provided out-of-network.

- 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 annual maximum benefit for the type of benefit.

- The person for whom the claim was filed had not yet satisfied any required deductibles.

- 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 recover (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 on page 39 of this Summary).

- The benefit or the Fund was terminated.

- Fund assets were insufficient to meet claim obligations.

The above list does not include 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.

If your claim is denied by BAS, EHIM, A.D.N. Administrators, EyeMed, or Mutual of Omaha, you will be informed of the reason for the denial by BAS, EHIM, A.D.N. Administrators, EyeMed, or Mutual of Omaha, as appropriate. 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

1. Medical/Hospital/Surgical Benefits (BAS),
Prescription Drug Benefits (EHIM),
Dental Benefits (A.D.N. Administrators),
Vision Benefits (EyeMed)
Life Insurance Benefits (Mutual of Omaha)
Accidental Death and Dismemberment (Mutual of Omaha)
Short-Term Disability Benefits (Mutual of Omaha)

All information regarding appealing a denial of benefits by BAS, EHIM, A.D.N Administrators, EyeMed, or Mutual of Omaha can be found in the Insurance Benefit Guide you received with this Summary, or the Explanation of Benefits you received regarding the claim. If you did not receive the latest Insurance Benefit Guide with this Summary, please notify the Fund Office immediately because it is an integral part of this Summary.

2. Eligibility Determinations

You, your spouse or your dependent ("claimant") may appeal a denial of a claim related to an eligibility determination by writing out the reasons for your disagreement and the facts on which you rely and mailing your appeal within **180 days** of the notice of denial to the Board of Trustees, SEIU Michigan Health and Welfare Fund, 30700 Telegraph Road, Suite 2400, Bingham Farms, Michigan 48025. 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 or other ID number, and the 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 the 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 their decision and the reasons for it in writing within five days after they make their decision on the appeal.

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's decision was based.

ADDITIONAL ADMINISTRATIVE MATTERS

1. Examinations

The Board of Trustees has the right to ask a doctor of its choice to examine a person for whom benefits are being claimed. It also has the right to examine any and all hospital or medical records relating to a claim.

2. Free Choice of Provider

You have the free choice of any provider.

However, no benefits will be paid if you select a medical, hospital or surgical provider that is not part of Cigna OAP Network.

Benefits paid under the Fund's contracts with its other service providers may be severely limited or altogether excluded if you select a provider that is not part of the respective service provider's network.

3. Explanation of Benefits

After you make a claim for benefits, you should receive an "Explanation of Benefits" ("EOB") from BAS, EHIM, A.D.N. Administrators, or EyeMed, stating what has been paid. You are

responsible for paying any amount remaining due, and you should contact the service provider with any questions regarding your EOB.

4. Proof of Authority in the Event of Your Incapacity

If you become mentally, physically or otherwise unable to handle your business affairs, the Fund may need to deal with a legally appointed guardian, conservator or person holding the power of attorney on your behalf. You, or your representative, are responsible for providing the Fund with any information and documentation regarding someone who has or may have authority to act in your place.

5. Trustee Interpretation and Authority

Except as may be provided under contracts of insurance entered into by the Fund, under the terms of the Plan and the Trust establishing the Fund, the Board of Trustees has the sole authority to interpret and apply the rules of the Plan, the Trust and any other rules and regulations, procedures or administrative rules adopted by the Board of Trustees. Decisions of the Board of Trustees or, where the responsibility of the Board has been delegated to others, such delegates, will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Board of Trustees or its authorized delegates is challenged in court, the Trust Agreement and the Plan provide that such decision is to be upheld unless a court with proper jurisdiction finds and issues a decision that it was arbitrary and capricious.

All benefits under the Plan are subject to the Board of Trustees' authority under the Trust Agreement to change them. The Board of Trustees has the authority to increase, decrease, change, amend and terminate benefits, eligibility rules or other provisions of the Plan as it may determine to be in the best interests of the Plan participants and beneficiaries.

The Plan is maintained for the exclusive benefit of the Plan's participants and their eligible dependents. All rights and benefits granted to a participant under the Plan are legally enforceable.

6. Workers' Compensation Not Affected

This Plan is not in place of and does not affect any requirement for coverage under any Workers' Compensation law, occupational diseases law or similar law. Benefits which would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws.

7. Plan Discontinuation or Termination

The Fund and its Plan may be discontinued or terminated under many circumstances – for example, if future collective bargaining agreements and participation agreements do not require contributions to the Plan. In such event, benefits for covered expenses incurred by the termination date will be paid on behalf of eligible participants and their dependents as long as the Fund's assets are more than its liabilities (except as may be covered by contracts of insurance entered into by the Fund, to the extent of premiums paid). 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.

8. Right of Offset

If any payment is made by the Fund to or on behalf of a person who is not entitled to the payment or to the full amount of such payment, the Fund has the right to reduce future payments to that person or to the person responsible for the erroneous payment by the amount of the erroneous payment. This right of offset will not limit the right of the Fund to recover such erroneous payments in any other manner.

9. Legal Actions – *IMPORTANT NOTICE*

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. In addition, under the Plan, any such action must be brought in the United States District Court where the Plan is administered.

Your rights with respect to any insurance company are governed by the rules, regulations and laws governing the insurance company.

You should seek legal advice regarding these limitations.

10. Altered or Forged Claims

Any claim form or other materials submitted by or on behalf of any person 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 losses it suffers as a result of such material alteration or forged or false information in any manner.

11. Right to Obtain, Require and Rely on Information

The Board of Trustees shall have the right to require, as a condition precedent to the payment of any benefit under the Plan, all information which it reasonably deems necessary, including records of employment, proof of dates of birth and death, marital status, independent medical examinations of any person for whom benefits are being claimed, any and all medical records relating to a claim, etc., and no benefit dependent in any way upon such information shall be payable unless and until such information so required is furnished. Such evidence shall be

furnished by the Union, employers, employees, participants, dependents, beneficiaries, alternate recipients or the representative of any of them.

The Board of Trustees shall, in the absence of contrary evidence presented to it, have the right in administering the Plan to rely upon information provided to it by the Union, the employers, employees, participants, dependents, beneficiaries, alternate recipients or the representatives of any of them. Neither the Board nor the Fund shall be held liable for good faith reliance thereon.

12. Medicare

Eligibility for Medicare

You and any of your covered dependents are eligible for Medicare, the health program provided under Social Security for people 65 and older, if:

- You (or any of your covered dependents) are age 65 or older;
- You (or any of your covered dependents) who have received Social Security Disability benefits for 24 months or longer are under age 65; or
- You (or any of your covered dependents) qualify as an eligible person who needs hemodialysis treatment or a kidney transplant because of chronic kidney disease.

Contact your Social Security Administration office three months prior to your 65th birthday, or, if you are otherwise eligible, to find out the enrollment requirements.

Medicare has two kinds of health insurance available to you and your covered dependents.

- Part A, the hospital insurance, helps with the cost of hospitalization and related care. Part A Medicare is automatic for those 65 and over and for disabled persons under 65. Hemodialysis patients must apply for Part A through a Social Security Administration Office.
- Part B, the medical insurance, helps pay doctor bills and other medical expenses. Part B Medicare is voluntary. All persons entitled to coverage under Part A can enroll in Part B.

If you have any questions about your Medicare benefits or Medicare's enrollment requirements, consult a Medicare office.

Medicare also has prescription drug insurance available to you and your covered dependents through Medicare Part D programs.

Relationship Between Medicare and the Fund's Medical Coverage

This section sets out the rules for coverage if you or any of your covered dependents are both covered by the Fund and eligible for Medicare. When Medicare is "primary," that means that you must file any medical claims with Medicare first – Medicare will pay first, and the Fund will pay any amounts that are covered by the Fund that remain. When the Fund is "primary," that

means that you must file any medical claims with the Fund first – the Fund will pay first, and Medicare will any amounts that it covers that remain.

Medicare is generally primary if:

- You or any of your covered dependents is over age 65 and not actively working;
- You or any of your covered dependents is under age 65 and have received Social Security Disability benefits for 24 months or longer;
- You or any of your covered dependents under age 65 is covered by Medicare based on end-stage renal disease (needing hemodialysis treatment or a kidney transplant because of chronic kidney disease) for more than 30 months.

When Medicare is primary, you must file any medical claims with Medicare first.

The SEIU Michigan Health and Welfare Fund is primary if:

- You or any of your covered dependents are over age 65 and still actively working;
- You or any of your covered dependents are under age 65 and
  - have received Social Security Disability Benefits for less than 24 months;
  - have been covered by Medicare based on end-stage renal disease for 30 or fewer months.

When the Fund is primary, claims must be filed with the Fund first. The Fund will pay its regular benefit in full. Any claim amounts not paid by the Fund may be filed with Medicare. Medicare will review the claim to determine if it will pay any benefits in addition to the benefits paid by the Fund.

It is intended that the participant and his/her eligible dependents be fully reimbursed for Covered Charges under this Fund and Parts A and B Medicare, to the extent that the combined benefits do not exceed 100% of the total covered charges. Covered Charges are those for which payments may be made under the Fund and are subject to the general benefit limitations and maximums described elsewhere in this booklet.

If an individual is eligible to enroll for Medicare benefits, the Fund will not pay a provider in excess of the amount the Fund would have paid if the provider had submitted its bills and was paid through Medicare.

Please note that your coverage with the Fund will terminate when the Fund is notified that you are no longer actively employed with a participating employer and the Fund does not receive all contributions on your behalf that are required by the terms of the collective bargaining agreement covering you, unless you are eligible for and elect COBRA Coverage. You should contact the Fund Office if you have any questions concerning the effect Medicare will have on your coverage.

13. Medicaid

For participants and dependents eligible for Medicaid benefits, the Fund will reimburse Medicaid payments made to participants and dependents as required under state Medicaid laws, the Fund will ignore Medicaid eligibility when enrolling a participant or dependent or making any benefit payment determination, and the Fund will comply with any subrogation rights required under state Medicaid laws.

If you or your dependents are entitled to Medicaid at the same time you are eligible for benefits from the Fund, the Fund will be the primary payer of benefits.

14. Coordination of Benefits / Non-Duplication of Benefits

Coordination of benefits provisions come into play whenever an eligible person has other coverage under any health care plan, fund, group insurance program, Medicare, or any statute (law).

Under these provisions, the Fund will pay the benefits in accordance with its applicable schedule of benefits if it is considered to be primary. Otherwise, the other plan, fund, program, etc., will be required to pay the benefits up to the maximum amount payable in accordance with its schedule of benefits and the Plan will then pay any remaining amounts not otherwise covered up to and in accordance with its schedule of benefits so that, in the aggregate, no more than 100% of the incurred covered expenses will be paid.

The Fund will not duplicate benefits paid to you or your dependents under another health care plan, fund, policy, contract, program or statute. Benefits from the Fund are subject to, and limited to, benefits payable in accordance with these coordination of benefits provisions. Coordination of benefits provisions are rules which determine the order in which two or more plans which may be covering you or your dependents pay benefits first, so that benefits will be paid up to but not to exceed 100% of the Plan's allowable expenses on the claim. These rules apply to every eligible person covered by the Plan and to all benefits payable under the Plan, **except** life insurance, accidental death and dismemberment benefits, and short-term disability benefits.

Generally speaking, the following rules are applied to determine whether the SEIU Michigan Health and Welfare Fund or the other health care plan, fund, program, policy or statutory payer pays first in accordance with its schedule of benefits.

A. If the other plan, fund, program, policy or statutory payer has not adopted a coordination of benefits provision, it shall be required to pay first.

B. If both have coordination of benefits provisions, then

    (i) the plan in which the covered person is covered as an employee shall pay in accordance with its schedule of benefits as primary and the one in which the covered person is covered as a dependent shall pay any remaining balance up to its maximum schedule of benefits.

(ii) the plan that covers the covered person as an active employee or dependent of an active employee shall pay in accordance with its schedule of benefits as primary and the plan that covers the individual as a COBRA participant shall pay any remaining balance up to it maximum schedule of benefits.

(iii) where the claim is for an eligible dependent child, the following order of priority shall be followed in determining which plan, fund, program, policy or statutory payer shall pay first:

(a) the plan covering the child's parent who has the earlier birth date anniversary in the calendar year shall be primary,

(b) if both parents have the same birth date, the plan that covered the child for the longer period of time shall be primary,

(c) if the child's parents are divorced, or legally separated, the plan covering the parent who is financially responsible for the health care of the child pursuant to court decree shall be primary. If there is no court decree, the plan covering the custodial parent shall be primary. If the custodial parent is remarried, the plan covering the spouse of the custodial parent is primary over that which covers the non-custodial parent.

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. The Fund Office, and/or the Fund's service providers may periodically ask you to update your COB information. Please help us serve you better by responding to requests for COB information quickly.

15. Subrogation and Reimbursement

In the event of any payments of services to or on behalf of any person under this Plan, the Fund shall, to the extent of such payments, be subrogated to all rights of recovery of that person (or his representative(s)) arising out of any claim or cause of action which may accrue against a third party, including any occupationally related claim or cause of action covered by the Michigan Workers' Disability Compensation Act or Occupational Disease Act or similar federal or state statutes. That person (or his representative(s)), by acceptance of benefits provided by this Fund, hereby agrees to reimburse the Fund for any benefits so paid hereunder out of monies recovered, fully or partially, from such third party as the result of judgment, settlement or otherwise, irrespective of how differentiated, without any offset for expenses, including legal fees, that person (or his representative(s)) may owe, and before that person (or his representative(s)) pays any other individual, organization or entity out of that full or partial recovery (i.e., the Fund has first priority with respect to its rights under this provision). Such monies recovered shall be deemed to be held in constructive trust for the benefit of the Fund, regardless of who holds those monies. That person (or his representative(s)) may take no action which would prejudice the Fund and/or any of the Fund's designees' rights, and that person (or his representative(s)) hereby agrees to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Board of Trustees may require to facilitate the enforcement of the Fund's rights, including but not limited to executing the Fund's standard lien

acknowledgement form. The Fund and/or any of the Fund's designees will not be responsible for attorney's fees or costs incurred and/or paid by or on behalf of that person (or his representative(s)) unless the Fund and/or any of the Fund's designees has agreed in writing to pay such fees or costs or some portion thereof.

If the Fund and/or any of the Fund's designees pays benefits on behalf of any person and that person (or his representative(s)) receives a settlement, that person (or his representative(s)) must repay the Fund and/or any of the Fund's designees up to the amount of benefits it/they have paid. If that person (or his representative(s)) does not do so, the Fund and/or any of the Fund's designees may exercise its rights at its own discretion and treat the amount of benefits paid as a debt of that person (or his representative(s)) to the Fund and/or any of the Fund's designees and may pursue recovery of said amount from that person (or his representative(s)) and/or reduce any future benefits payable on behalf of that person (or his representative(s)) in this amount until this debt has been cancelled.

16. Restitution Where Benefits Improperly Received

The Fund and its Board of Trustees shall have the right to pursue restitution from any person who receives benefits of any description from the Fund to which such person was not entitled, whether by virtue of the ineligibility of such person at the time services were rendered, by virtue of receipt of excluded benefits or otherwise.

EXCLUSIONS AND GENERAL LIMITATIONS

In addition to the exclusions and limitations listed earlier in the Summary and except as may be provided for under the terms of the Plan or the policies of insurance providing benefits or a required by law, the Plan shall <u>not</u> provide benefits for the following unless otherwise noted:

a. The Plan will **NOT** provide any benefits (including, short term disability, etc.) for treatment of injuries sustained in a motor vehicle accident or other motor vehicle licensed to be on the road or complications resulting for such injuries or accident.

b. The Plan will **NOT** provide for treatment of injuries resulting from causes other than sickness, accidental injury or disease. However, the Plan will provide for treatment of injuries resulting from domestic violence. The Board of Trustees may require details describing the incident, including a copy of the police report where available.

c. The Plan will **NOT** provide for expense incurred if the person is engaged in any unlawful act.

d. The Plan will **NOT** provide for benefits for injuries received or illnesses connected with working for pay or profit.

e. The Plan will **NOT** provide for loss or expense from sickness, or disease which 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, unless the person who is seeking benefits payable for such sickness, disease or accidental bodily injury signs an agreement stating that the Fund

shall be subrogated to all rights of recovery of that person (or his representative(s)) arising out of any claim or cause of action which may accrue against a third party and to reimburse the Fund for any benefits so paid by the Fund out of monies recovered. If the claimant or his representatives fail to cooperate with the Fund's rights or comply with any of the obligations set out in the Plan or in the Agreement, coverage will immediately terminate even if an agreement has been signed..

f. The Plan will **NOT** provide short-term disability benefits if you are unable to work because of an accident occurring on the job or an illness connected with employment.

g. The Plan will **NOT** provide for services that would not be charged if there were no insurance.

h. The Plan will **NOT** provide for services for which a charge is not customarily made, services for which the patient is not obligated, nor services available without cost.

i. The Plan 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.

j. The Plan will **NOT** provide for care and services available at no cost in a veteran's, marine or other federal hospital or any hospital maintained by any state or governmental agency.

k. The Plan will **NOT** provide for care and services payable by government-sponsored health care programs such as Medicare or TRICARE. However, the Plan will provide for prescription drugs that are payable by a Medicare Part D prescription drug plan.

l. The Plan will **NOT** provide for payment of surcharge or non-resident tax levied by community hospitals, except where required by law.

m. The Plan will **NOT** provide for medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location.

n. The Plan 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 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.

o. The Plan will **NOT** provide prescription drug coverage for age-related appearance or weight loss purposes.

p. The Plan will **NOT** provide for hospital care and medical services and supplies provided **prior** to the effective date of coverage or **after** the coverage termination date.

q. The Plan 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.

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

s. The Plan will **NOT** provide for television, telephone, guest trays or other non-essential personal items and services, including take-home prescription drugs and supplies.

t. The Plan will **NOT** provide for court-ordered hospital confinements and treatment required by court orders, which is the result of an order of any court of law to any participant or dependent, even when prescribed by a physician.

u. The Plan will **NOT** provide for comprehensive nutritional programs or for visits with specialists in endocrinology and visits when required solely for the purpose of weight loss or for treatment of obesity only or for expense incurred for dietary supplements and nutritional lectures and quick weight loss programs and clinics.

v. The Plan will **NOT** provide for installation of air conditioning units, sun lamps, humidifiers for environmental controls, whirlpools, air filters, bathroom rails, special toilet seats, commodes, chair lifts, or other non-essential home-installed conveniences even when prescribed by a physician, including ergometers, exercycles, bicycles, etc.

w. The Plan will **NOT** provide for psychological tests for vocational guidance or counseling.

x. The Plan will **NOT** provide for expense incurred for family planning, semen analysis, fertility and infertility analysis and diagnostic expense or in vitro-fertilization or artificial insemination.

LEGAL NOTICES

ERISA RIGHTS

As a participant in the SEIU Michigan Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and the union hall, all Plan documents including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) filed by the Fund 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 Board of Trustees, copies of documents governing the

operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Board of Trustees is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

- Reduction or elimination of the exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage for another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage (note: there are limitations on plans' imposing a preexisting condition exclusion, and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).

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, who are 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, the union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you may be entitled 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. 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 at (866) 444-EBSA (3272). The web site address for the Employee Benefits Security Administration of the Department of Labor is http://www.dol.gov/ebsa.

You can read the materials listed above (all Plan documents including insurance contracts and collective bargaining agreements; copies of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor; updated summary plan description; and the Plan's annual financial report) by making an appointment at the Fund Office during normal business hours. Also, copies of the materials will be mailed to you if you send a written request to the Fund Office. There will a per-page charge for copying some of the materials. Before requesting materials, call the Fund Office and find out the cost. If a charge is made, your check must be attached to your request for the material.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND CONTACT THE FUND'S PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS.

The SEIU Michigan Health and Welfare Fund ("Plan") is required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) to make sure that health information that identifies you is kept private to the extent required by law.

The Plan is also required to give you this Notice regarding

1) the Plan's uses and disclosures of Protected Health Information ("PHI")
2) your privacy rights with respect to your PHI;
3) the Plan's duties with respect to your PHI;
4) your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and
5) the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic)

and, when applicable, includes "genetic information." De-identified information, which does not identify an individual and that cannot reasonably be expected to be used to identify an individual, is not PHI.

This Notice and its contents are intended to conform to the requirements of HIPAA. Please be advised that other entities that provide services to you related to your participation in the Plan have issued or may issue separate notices regarding disclosure of PHI that is maintained on the Plan's behalf by those entities.

How the Plan May Use and Disclose PHI About You

The following categories describe different ways that the Plan uses and discloses PHI. Not every use or disclosure in each category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories. Except for the purposes described in the categories below, we will use and disclose PHI only with your written authorization. You may revoke such authorization at any time by writing to the Plan's Privacy Officer.

Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

For Payment. The Plan may use and disclose PHI about you for payment purposes such as to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. The Plan may also share PHI with a utilization review or precertification service provider. Likewise, the Plan may share PHI with another entity to assist with the coordination of benefit payments.

For Health Care Operations. The Plan may use and disclose PHI about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use PHI in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Plan administrative activities. The disclosure of PHI that is genetic information for underwriting purposes is prohibited and the Plan will not disclose any of your genetic information for such purposes.

To Inform You About Treatment, Treatment Alternatives or Other Health Related Benefits. The Plan may use your PHI for treatment purposes and other related benefits. The Plan may use your PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination, or (4) recommended alternative treatments, therapies, health care providers, or settings of care. For instance, the Plan may forward a communication to a participant who is a smoker regarding a smoking-cessation program.

For Disclosure to the Fund's Board of Trustees. The Plan may disclose your PHI to the Plan's Board of Trustees (Plan Sponsor) for plan administration functions performed by the Plan Sponsor on behalf of the Plan including, but not limited to, reviewing appeals. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or for modifying, amending or terminating the group health plan. "Summary health information" is information that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with federal regulations.

Business Associates. The Plan may disclose PHI to its business associates that perform functions on the Plan's behalf or provide the Plan with services if the information is necessary for such functions or services. For example, the Plan may use another company to perform billing services on its behalf. All of the Plan's business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in their agreement with the Plan.

Other Uses and Disclosures for which Consent, Authorization or Opportunity to Agree or Object is Not Required

When Legally Required. The Plan will disclose your PHI when it is required to do so by any federal, state or local law.

For Public Health Activities. The Plan may disclose your PHI for public health activities such as the reporting of vital events such as birth or death or the tracking of products regulated by the Food and Drug Administration.

For Reporting Abuse, Neglect or Domestic Violence. The Plan may disclose your PHI when required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

To Conduct Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, the Plan may not disclose your PHI if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, the Plan may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to you of the request or, if such assurance is not forthcoming,

if the Plan has made a reasonable effort to notify you about the request or to obtain an order protecting your PHI.

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your PHI to a law enforcement official for certain law enforcement purposes, including the reporting of certain types of wounds, upon the request of a law enforcement official for locating a suspect, fugitive, material witness, missing person, or crime victim, to report a death, to report a crime on the premises and to report a crime in a medical emergency. A disclosure of information about an individual who is or is suspected to be a crime victim may be made only if a) the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances, b) the law enforcement official represents that the information is not intended to be used against the individual and the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and c) the Plan determines disclosure is in the best interest of the individual as determined by the exercise of its best judgment.

To Coroners, Medical Examiners and Funeral Directors. The Plan may release PHI to coroners or medical examiners for duties authorized by law or to funeral directors consistent with applicable law.

Organ and Tissue Donation. If you are an organ donor, the Plan may release PHI to organizations that handle organ procurement or transplantation.

For Research. The Plan may disclose your PHI for research subject to certain conditions regarding the manner in which the research is conducted.

In the Event of a Serious Threat to Health or Safety. The Plan may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person when consistent with applicable law and standards of ethical conduct and the Plan in good faith believes such use or disclosure is necessary.

For Specified Government Functions. In certain circumstances, Federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans affairs, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Workers' Compensation. The Plan may release your PHI to the extent necessary to comply with laws related to workers' compensation or similar programs.

Other Uses and Disclosures

The Plan will not (1) supply confidential information to another entity for its marketing purposes in violation of the privacy regulations, or (2) sell your confidential information in violation of the privacy regulations.

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to the Plan will be made only if you provide a written authorization.

The Plan asks you to complete an authorization form if you would like someone, such as a spouse, to be able to have access to your PHI.

If you provide the Plan with written authorization to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures that the Plan has already made with your permission.

Your Rights Regarding The Privacy Of Your Personal Health Information

You have the following rights:

The right to request restrictions or limitations on the PHI the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. The Plan is not, however, required to agree to your request with the exception of a request for a restriction of a disclosure of PHI pertaining solely to a health care item or service for which the health care provider involved has been paid out of pocket that is for purposes of carrying out payment or health care operations (and not for the purposes of carrying out treatment).

To request restrictions, you must make your request in writing to the Plan's Privacy Officer. In your request, you must tell the Plan (1) what information you want to limit, (2) whether you want to limit the Plan's use, disclosure or both; and (3) to whom the limits apply.

The right to request to receive confidential communication of your PHI by an alternative means or at an alternative location if a disclosure of your PHI could endanger you. The request must be made in writing to the Plan's Privacy Officer and must specify the alternative location or other method of communication that you prefer (for example, using an alternate address). Your request must include a statement that the restriction is necessary to prevent a disclosure that could endanger you. The Plan does not refuse to accommodate such a request unless the request imposes an unreasonable administrative burden. If the request is granted, the documentation of your request will be placed in your record.

The right to access documents regarding your eligibility, payment of claims, appeals or other similar documents in your Designated Record Set for inspection and/or copying. If the information you request is in an electronic health record, you may request that these records be transmitted electronically. Your request for access to documents with your PHI must be in writing to the Plan's Privacy Officer. When a request for access is accepted (in whole or in part), you will be notified of the decisions and you may then inspect the PHI, copy it, or both, in the form or format requested at a time and place convenient to you and the Plan. If you would like, you may receive a summary of the requested PHI instead of your entire record, for a reasonable fee. You may also receive a copy of your PHI by mail if you prefer. (The Plan charges a reasonable, cost-based fee for copying, including labor and supplies [for instance, paper,

computer disks] and for postage if you request that the information be mailed. No fee is charged for retrieving or handling the PHI or for processing the participant's request for access.)

If a request for access is denied (in whole or in part), the Plan will grant access to PHI for which there are no grounds to deny access. The Plan will also inform you why your request for access was denied, how to appeal the denial (if the denial is reviewable), and how to file complaints with the Plan and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, the Plan will designate a licensed health care professional, not involved in the original denial decision, to serve as a reviewing official, and will notify you in writing of the reviewing official's determination.

The right to request to amend your PHI if it is inaccurate or incomplete. You may request that your PHI be amended. That request must be in writing to the Fund's Privacy Officer and include a reason why your PHI should be amended. If you do not include a reason, the Plan will not act on the request. When a request for amendment is accepted (in whole or in part), the Plan will inform you that your request for amendment has been accepted. The Plan will request from you permission to contact other individuals or health care entities that you identify that need to be informed of the amendment(s), and will inform them and other entities with whom the Plan does business who may rely on the disputed PHI to your detriment. The Plan will identify the record(s) that are the subject of the amendment request and will append the amendment to the record.

If a request for amendment is denied, you will be notified why the request was denied (e.g., the information requested was not created by the Plan, is accurate and complete, is not part of the record, or may not legally be changed such as information compiled in anticipation of a civil, criminal or administrative proceeding), how to file a statement of disagreement or a request that the Plan provide the request for amendment and the denial in any future release of the disputed PHI, and how to file a complaint with the Plan or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, the Plan may write a rebuttal statement and will provide a copy to the participant, and the Plan will include the request for amendment, denial letter, statement of disagreement, and rebuttal (if any), with any future disclosures of the disputed PHI. If you do not choose to write a statement of disagreement with the denial decision, the Plan is not required to include the request for amendment and denial decision letter with future disclosures of the disputed PHI unless you request the Plan to do so. When the Plan receives notification that your PHI has been amended, the Plan will ensure that the amendment is appended to your records, and will inform entities with whom it does business that may use or rely on your PHI of the amendment and require them to make the necessary corrections.

The right to obtain an accounting of disclosures of your PHI. The right to an accounting extends to disclosures, other than disclosures made (1) for the purposes of treatment, payment or health care operations, including those made to business associates (vendors), (2) to an individual (or personal representative) about his or her own PHI, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for national security or intelligence purposes and (8) to correctional institutions or law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to the Plan's Privacy Officer. Your request must specify a time period, which may not be longer than six (6) years. You may request and receive an accounting of disclosures once during any twelve (12) month period for no charge. If you request more than one accounting within the same twelve (12) month period, a reasonable, cost-based fee may be charged. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You also have the right to an accounting of disclosures of electronic health records for purposes of payment, treatment and health care operations. The right to such an accounting depends on whether the Plan maintains such electronic health records and, if so, when the electronic health records were acquired by the Plan and when the disclosure occurred.

The right to receive a paper copy of this Notice and any revisions to this Notice. You may request a copy of this Notice is writing to the Plan's Privacy Officer at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- a birth certificate identifying the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Legal Duties of the SEIU Michigan Health And Welfare Fund Regarding Your Health Information

The Plan is required by law to maintain the privacy of your PHI as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. If your PHI is improperly accessed, acquired, used, or disclosed, the Plan will notify you, as required by law. That notification may include a description of what happened, the information involved, and the steps you can take to protect yourself.

The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI the Plan has about you as well as any information the Plan receives in the future. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

Minimum Necessary Standard

When using, disclosing or requesting PHI, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual or pursuant to an authorization;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

Your Right To File A Complaint

You have the right to express complaints to the SEIU Michigan Health and Welfare Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the SEIU Michigan Health and Welfare Fund should be made in writing to the Fund's Privacy Officer. The SEIU Michigan Health and Welfare Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

For More Information Contact The Privacy Officer

For questions about this Notice, to exercise your privacy rights, or to file a complaint, contact the Plan's Privacy Officer, 30700 Telegraph Road, Suite 2400, Bingham Farms, MI 48025; 248-645-6550.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). "Loss of eligibility" includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It does not include a loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim. However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at 30700 Telegraph Road, Suite 2400, Bingham Farms, MI 48025.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending provider and the patient.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

If you would like more information on WHCRA benefits, contact HAP.

SOCIAL SECURITY NUMBER PRIVACY POLICY

The SEIU Michigan Health and Welfare Fund is required by Michigan law to make sure that your Social Security number and the Social Security numbers of your family members are kept private as set forth in that law.

The law permits the Fund to use Social Security numbers to verify your identity and the identities of your family members and to perform other functions related to providing health and welfare benefits under the Fund's Plan. Therefore, the Fund will continue to require Social Security numbers on application and enrollment forms. When your employer pays contributions on your behalf, the law permits your employer to provide the Fund with your Social Security number so that the Fund may determine your eligibility status. The law also permits the Fund to use Social Security numbers when authorized or required to do so by state or federal statute, by court order, or pursuant to legal discovery or process. The Fund will ensure to the extent practicable the confidentiality of those Social Security numbers.

In order to protect your privacy and in compliance with the law, the Fund's third-party administrator, TIC International Corporation ("TIC"), and other service providers will use

alternate identification numbers wherever feasible, including on monthly notices of contributions. Social Security numbers are not printed on the exterior of any envelope or package sent through the mail or in a manner that can be seen from the exterior of such envelope or package. The Fund's website is secure and permits participants to access information through use of a password other than their Social Security number.

Only TIC's employees and agents and employees and agents of other Fund service providers may access the Social Security numbers of Fund participants and family members and only as necessary to provide services to the Fund. TIC uses practical means to limit access to written and electronic records in its possession that contain Social Security numbers to those employees and agents whose job duties require such access, such as securing areas where Social Security number information is located when not in use and requiring the use of passwords for access to electronic files containing Social Security numbers. TIC disposes of documents that contain Social Security numbers that the Fund is not actively using or is not otherwise obligated to retain by shredding and other processes that protect the confidentiality of the Social Security numbers. TIC's employees and agents must not disclose Social Security numbers by publicly displaying more than four sequential digits of a Social Security number or in any other manner prohibited by law.

The Fund notifies all service providers that they must ensure, to the extent practicable, the confidentiality of all Social Security numbers related to Fund participants and their families as required by law. The Fund may take action regarding service providers who fail to protect adequately the confidentiality of those Social Security numbers, including the termination of contracts.

Service Employees' International Union

SEIU Michigan Health and Welfare Fund TIC International Corporation 30700 Telegraph Road, Suite 2400 *(Bingham Office Center--Between 12 & 13 Mile)* Bingham Farms, Michigan 48025	**248-645-6550** **Fax: 248-645-6557** **8:15 AM – 4:30 PM EST** ***Benefit Office*** **www.seiumichiganbenefits.org**
SEIU Local 1, Detroit Union Office 2211 East Jefferson Avenue, 3rd Floor *(Corner of Jefferson & Chene)* Detroit, Michigan 48207	**313-567-3900** **Fax: 313-567-3921** **9 AM – 5 PM EST** **www.seiu1.org**
SEIU Local 1, Chicago Union Office *Main Office for Local 1* 111 East Wacker Drive, Suite 1700 Chicago, Illinois 60601	**312-240-1600** **9 AM – 5 PM CST** **www.seiu1.org**
Member Resource Center *For ALL Local 1 Members (Chicago, Detroit, Ohio)* Grievances, Dues, and COPE	**877-233-8880** ***9*** **AM – 5 PM CST**
Open Enrollment **Closed Thanksgiving Weekend** *New Enrollees or* *Adding a Spouse or* *Adding a Dependent to age 26*	**November 1 – 30** **Benefits begin January 1** **www.seiumichiganbenefits.org**
SEIU National Industry Pension Fund (NIPF) 11 DuPont Circle, N.W., Suite 900 Washington, D.C. 20036-1202 *(Plan for your retirement 3-4 months in advance.)*	**1-800-458-1010** **www.seiufunds.org**

Fund Website
www.seiumichiganbenefits.org