SUMMARY PLAN DESCRIPTION

OF

EDWARD W. SPARROW HOSPITAL ASSOCIATION
MNA EMPLOYEES
HEALTH REIMBURSEMENT ARRANGEMENT

January 2021

In the case of a conflict, the Plan, and not this Summary Plan Description, will govern.

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EDWARD W. SPARROW HOSPITAL ASSOCIATION
MNA EMPLOYEES
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION

IMPORTANT NOTICE

This summary plan description describes the Plan as in effect on January 1, 2021. If you have questions about the Plan or your rights under the Plan, contact the Fund Office. However, any verbal response cannot modify or contradict the written terms of the formal documents.

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

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MNA EMPLOYEES
HEALTH REIMBURSEMENT ARRANGEMENT

IMPORTANT CONTACT INFORMATION

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If you have any questions about the Fund,
you should contact the Fund Office or the Joint Board of Trustees.

AGENT DESIGNATED FOR SERVICE OF LEGAL PROCESS

Derek L. Watkins
Watkins, Pawlick, Calati and Prifti, PC
1423 E. Twelve Mile Road
Madison Heights, Michigan 48071

Legal Process may also be served upon any Trustee or the Plan Administrator.

INTRODUCTION

To All Participants

We are pleased to provide you with this summary description of your Plan. As you read it, keep in mind that it is an effort to summarize simply the principal provisions of the formal Plan.

It 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. If there is any conflict or difference between this summary and the formal Plan, the Plan and not this summary will control.

You should read this material carefully and keep it for reference. It will help you understand how the Plan works, what rights and benefits it provides for you and how to obtain those benefits. This Summary Plan Description supersedes and replaces any Summary Plan Description previously issued by the Fund.

Each year, you will receive a summary of material modifications that will include a report of changes in the Plan made after January 1, 2021, if any material changes are made to the Plan. Like this summary, those notices are intended as a general statement of changes and are not a substitute for the Plan itself. This Summary Plan Description and other notices are also posted on the Fund's website:

http://www.sparrowmnahra.org/

That website contains useful information such as the amount of contributions received by the Fund on your behalf, information on any changes to the Plan that may be made after this Summary Plan Description and Plan are printed and access to a secure benefit inquiry site. You may receive, free of charge, a paper copy of the information on that website, or any of the formal documents identified above, by contacting the Fund Office.

No person has any vested rights to any benefit provided by the Fund, now or at any time in the future.

If you have any doubt or question about any provision of the Plan or the summary or your rights under the Plan, do not hesitate to contact the Fund Office, preferably in writing, to have your doubt or question answered. However, any verbal response cannot modify or contradict the written terms of the Plan.

Joint Board of Trustees

Teresa Znidarsic, Chairperson	Marianne George, Secretary
William Howe	Mark A. Cummings
Cindy LaFountain	Jessica Lannon
Mike Reinerth	Andrew Smith

January 2021

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DOING YOUR PART

You have certain responsibilities in order to protect your rights and eligibility for benefits from the Fund.

Read this book. You and your spouse should take the time to read this benefit book and familiarize yourselves with the eligibility and benefit rules.

When you become eligible, complete an enrollment form immediately and return it to the Fund Office.

Keep the Fund Office informed about you. Failure to make certain that the Fund Office always has current and accurate information about you and your dependents can result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that you or your dependents might otherwise reasonably expect the Fund to provide on the basis of the description of benefits in this Summary. It may further result in missed notices from the Fund Office.

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

- Change of address
- Changes in your family, such as your marriage, your child attains the age of 26, birth, adoption, any death or divorce or a child losing dependent status
- Start of disability
- Termination of disability
- Termination of your employment
- A court or the friend of the court issuing a qualified medical child support order directing that health care coverage be provided for your child(ren) through the Fund
- You or your dependent joining the armed forces of any country

Your surviving 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 that they want 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. You may be held liable for claims paid by the Fund**

Keep documents that you receive from the Fund, such as:

- **Bills and Explanations of Benefits ("EOBs").** 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.

- **Notices.** After the publication of this book, you will receive notices of benefit changes as they occur. You should keep those together with this book in order for you to have a complete record of the Fund's communications to you on your benefits. You will also receive annual notices relating to the Fund and your rights.

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

Identify yourself. When you write to or call the Fund Office, always include your name and other identifying information. 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.

Helpful Tip: When calling any provider customer service, please remember to document the date, time and name of the department of the representative you speak with. This could help locate your call should there be any discrepancies or questions in the future.

STATEMENT OF ERISA RIGHTS

As a participant in the Edward W. Sparrow Hospital Association MNA Employees Health Reimbursement Arrangement, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits.

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union hall, all documents governing the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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

Continue HRA Plan Coverage

Continue HRA Plan coverage for yourself, your spouse and dependents if there is a loss of coverage under the Plan as a result of a qualifying event and the Association had more than 19 employees during the prior year. You or your dependents may have to pay for such coverage. Please contact the Fund Office if you have questions about the rules governing your COBRA continuation coverage rights.

Reduce or eliminate exclusionary periods of coverage for preexisting conditions under the Association's major medical health insurance plan, if you have creditable coverage from another employer's major medical health insurance plan. You should be provided a certificate of creditable coverage, free of charge, from your major medical health plan or health insurance issuer when you lose coverage under the Association's major medical health insurance plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your major medical health insurance coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called Afiduciaries@ of the Plan, have a duty to do so prudently and in the interest of you and

other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's Claim and appeal procedures.

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, 211 W. Fort Street, Suite 1310, Detroit, Michigan 48226, (313) 226-7450, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), 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, (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 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 be 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.

SUMMARY PLAN DESCRIPTION

DEFINITIONS OF SOME KEY TERMS

What are the Employer and the Union?

The employer is the Edward W. Sparrow Hospital Association (Association). The Union includes both the Professional Employee Council Sparrow Hospital (PECSH) and the Michigan Nurses Association (MNA). Affiliates of the Association are not considered to be the employer.

What is the "HRA" or "Benefit Account"?

Your HRA or benefit account is a bookkeeping account used to record the portion of employer contributions attributed to you over the course of your work as an eligible employee and is adjusted over time based on certain investment earnings and losses and Plan expenses. Your benefit account is ultimately the basis on which the Fund determines whether you are eligible to be reimbursed for a qualified medical expense. Your benefit account is not segregated from the benefit accounts of others and your access to the benefits provided through your benefit account is subject to the terms of the Plan. No person has <u>any</u> vested rights to a benefit account provided by the Fund, now or at any time in the future.

What is the "Benefit Commencement Date"?

Your benefit commencement date is the earliest you, your spouse or dependents may have access to your benefit account. A benefit commencement date is any of the following: (1) the first day of the month following the date you reach normal retirement (age 55 after 5 Years of Employer Service) and stopped working in any position for the Association and each of its affiliates; (2) the first day of the month following you or your dependents Disability; or (3) your death. Your Spouse or Dependent may have their own benefit commencement date based on their disability.

What is the "CBA" or "Collective Bargaining Agreement"?

The CBA is the primary agreement under which the Plan was created and is maintained. The CBA is between the Union and the Association.

What is Covered Employment?

Covered employment is work for the Association in a job classification covered under the collective bargaining agreement between the Association and the Union. Covered employment does not include work for the Association outside of the bargaining unit or any work for an affiliate of the Association.

Who is an Eligible Employee?

An eligible employee is generally someone who is actively employed in "covered employment" as of the last pay period of the payroll year and has earned the required number of years of employer service.

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Example 1: James was hired in March of 2018 to work in covered employment. Because he was hired after January 1, 2018. He must earn five years of uninterrupted years employer service to become an Eligible Employee. Assume he continues to work in covered employment from the date he was hired in 2018 through the last payroll period of 2022 and earned a year of service in each of 2018, 2019, 2020, 2021 and 2022. Because he earned his fifth year of service in 2022, he became an Eligible Employee.

What does it mean to be Disabled or have a Disability?

Under the Plan, you are considered to be disabled or have a disability if you are eligible for and receiving Long Term Disability benefits from the Association. Your spouse or dependent is considered to be disabled or have a disability if they are receiving Social Security Administration Disability benefits. Under the Plan, the Fund does not make its own medical determinations regarding your disability, but, rather, relies on determinations that are made when you access other benefits.

Who is considered a Spouse or Dependent under the terms of the Plan?

Your Spouse is the person who is legally married to you as determined under applicable State law and who is treated as a spouse under the Internal Revenue Code; provided, however, your spouse does not include a person legally separated from you under a judgment of divorce or separate maintenance. Your Dependent(s) is generally, a relative you claim as a dependent in your annual tax filing (it includes any individual who would be a dependent under the Internal Revenue Code Section 152).

What are Paid Hours?

Paid Hours are the number of hour(s) for which an eligible employee is paid, or entitled to payment, for covered work and hour(s) for which back pay, irrespective of mitigation of damages, is awarded or agreed to by the Association, to the extent such award or agreement is intended to compensate the eligible employee for periods during which the eligible employee would have been engaged in covered work (such hour(s) to be credited to the Plan Year or Plan Years to which the award or agreement for back pay pertains). Paid Hour(s) also include hour(s) for which an eligible employee is paid but for which no work was performed (such as paid sick leave, paid vacation or comp time) attributable to Covered Work.

What is a "Break in Service"?

A Break in Service occurs if you do not return to covered employment within one hundred and eighty (180) days of voluntarily or involuntarily terminating employment with the Association or remaining employed with the Association but moving to a position that is not in covered employment.

Example 2: Similar to **Example 1** above, James was hired in March of 2018 to work in covered employment. He earned a year of service in each of 2018, 2019, 2020, and 2021; however, after working more than 1,000 hours in 2022, James was not employed in covered

employment during the last payroll period of 2022. He is later hired back into covered employment in 2024. Because he did not earn a fifth year of service in 2022 he did not become an Eligible Employee. Because he was not working in covered employment at all during 2023 (more than 180 days) he suffered a Break in Service and forfeit the prior years of service he earned.

What is a "Year of Employer Service"?

A year of employer service has two different meanings depending on when you worked. For work on or after January 1, 2018, it means a payroll year in which the individual worked at least 1,000 hours and is actively employed as of the last pay period of the payroll year in a job classification covered under the collective bargaining agreement between the Association and the Union without having terminated, voluntarily or involuntarily, your employment with the Association or moving to a position outside of covered employment for a period of more than one hundred and eighty calendar days. Such an interruption is known as a "Break in Service". No type of employment with an affiliate of the employer will be counted toward the 1,000 hours requirement or prevent a break in service. If you earn less than five years of employer service before a break in service, those years will be disregarded in any calculation following your later return to covered employment.

Prior to January 1, 2018, a year of employer service has a similar meaning, but any type of employment with the Association or one of its affiliates would have prevented a break in service.

Example 3: Carla worked 1,800 hours during 2019. She was also an active employee during the last payroll period of 2019. She did not terminate her employment with the Association at any time during 2019. Because she worked 1,000 hours or more and was an employee during the last payroll period of 2019, she earned a Year of Employer Service for her work in 2019.

What are "Uninterrupted Years of Employer Service"?

Uninterrupted years of employer service are the number of years of employer service you have earned since your most recent date of hire into covered employment without interruption by a break in service; or, without having terminated, voluntarily or involuntarily, your employment with the Association or moving to a position outside of covered employment for a period of more than one hundred and eighty (180) calendar days.

Example 4: Assume the same fact as **Example 3** above; however, Carla terminates her work in covered employment on January 1, 2020 and goes to work for an affiliate of the Association. On July 6, 2020, Carla returns to covered employment for the Association. Because she worked outside of covered employment for more than 180 days, she has suffered a Break in Service. July 1, 2020 is her new date of hire. She works 1,000 hours in the remaining months of 2020 and is employed in covered employment during the last payroll period of 2020. She will have earned a Year of Employer Service for her work in 2020, but her 2019 Year of Employer Service is forfeit as a result of her Break in Service and she only has one Uninterrupted Year of Employer Service.

Who is an Eligible Retiree?

An Eligible Retiree is an eligible employee who has earned at least five years of employer service and reached the date they would be eligible to become a Participant. Generally, the date you terminate your employment at or after age 55 and have five years of employer service, or the date you are determined to be disabled under the terms of the Plan.

Who is an Inactive Eligible Employee?

An inactive eligible employee is one who has earned five years of employer service, but is no longer working in covered employment and not yet eligible to become a participant. Your benefit account, if any, is not forfeit, but you will not be able to access it until after you reach age 55 or are determined to be disabled and submit a completed enrollment form. During that period, you should keep the Fund informed of your current address so that you can continue to receive updates regarding the Plan and any changes that may impact your right to benefits.

> **Example 5**: Clara was hired in March of 2018 to work in covered employment and continued to work in covered employment through the last payroll period of 2022. She earned a year of service in each of 2018, 2019, 2020, 2021 and 2022; however, after working more than 1,000 hours in 2023, Clara moved out of covered employment and was not employed in the last payroll period of 2023. Because she earned her fifth year of employer service in 2022 she became an Eligible Employee. When no year of employer service was recognized in 2023, she became an Inactive Eligible Employee as a result.

Who is a Former Employee?

A Former Employee is one who has earned less than five years of employer service and is no longer working in covered employment. A former employee forfeits their benefit account and is no longer connected to the Plan.

> **Example 6**: Cecilia was hired in March of 2016 to work in covered employment and continued to work in covered employment through the last payroll period of 2019. She earned a year of service in each of 2016, 2017, 2018, and 2019. Cecilia left work in covered employment to work for an affiliate of the Association on January 1, 2020. On July 6, 2020, Cecilia returns to covered employment for the Association. Because she worked outside of covered employment for more than 180 days, she has suffered a Break in Service. Because she has not earned five years of employer service, she becomes a Former Employee and her benefit account is forfeit. Her new hire date will be July 1, 2020 and she will remain a Former Employee until she qualifies as an Eligible Employee again. Even if she qualifies as an Eligible Employee again, her prior benefit account will remain forfeit.

PARTICIPATION AND ELIGIBILITY

Who may become a participant?

Inactive Eligible Employees and Eligible Employees who have reached their benefit commencement date before having a Break in Service may become participants. If you are actively

employed by the Association in covered employment during the last pay period of the payroll year, you may become an Eligible Employee. For those hired into such employment before January 1, 2018, you need to earn one year of employer service by the last day of the payroll year to become an eligible employee. If you were hired on or after January 1, 2018, you need to have earned at least five years of employer service as of the last day of the payroll year to become an eligible employee.

When and How do I become a participant (initial eligibility)?

If you are an Inactive Eligible Employee or Eligible Employee described above, have completed at least five years of employer service and have a positive benefit account balance, you are eligible to become a participant on 1) the first day of the month following your termination of any employment with the Employer, including any of its affiliates, and retirement (at age 55 or later) or 2) the first day of the month following the date you are determined to be disabled.

Upon meeting the eligibility criteria, **you must submit a completed enrollment form in order to become a participant.** You will not become a participant sooner than the first day of the month following the month in which your completed enrollment form has been received by the Fund. If the Fund Office does not have this information, you cannot receive benefits, even if you otherwise meet the eligibility requirements for benefits to commence.

It is important to know that this is a retiree-only Plan. Only retirees (based on age or disability) can be participants. **No current employee can receive benefits from the Plan.**

Before your benefit commencement date, you are not considered a participant because you cannot submit reimbursable medical expenses for reimbursement.

The eligibility rules represent the requirements which must be satisfied for you and your dependents to become, and to remain eligible for benefits from this Plan. In the event the requirements are not satisfied, eligibility is lost and benefits are not payable. The Joint Board reserves the right to deny benefits to any claimant who is, in its sole and exclusive determination, attempting to subvert the purpose of the Plan or who does not present a bona fide claim. This includes the right to retroactively terminate any claimant as a result of fraud or an intentional misrepresentation of a material fact.

What does it mean to be a Participant?

While you are a participant, you will be able to submit qualified medical expenses for reimbursement. You are not considered a participant under the Plan until you meet the eligibility requirements noted above to have access to your benefit account.

It is important to note that if your Spouse or Dependent is eligible as your beneficiary due to their own disability, you are not a participant in the plan and cannot have your qualified medical expenses reimbursed. The benefit account is available only for your Spouse or Dependent's qualified medical expenses.

How do I continue my Participation in the Plan (continuing eligibility)?

You will remain a participant for so long as you have a positive balance in your benefit account and your participation is not otherwise ended under the terms of the Plan.

To ensure your participation is not interrupted you should keep the Fund Office informed of your current address, whether you have returned to work for the Association and other pertinent information. Failure to make certain that the Fund Office always has current and accurate information about you and your dependents can result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that you or your dependents might otherwise reasonably expect the Fund to provide on the basis of the description of benefits in this Summary.

How does my participation in the Plan end (termination of eligibility)?

Your participation can end for various reasons. Generally, it will end when you exhaust your benefit account, but it can also end if you are: 1) reemployed in any capacity by the Association or one of its affiliates; 2) you opt out of the Plan; 3) your benefit account balance is forfeit; 4) the Plan is modified or terminated; or 5) if your participation is based on disability, you are no longer disabled.

Your participation may be continued as required by applicable law (which may include the continuation coverage rules of COBRA and FMLA, and the qualified military service rules of USERRA) or unless otherwise provided in the Plan.

It is important to remember the Plan is continued subject to the right of the Association and the Union to bargain a modification or termination or the right of the Joint Board to modify or terminate the Plan. Those parties have reserved the right, at any time, to modify, amend or terminate any existing or future benefit or condition of eligibility or any other term or condition of the Plan.

Once my participation terminates, can I become a participant again?

You may be eligible to become a participant again, but it depends on why your participation ended and what you do after it ends.

If your participation terminated because you exhausted your benefit account, your participation in the Plan ends and you generally will not become a participant again. However, if you become an eligible employee again and have contributions remitted on your behalf you may become a participant again.

If your participation terminated because you were reemployed in any capacity by the Association or one of its affiliates and you did not exhaust your benefit account, you may become a participant again on 1) the first day of the month following your termination of any employment with the Association, including any of its affiliates, and retirement (at age 55 or later) or 2) the first day of the month following the date you are determined to be disabled. **You must submit a new completed enrollment form in order to again become a participant.** You will not become

a participant sooner than the first day of the month following the month in which your new completed enrollment form has been received by the Fund Office.

> **Example 7**: Jim has worked in covered employment earning 20 years of employer service. When he reached the age of 60 and stopped working for the Association, he submitted a completed enrollment form and began to submit reimbursement requests for qualified medical expenses. He later returned to work for an affiliate of the Association and his access to his benefit account was terminated. After a few months of work, he again stops working for the affiliate and submits a new completed enrollment form. He will again have access to his benefit account beginning the first of the next month.

If your participation terminated because you opted out of the Plan, you will not become a participant again until a subsequent Plan Year where you have opted back into the Plan. You may only opt back into the Plan during a subsequent Open Enrollment Period when you are otherwise eligible to be a participant or if you meet the requirement for a special enrollment. Special enrollments allow you to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for other coverage. However, you must request enrollment within 30 days after your or your dependents' other coverage ends. 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 in the Plan, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Contact the Fund Office, to request special enrollment or obtain more special enrollment information.

Special enrollment rights have also been added to the Plan by the Children's Health Insurance Program Reauthorization Act of 2009. If you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in the Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided, coverage ends.

In addition, if you have declined enrollment in the Plan for yourself or your dependents (including a spouse), and later become eligible for state assistance through a Medicaid or Children's Health Insurance Program that provides help with paying for Plan coverage, then there may be a right to enroll in the Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

If your participation terminated because your benefit account was forfeit, you would not become a participant again. Forfeiture of a participant's benefit account currently occurs when the participant passes away and is not survived by a Spouse or Dependents.

If your participation terminated because the Plan was terminated or modified, whether you can become a participant again would depend on the modification.

If your participation terminated because you were no longer disabled, but did not exhaust your benefit account, you may become a participant again on 1) the first day of the month following your termination of any employment with the Association, including any of its affiliates, and retirement (at age 55 or later) or 2) the first day of the month following the date you are determined

to be disabled again. **You must submit a new completed enrollment form in order to become a participant.** You will not become a participant sooner than the first day of the month following the month in which your new completed enrollment form has been received by the Fund.

Can my Spouse or Dependent participate in the Plan?

Neither your Spouse nor your Dependents can be participants in the Plan; however, they can receive benefits through your benefit account. When you are a Participant, you may submit reimbursable medical expenses of your Spouse and Dependents. In addition, if your Spouse or a Dependent becomes disabled (they are receiving Social Security Administration Disability benefits) they may gain access to your benefit account for their reimbursable medical expenses. It is important to note that you may not submit your reimbursable medical expenses when access to your benefit account is based on the disability of your Spouse or Dependent. Finally, if you pass away and are survived by your Spouse or Dependent, they may gain access to your benefit account for their reimbursable medical expenses.

> **Example 8**: Judy worked in covered employment earning 10 years of employer service. Her husband began receiving Social Security Disability benefits. Judy's husband submitted a completed enrollment form and began to submit reimbursement requests for his qualified medical expenses. None of the requests included Judy's qualified medical expenses.

BENEFIT ACCOUNT

How do I accrue an HRA or benefit account?

You accumulate an HRA or benefit account based on employer contributions remitted during a payroll year where you previously qualified as an eligible employee. As a reminder, if you were hired after January 1, 2018, you must have five uninterrupted years of employer service to have contributions remitted on your behalf.

> **Example 9**: Similar to **Example 1** above, James was hired in March of 2018 to work in covered employment and continued to work in covered employment through the last payroll period of 2022. He earned a year of service in each of 2018, 2019, 2020, 2021 and 2022. He earned a fifth year of service in 2022 and will be an Eligible Employee. He continues working in covered employment for more than 1,000 hours in 2023 and is employed in covered employment during the last payroll period of 2023. Employer contributions will be made on his behalf for the first time for work he performs in 2023.

> **Example 10**: Similar to **Example 1** above, James was hired in March of 2018 to work in covered employment and continued to work in covered employment through the last payroll period of 2022. He earned a year of service in each of 2018, 2019, 2020, 2021 and 2022; however, after working more than 1,000 hours in 2023, James was not employed in the last payroll period of 2023. He is later hired back into covered employment in 2024 and worked more than 1,000 hours in that year. Because he earned a fifth year of employer service in 2022 he became an Eligible Employee. No year of service was recognized in 2023 and he became an Inactive Eligible Employee as a result. Although he earned a year

of service in 2024, he must earn four additional continuous years of service before contributions can be made to the Fund on his behalf in a future year.

Your benefit account is also based on an allocation of certain investment gains and losses, Plan expenses and the forfeitures of other benefit accounts. Each of these is allocated based on the terms of the collective bargaining agreement.

Employer contributions are allocated based on your uninterrupted years of employer service. Eligible employees receive an allocation based on which of three tiers they are in: 1) 1-9 years of employer service; 2) 10-14 years of employer service; and 3) 15 or more years of employer service. Your allocation is based on the total employer contribution for your tier and the number of paid hours you and others in that tier worked.

Investment gains and losses, after accounting for Plan expenses, are allocated based on the relevant measuring period, generally a Plan Year. Any earnings remaining after covering Plan expenses, or losses including Plan expenses are allocated pro rata, or on such other basis as the Joint Board determines, to eligible employees and inactive eligible employees who are not yet eligible retirees. A pro rata allocation means the portion of the investment gains or losses allocated is based on the then current value of your benefit account and its relation to each other applicable benefit account. Net investment gains or losses are not allocated to the benefit accounts, if any, of an eligible retiree, a participant, or a former employee. Allocations are made during the 90 day period following the Fund's receipt of employer contributions, or such other date determined by the Joint Board. The total assets of the Fund are invested in accordance with the terms of the Trust Agreement and monitored by the Joint Board with assistance from an investment consultant.

Plan expenses generally include, but are not limited to, administrative fees and expenses owing to any third party administrative service provider, investment consultant, accountant, attorney, specialist, or other person or organization that may be employed by the Joint Board in connection with the administration of the Plan and Trust, and are paid solely from Trust assets. When there are no investment gains, or the investment gains are insufficient to cover all Plan expenses, the Plan expenses, or remaining unpaid expenses, are allocated the same as investment losses. Allocations are made at the same time investment earnings or losses would be allocated, or such other date determined by the Joint Board. The Association is not required to pay any Plan expense, the Association's sole financial obligation under the Plan and Trust is to make the contributions that are required by the Collective Bargaining Agreement.

Forfeitures of other's benefit accounts are allocated on a pro rata basis to the benefit accounts of eligible employees with fifteen or more years of employer service. Unlike the pro rata allocations above, this pro rata allocation is based on the relation of the ***paid hours*** of each eligible employee with fifteen or more years of service as of the end of the prior payroll year, ***not the relative values of their benefit accounts***. Allocations are generally made around the same time as the allocation of investment gains and losses, or such other date as determined by the Joint Board.

Your benefit account is not allocated investment earnings or losses, Plan expenses or forfeiture allocations while you are a Participant and, therefore, the value will not increase while you are using your benefit account to reimburse reimbursable medical expenses. It only goes down based on the amount you are reimbursed.

In the case of a conflict, the Plan, and not this Summary Plan Description, will govern.

Is there any limit to the benefit account I can earn?

No, currently the Plan does not limit the value of the benefit account you can earn.

Once I earn a benefit account, can it be lost or forfeit?

Yes. First, no person has any vested rights to a benefit account provided by the Fund, now or at any time in the future. Your benefit account value may be modified by the termination or amendment of the Plan or a change negotiated in the collective bargaining agreement.

If you become a Former Employee, you will forfeit your benefit account. (Former Employees forfeit their benefit account upon termination from covered employment, voluntarily or involuntarily, if the termination occurs before earning five years of employer service.) If you die and have no surviving Spouse or Dependent(s), your benefit account will be forfeit. If your surviving Spouse or Dependent(s) die and you do not have any other remaining Spouse or Dependent(s), your benefit account will be forfeit. Once a forfeiture occurs, the benefit account will not be reinstated unless the forfeiture occurred in error.

If you terminate covered employment (voluntarily or involuntarily) after you have earned five years of employer service, your benefit account is not forfeit, but you will not be able to access it until after you reach age 55 and terminate employment with the Association and all of its affiliates, or are determined to be disabled, and submit a completed enrollment form. During that period, you should keep the Fund informed of your current address so that you can continue to receive updates regarding the Plan and any changes that may impact your right to benefits.

> **Example 11**: Juan began working in covered employment during 2011. In 2017, he left that employment to work for an affiliate of the Association. He has not returned to covered employment since he left. During the period he worked in covered employment, he earned five Years of Employer Service. Under the Plan, based on the changes that became effective January 1, 2018, he will become and continue to be an Inactive Eligible Employee and will not forfeit his benefit account whether he continues to work for the affiliate of the Association or leaves to work for another unrelated employer. However, note that if Juan again returns to covered employment with the Association, even though he has not forfeit his benefit account, he will need to have five uninterrupted years of employer service before additional contributions can be remitted on his behalf.

> **Example 12**: Assume the same facts as **Example 11** above, but Juan did not start working in covered employment until 2015 and he earned two, not five, years of service by the time he left covered employment to work for an affiliate of the Association in 2017. He did not return to covered employment on or before June 30, 2018 (180 days); so, he became a Former Employee and the contributions previously made on his behalf were forfeit.

Finally, your benefit account is reduced by an amount equal to each reimbursable medical expense which is approved and paid by the Plan.

BENEFITS AND CLAIMS

What benefits does the Fund provide?

The Fund provides for the reimbursement of certain qualified medical expenses following your retirement or disability, or, if your Spouse or Dependent becomes disabled, their qualified medical expenses.

Under what circumstances will I be eligible for benefits?

Generally, in order to be eligible for benefits you must stop working for the Association and any of its affiliates, meet the benefit commencement rules to become a Participant, and have a benefit account sufficient to cover the reimbursable medical expense for which you are applying. The benefit commencement rules are tied to your retirement at or after age 55 or disability.

When will I be eligible for benefits based on retirement?

You must stop working for the Association and its affiliates, reach the age of 55, earn at least five years of employer service, and submit a completed enrollment form. Then, beginning the first of the next month, you may submit documents supporting your reimbursable medical expenses on a monthly basis for approval by the Fund Office.

When will I be eligible for benefits based on disability?

You must stop working for the Association and its affiliates, be eligible for and receiving Long Term Disability benefits provided under the collective bargaining agreement, earn at least five years of employer service, and submit a completed enrollment form. Then, beginning the first of the next month, you may submit documents supporting your reimbursable medical expenses on a monthly basis for approval by the Fund Office.

How often can I receive benefits?

You may submit requests for benefits monthly. Claims must be submitted no later than March 31 of the year following the year in which it was incurred. The Joint Board may adopt rules regarding minimum monthly reimbursement benefits that will be paid to any one individual in any one month, but currently have not done so.

How much are the benefits?

Each benefit paid is equal to the substantiated reimbursable medical expense submitted.

Does the Plan limit my choice of provider?

No; under the Fund's Plan you have the free choice of any provider as it will reimburse any qualified medical expense.

Does the Plan provide a death benefit?

No cash death benefit will be paid from the Plan after your death; however, if amounts are available in your benefit account after your death, then your surviving Spouse and Dependents may in some circumstances, be eligible to submit claims for eligible medical expenses for reimbursement from your benefit account until the account balance is reduced to zero.

What are qualified or reimbursable medical expenses?

Qualified or reimbursable medical expenses are those that would generally qualify for a tax deduction for medical and dental expenses. Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and for the purpose of affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes. They don't include expenses that are merely beneficial to general health, such as vitamins or a vacation. These are explained in IRS Publication 502, Medical and Dental Expenses. Following is a summary of some specific expenses eligible for reimbursement from your Medical Reimbursement account, as listed in Publication 502:

- Acupuncture.
- Alcoholism inpatient treatment at a therapeutic center, including meals and lodging provided by the center during treatment and transportation expenses to and from Alcoholics Anonymous meetings in your community if the attendance is pursuant to medical advice that membership in Alcoholics Anonymous is necessary for the treatment of a disease involving the alcoholism.
- Ambulance.
- Artificial limbs.
- Artificial teeth.
- Birth control pills prescribed by a doctor.
- Braille books and magazines for use by a visually impaired person, limited to the cost that is more than the cost of regular printed editions.
- Breast pumps and supplies that assist lactation.
- Breast reconstruction surgery following a mastectomy for cancer.
- Capital expenses paid for special equipment installed in a home, or for improvements, if the main purpose is medical care for you, your Spouse or your dependent. See IRS Publication 502 for more detailed information.
- Car improvements, such as special hand controls and other special equipment installed in a car for the use of a person with a disability.
- Chiropractor medical care.
- Christian Science Practitioner medical care.
- Contact lenses needed for medical reasons, including the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner.
- Crutches, including purchase or rental.
- Dental treatment for the prevention and alleviation of dental disease.

- Preventive treatment includes services of a dental hygienist or dentist for procedures such as teeth cleaning, application of sealants and fluoride treatments to prevent tooth decay.
- Treatment to alleviate dental disease include services of a dentist for procedures such as X-rays, fillings, braces, extractions, dentures and other dental ailments.
- Diagnostic devices used in diagnosing and treating illness and disease.
- Disabled dependent care expenses. However, these expenses may qualify as medical expenses and work-related expenses for a credit for dependent care; you cannot apply for a credit if you are reimbursed for these costs as a medical expense.
- Eye or vision correction surgery to treat defective vision, such as laser eye surgery or radial keratotomy.
- Eyeglasses needed for medical reasons, including fees paid for eye examinations, such as optometrist fees.
- Fertility enhancement procedures to overcome an inability to have children, including:
- Procedures such as in vitro fertilization, temporary storage of eggs or sperm; and
- Surgery, including an operation to reverse prior surgery that prevented the person from having children.
- Guide dog or other service animal costs related to buying, training and maintaining a guide dog or other service animal to assist a visually-impaired person, hearing-impaired person or a person with other physical disabilities.
- Health institute fees you pay for treatment if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment.
- Health Maintenance Organization (HMO) amounts to entitle you, your Spouse or a dependent to receive medical care from the HMO.
- Hearing aids and batteries to operate them.
- Home care.
- Hospital services when receiving inpatient care at a hospital or similar institution if the main reason for being there is to receive medical care, this includes meals and lodging.
- Insurance premiums for policies that cover medical care; certain restrictions apply (see IRS Publication 502). These premiums may include:
- Employer-sponsored health insurance plan premiums that are included in box 1 of your Form W-2, Wage and Tax Statement.
- Medicare A premiums if you are not covered under Social Security (or were not a government employee who paid Medicare tax) and you voluntarily enroll in Medicare A.
- Medicare B premiums.
- Prepaid insurance premiums, under specific circumstances.
- Intellectually and developmentally disabled individual special home costs; certain restrictions apply (see IRS Publication 502).
- Laboratory fees.
- Lactation expenses.
- Lead-based paint removal costs to prevent a child who has or had lead poisoning from eating the paint; certain restrictions apply (see IRS Publication 502).

- Long-term care services and premiums for qualified long-term care insurance contracts; certain restrictions apply (see IRS Publication 502).
- Meals at a hospital or similar institution if a principal reason for being there is to get medical care.
- Medical conference expenses for admission and transportation to a medical conference if the medical conference concerns the chronic illness of yourself, your Spouse or your dependent; certain restrictions apply (see IRS Publication 502).
- Medical information plan expenses relating to a plan that keeps medical information in a computer data bank and retrieves and furnishes the information upon request to an attending physician.
- Medical supplies, such as bandages.
- Nursing home, home for the aged or similar institution expenses for yourself, your Spouse or your dependents, including meals and lodging in the home if a principal reason for being there is to get medical care.
- Nursing services, such as giving medication or changing dressings, as well as bathing and grooming the patient. These services can be provided in your home or another care facility. Certain restrictions apply (see IRS Publication 502).
- Physical examination (annual) and diagnostic tests by a physician. You do not have to be ill at the time of the examination.
- Pregnancy test kit.
- Prescribed medicines and drugs.
- Prosthesis.
- Psychiatric care, including the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care.
- Psychoanalysis.
- Psychologist medical care.
- Special education, learning disabilities and tuition paid on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments, including nervous system disorders. Certain restrictions apply (see IRS Publication 502).
- Sterilization (a legally performed operation to make a person unable to have children).
- Stop-smoking programs, not including drugs that do not require a prescription, such as nicotine gum or patches, which are designed to help stop smoking.
- Substance abuse inpatient's treatment at a therapeutic center, including meals and lodging at the center during treatment.
- Surgery or operations that are legal and not for unnecessary cosmetic surgery.
- Telephone special equipment that lets a hearing-impaired person communicate over a regular telephone, including teletypewriter (TTY) and telecommunications device for the deaf (TDD) equipment as well as the cost of repairing the equipment.
- Television equipment that displays the audio part of television programs as subtitles for hearing-impaired persons. This may be the cost of an adapter that attaches to a regular set. It also may be the part of the cost of a specially equipped television that exceeds the cost of the same model regular television set.
- Therapy received as medical treatment.

- Transplants when you are a donor or a possible donor of a kidney or other organ, including transportation and expenses you pay for the medical care of a donor in connection with the donating of an organ.
- Transportation primarily for, and essential to, medical care; certain restrictions apply (see IRS Publication 502).
- Vasectomy.
- Weight-loss programs to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension or heart disease). This may include membership fees in a weight reduction group as well as fees for attendance at periodic meetings. In general, this does not include diet food or beverages; however, some exceptions may apply. See IRS Publication 502 for more detailed information.
- Wheelchairs or autoettes used mainly for the relief of sickness or disability, and not just to provide transportation to and from work. The cost of operating and maintaining the autoette or wheelchair is also an Eligible Expense.
- Wig costs purchased on the advice of a physician when hair is lost from disease.
- X-rays for medical reasons.

What are examples of things that do not qualify as reimbursable medical expenses?

The following are some items that are not qualified or reimbursable medical expenses:

- Expenses incurred before you became a Participant in the Plan.
- Babysitting, childcare and nursing services for a normal, healthy baby, even if the expenses enable you, your Spouse or your dependent to get medical or dental treatment. Also, any expense allowed as a childcare credit cannot be treated as an expense paid for medical care.
- Controlled substances that are in violation of federal law (even if legalized by state law).
- Cosmetic surgery or procedures that are not necessary, including any procedure that is directed at improving appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease, such as face lifts, hair transplants, hair removal (electrolysis), teeth whitening and liposuction. (Medical expenses for cosmetic surgery necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease may be eligible).
- Dancing lessons, swimming lessons, etc., even if recommended by a doctor or for improvement of general health.
- Diaper service or diapers (unless needed to relieve the effects of a particular disease).
- Funeral expenses.
- Future medical care (including medical insurance) to be provided substantially beyond the end of the year (unless future care is purchased in connection with obtaining covered lifetime care or long-term care.
- Health club dues, amounts paid to improve one's general health or relieve physical or mental discomfort not related to a particular medical condition or membership

costs for any club organized for business, pleasure, recreation or other social purpose.

- Household help costs, even if recommended by a doctor. (Certain expenses paid to a person providing nursing-type services or certain maintenance or personal care services provided for qualified long-term care may be reimbursable.)
- Illegal operations, treatments or controlled substances, whether provided or prescribed by licensed or unlicensed practitioners.
- Insurance premiums, except as specifically provided otherwise as reimbursable.
- Maternity clothes.
- Medicines and drugs brought in (or ordered shipped) from another country, unless imported legally. (A prescribed drug purchased or consumed in another country may be reimbursable if the drug is legal in both the other country and the United States.)
- Non-prescription drugs and medicines, except insulin (while prescription copayments are eligible expenses, non-prescription, over-the-counter medications are not eligible for reimbursement).
- Nutritional supplements, vitamins, herbal supplements, natural medicines, etc. unless recommended and prescribed by a medical practitioner as treatment for a specific medical condition diagnosed.
- Personal use items ordinarily used for personal, living or family purposes unless it is primarily to prevent or alleviate a physical or mental defect or illness.
- Veterinary fees.
- Weight loss programs to improve appearance, general health or sense of well-being; this includes diet food or beverages that substitute for what is normally consumed to satisfy nutritional needs. (Weight loss treatment for a specific disease diagnosed by a physician, such as obesity, hypertension, or heart disease, may be reimbursable).
- Expenses reimbursable from other sources. You cannot be reimbursed for amounts that are reimbursable from other sources, such as:
    - Amounts that are fully covered or reimbursed by another insurance policy or plan.
    - Amounts that are fully reimbursed by a flexible spending account if you contribute a part of your income on a pre-tax basis to pay for the qualified benefit;
    - Any payment or distribution for medical expenses out of a health savings account (contributions to health savings accounts may be deducted separately);
    - Expenses paid for with a tax-free distribution from an Archer Medical Spending Account (MSA) to which you contribute; and
    - Amounts paid for health insurance used to figure any Health Coverage Tax Credit.
    - Amounts paid or payable under any Federal or State accident plan.

What if I receive a benefit, but don't cash the check or lose the check?

If any benefit payment to you from the Fund is unclaimed for a period of two years, it will revert to and become part of the Fund. Therefore, it is important for you to contact the Fund Office immediately if you lose a benefit payment.

What if I receive a benefit for which I am not eligible?

If it is determined that any benefit paid under the Plan should not have been paid for any reason, the amount of the overpayment must be returned by you to the Fund. If you fail to make the repayment after being requested to do so, you may be disqualified from receiving any further or future benefits until the repayment has been completed. The Joint Board also reserves the right to recover benefits improperly paid to you by all legal means, including offsetting the amount against future benefit payments or litigation.

FUNDING, ADMINISTRATION, CLAIMS, APPEALS AND OTHER MATTERS

How is the Fund financed?

The Fund is financed through employer contributions based on the collective bargaining agreement, and income from investments.

Is there any way I can be sure that the proper contributions are being made to the Fund on my behalf?

The Fund's auditor reviews the annual employer contribution and its allocation. It is your responsibility to keep permanent records of your employment, including your pay stubs, and other information that proves you worked and for how many hours, so that the Fund will have the information necessary to grant you the benefits to which you are entitled.

May I assign, pledge or sell my right to benefits?

No. Your benefits cannot be assigned, pledged or sold to anyone, or used as security for a loan by you. However, the IRS, the State of Michigan, the Friend of the Court, and any judgment creditor may levy or garnish benefits currently being paid to you, which the Fund must honor.

Who administers the Plan?

The Plan is administered by its Joint Board, which has hired TIC International Corporation to run the Plan on a day-to-day basis. The address and phone number of the Fund Office appear at the front of this booklet.

One word of caution: no one, not Union officials, employers or individual Trustees, has the authority to speak for the Joint Board regarding the rules or benefits of the Fund, except the full Joint Board.

How do I apply for benefits?

First, you must submit a completed enrollment form to become a Participant.

Once you are a participant, claims for benefits under the Plan must be submitted to the Fund Office in writing by you (or your authorized representative) using a reimbursement request form. You will also be required to submit documents that support your claim such as an Explanation of Benefits provided by another plan that covered a portion of the expense.

An enrollment form and reimbursement form can be obtained from the Fund's website or the Fund Office.

You can contact the Fund Office for additional copies of the necessary forms or for assistance in submitting your claims. You can also use the Fund's website to submit claims.

How do I access the Fund's website?

You may log on to the Fund's website at http://www. sparrowmnahra.org to view and print plan documents, forms, submit claims and obtain other useful information.

In order to realize the best compatibility with website documents, we recommend that you confirm you are using the latest version of your preferred web browser and have the latest version of Adobe Acrobat Viewer.

You may also view your own personal account information via the secured Benefit Inquiry Site (BIS). The BIS will allow you to verify that the Fund has accurate personal information about you and your family. In addition, you can check the Fund's records for up-to-date information regarding employer contributions made in your behalf.

How do I login and create an account on the Fund's website?

To login and create your own BIS account, follow these instructions:

- Go to http://www.sparrowmnahra.org
- Click on the desired Plan link at the top of the page, i.e. Health Care Reimbursement
- Click on the Current Benefit Status link. (This will open either a new web browser window or tab, depending on how your web browser is configured.)
- In the ID field, type your numeric Social Security Number, using no hyphens or spaces.
- During your initial login, use the Fund's generic password: 7M3D6YB
- Click on the Login Button.

On the Welcome New Participants screen, you will be prompted to enter identifying information, create a password hint question and answer, as well as a new password for future logins. Example:

- First Name: John
- Last Name: Smith

- Middle Initial: I
- Mother Maiden Name: Jones
- New Password:(You must create this password using 8-15 characters, using no dictionary words and should be a mix of the following characters: Lower-case letters, upper-case letters, numbers and special characters such as !@#$%"&*(){}[]. Don't use the generic password.)
- Confirm New Password: (You must enter your new password just as you did above.)
- Secret Question: Who was my 1st grade teacher (You must choose a question to enter here.)
- Answer: Michalson (We recommend a one-word answer, so you can answer the question identically to how it was originally entered, in case you ever lose or forget your password.)

After entering the above information, click the Sign-Up Button and you will be returned to the original login screen.

To sign in once your account has been created, type your numeric Social Security Number in the ID field and then use the new password you created in the steps above.

Click on the Login Button and you will be taken to the Employee Menu.

Note: In the event that you forget your password, click on the Forgot Password link on the main Sign On screen. You will then be prompted for your Name and SSN#. Click the Submit button and your browser will return your secret question to you. Enter the answer exactly as you typed it in when you set up your password. Once again, click on submit, and if you have entered the correct response, your password will be displayed on the next screen.

If you have any difficulties logging in, please do not hesitate to contact Jamie Kline (517-327-2149) or Greg Smith (517-327-2148) in the Fund Office.

How do I submit claims on the Fund's website?

Once you have logged into the Fund's web site, select "Current Benefit Status" under Health. This will open the Benefit Inquiry Site. You will need to sign in using your Social Security number and password. On the BIS, under the Employee Menu, you will select "Claim File Uploads". In order to submit your claims through the website, you will first need to scan the claims. Once the claims have been scanned to your own system and you have verified their legibility, simply use the browse button and locate your claim files on your system and select them. Be sure to print and sign the Reimbursement Request Form and include it with your uploaded files. Once everything is ready to send, we recommend entering your email address into the field above the Upload area and then when you select the "Upload Claim Files" button, your claim will be sent to the Fund Office and you will receive confirmation and a transaction number indicating that the claim file load was successful.

Are there any other rules related to the requirement to submit an application for benefits?

Not currently; however, the Joint Board may establish additional rules and regulations governing the application for benefits and may require participants to sign such statements or affidavits as the Joint Board, in its sole and absolute discretion, deems appropriate.

In the case of a conflict, the Plan, and not this Summary Plan Description, will govern.

In addition, if in your application for benefits from the Fund, or in your response to any request by the Fund for information, you make any statement which you know or believe to be false, omit any material fact known to you, or fail to correct any information you previously furnished to the Fund immediately upon your discovery of its falsity or incompleteness, your benefits will be adjusted in light of the accurate information, and the amount of any overpayment made to you will be deducted from future payments. The Joint Board may also cancel a portion of your benefit account, require you to refund overpayments, terminate your entitlement to any future benefits under the Plan or prosecute any action in any court or before any agency of competent jurisdiction.

How do I collect my benefits?

Once you are found to be eligible for a benefit, your benefit payment will be paid by a check mailed to you at your current address in the Fund's records.

In addition, you can complete and return a direct deposit authorization form and agreement to receive benefit payments through direct deposit rather than by check.

Most benefits are paid on a monthly basis following receipt of a completed claim.

How do I appeal a denial of my claim for benefits?

If your claim is denied by the Fund Office, the denial and the reasons for that denial will be communicated to you via first class mail. Where appropriate, this notification of denial shall inform you of any statements, documents, papers or information that, if submitted to the Fund, may alter the result.

This notification of denial will also inform you of your right to appeal the denial by submitting a written request for review within *60 days* of the denial of a claim for benefits (or **180** days if you are appealing from a denial of an application for eligibility based on disability).

Such appeal must be addressed to the Joint Board at the Fund Office, and should include any information that you believe will enable the Joint Board to arrive at a favorable decision on your claim. If you wish, you may have a representative file your appeal.

You or your representative will have the opportunity to review pertinent documents and other information relevant to the claim free of charge upon submission of a written request to the Joint Board. 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 Section 2560.503-1(m)(8), 29 CFR 2560.503-1(m)(8).

You or your representative may submit issues, comments, additional legal arguments and new information in writing to the Joint Board for its consideration in the appeal. The review of the appeal will take into account all materials and information received before the review and decision on the appeal, whether or not that information was previously submitted or considered by the Fund Office in the initial determination on the claim.

The Joint Board (or a committee appointed by the Board and authorized to act on behalf of the full Joint Board) will review the claim on appeal "de novo" (meaning "anew" and not with deference to the earlier decision) and they will review the additional materials and information submitted, if any. The review will occur at the Joint Board's first regularly scheduled meeting following receipt of the appeal, unless the appeal is filed less than 30 days prior to such meeting. In that case, it will be reviewed at the subsequent Joint Board meeting. If, due to special circumstances, the Joint Board requires additional time to review the appeal, you or your representative will be notified in writing of the special circumstances and when a determination will be made. The Joint Board will communicate its decision and the reasons therefor in writing within 5 days after it makes its decision on the appeal.

Who is ultimately responsible for making decisions regarding claims?

The Joint Board, as the Plan Administrator, has the sole and exclusive authority to interpret and apply the rules of this Plan, the Trust and any other rules and regulations, procedures or administrative rules adopted by the Joint Board. Decisions by the Plan Administrator or, where responsibility has been delegated to others, its delegates, will be final and binding on all persons dealing with this Fund or claiming a benefit under this Plan. If a decision of the Plan Administrator or its authorized delegates is challenged in court, the Trust Agreement provides, and it is hereby stated as the express intent of this Plan, that such decision is to be upheld unless a court of competent jurisdiction finds and issues a decision that such decision of the Plan Administrator was arbitrary and capricious.

Is there a time limit for bringing a lawsuit against the Plan?

Yes. Under the terms of the Plan, any lawsuit brought against the Fund, the Joint Board, 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 first date you are sent a determination of your rights and/or benefits under the terms of the Fund's Plan, unless a shorter period is established by applicable statute, regulation or case law. ***Please also note that under the law, no action at law or equity may be brought for benefits until all of the Fund's claims and appeal procedures have been fully exhausted.***

Is there any limitation on what court I may file a lawsuit against the Plan?

Yes. Under the terms of the Plan, you can only file a lawsuit in the federal court for the district where the Fund Office is located, currently, the Western District of Michigan.

What are my rights if a Qualified Medical Child Support Order (QMCSO) is entered?

Under Federal law, the Fund must recognize qualified medical child support orders mandating continuation of health care coverage for certain dependent children.

A QMCSO is a medical child support order issued by a court of competent jurisdiction that creates or recognizes the right of the child to receive benefits which the participant or other beneficiary is entitled to receive under the Plan. A QMCSO is usually issued in a divorce or a paternity case in

which the eligible participant is ordered by the court to continue to provide medical support for their child or children, but it may also be in the form of a National Medical Support Notice (NMSN) issued by the Friend of the Court. The QMCSO cannot require the Plan to provide any type or form of benefit that is not already offered under the Plan, except to the extent necessary to meet the requirements of applicable law. The QMCSO must provide:

- the name and last known mailing address of the participant;
- the name and address of each alternate recipient;
- a reasonable description of the type of coverage to be provided by the Plan or the manner in which such coverage is to be determined;
- the period for which coverage must be provided; and
- each plan to which the order applies.

If the document is determined to be a QMCSO, the Fund will notify the participant and the custodial parent or issuing agency, as appropriate. If the document is determined not to be a QMCSO, the Fund will send a letter describing the reason for that determination. Any payment of benefits made by the Plan pursuant to a QMCSO, and notices and explanations of benefits relating to the alternate recipient will be sent to the parent(s) with physical custody.

What are my rights under the Family Medical Leave Act (FMLA)?

Under the Family and Medical Leave Act of 1993 (FMLA), if the Hospital has 50 or more employees during 20 or more weeks in the current or preceding year, you may have rights to continue certain benefits during a leave of absence for family or medical reasons. You may have to pay for coverage that is continued during your FMLA leave.

The Association determines whether you are eligible for family or medical leave under the Act, not the Fund Office or the Joint Board.

Both you and your employer are required to notify the Fund Office if you take a family or medical leave and to provide certain other information as required by the Board. Your coverage in the Plan will continue during the period of your family or medical leave, provided your employer makes contributions to the Plan 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 Joint Board.

What are my rights under the Genetic Information Non-Discrimination Act of 2008 (GINA)?

GINA prohibits the Association from:

- requesting that you or your family members undergo genetic testing;
- using genetic information to determine eligibility for coverage or to impose preexisting condition exclusions;
- collecting genetic information prior to enrollment or coverage; and,
- adjusting group premium or contribution amounts on the basis of genetic information.

The Association is also prohibited from discriminating against you with respect to your compensation or the terms, conditions or privileges of employment on the basis of your genetic information.

What are my rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA)?

If you leave your job to perform military service, you have the right to elect to continue your coverage in the Plan for you and for your dependents for up to 24 months while in the military. See the Plan Administrator for details.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed, generally without any waiting periods or exclusions (for example, pre-existing condition exclusions) except for service- connected illnesses or injuries.

Military service includes the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time or war or emergency.

For USERRA enforcement:

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, depending on the employer, for representation.

- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

COBRA CONTINUATION COVERAGE

This section contains important information about your right to COBRA continuation coverage. **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. 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 other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

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 section. 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 a qualifying event; however, as a retiree only Plan, it is unlikely that you will become a qualified beneficiary. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are the spouse of an employee, you may 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 may 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 Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the Association must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events.

You must notify the Plan Administrator 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, Edward W. Sparrow Hospital Association MNA Employees Health Reimbursement Arrangement, 6525 Centurion Dr., Lansing, Michigan 48917.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. However, 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 purchase a maximum of 36 months of coverage.

When the qualifying event is the death of the employee, the employee's becoming eligible for Medicare Part A or B (or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage is available for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee becomes entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee is available for up to 36 months after the date of Medicare entitlement.

Example: If you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your spouse and children

can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

There are two ways in which the 18-month period of COBRA continuation coverage can be extended, which are described below.

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 Plan Administrator in a timely fashion, you and your entire family may be entitled to purchase up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability must 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 Plan Administrator 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.

For more information about extending the length of COBRA continuation coverage visit https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf.

How much does COBRA Continuation Coverage Cost?

You do not have to show you are insurable to choose continuation coverage; however, under COBRA, you have to pay the full cost, including a 2% administrative surcharge, for your continuation coverage. If the Social Security Administration determines that you were disabled at the time of termination or reduction of hours and you elect to continue coverage beyond the 18-month period, you may be charged an additional 50% surcharge beginning on the 19th month of coverage.

If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the Election Form is received by the Fund Office.

You will have a grace period of at least 30 days to pay the monthly COBRA payment, except for the first monthly payment, for which you will have a one-time-only 45-day grace period.

Under What Circumstances Would COBRA Continuation Coverage Terminate?

The law also provides that you or your dependents' COBRA continuation coverage may be terminated by the Fund for any of the following reasons:

- The Fund no longer provides coverage for similarly situated employees;
- Your payment for continuation coverage is not received by the Fund in a timely fashion;
- You or your dependent becomes covered under another group health plan that does not include a pre-existing conditions clause that applies to you or to a covered dependent. If you are or become covered under another group health plan, you must notify the Fund Office immediately;
- You are receiving COBRA continuation coverage because of a disability defined under the Social Security Act and Social Security determines that you are no longer disabled. You must notify the Fund Office within 30 days of the date of any final determination by the Social Security Administration that you are no longer disabled; or
- You provide written notice to the Fund Office that you wish to end your COBRA continuation coverage.

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's 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 I sign up for COBRA continuation coverage or the Plan's COBRA alternative coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage or the Plan's COBRA alternative coverage?

If you sign up for COBRA continuation coverage or the Plan's COBRA alternative coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage or the Plan's COBRA alternative coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though – if you terminate your COBRA continuation coverage or the Plan's COBRA alternative coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have continued coverage under the Plan's COBRA alternative for 12 months, you may elect to continue coverage under the regular COBRA continuation coverage option at the unsubsidized rates applicable to that coverage for the remainder of the regular COBRA continuation coverage period (that is, 6 more months for a total of 18 months unless extended as explained above).

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage or the Plan's COBRA alternative coverage, you cannot, under any circumstances, switch to COBRA continuation coverage (unless you are still within the original 60-day election period) or the Plan's COBRA alternative coverage.

What if I still have questions about COBRA?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified at the start of this book. 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 http://www.HealthCare.gov.

MISCELLANEOUS PROVISIONS AND INFORMATION

CIRCUMSTANCES THAT CAN RESULT IN DENIAL OF OR LOSS OF BENEFITS

The Joint Board or its representatives have the authority to deny payment for claims, and the reasons for denial may include, but are not limited to, one or more of the following:

- The person receiving the services or seeking the benefit was not eligible for the specific benefit sought and/or any benefit under the Plan when the expense was incurred.
- The claim was not received by the Fund within the applicable time limit.
- The expense was for services not covered by the Fund or the expense was not actually incurred.
- The person for whom the claim was filed already received the maximum benefit for the type of benefit.
- The person for whom the claim was filed had not yet satisfied all requirements imposed by the Fund.
- The person for whom the claim was filed (or another person on their behalf) failed to cooperate with the Fund's right of reimbursement, or failed to remit the Fund's reimbursable amount from a recovery, including a partial recovery (in which case, future claims will be denied up to the amount of the Fund's reimbursable amount).
- Another entity was primarily responsible for paying benefits.

- Eligibility rules were changed, coverage was eliminated, or the benefit was reduced or discontinued by action of the Board of Trustees before the services were received.

- The Fund was terminated.

The above list does not list every reason a claim may be denied. It is only representative of the types of circumstances that might lead to a denial of a claim. If you have questions about a claim denial, contact the Fund Office, and be certain to review the section above regarding Appeals to avoid loss of rights.

RIGHT TO OBTAIN, REQUIRE AND RELY ON INFORMATION

The Joint Board shall have the right to require, as a condition precedent to the payment of any benefit under the Plan, all information which they reasonably deem 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, the Association, Participants, Dependents, beneficiaries, alternate recipients or the representative of any of them.

The Joint Board shall, in the absence of contrary evidence presented to them, have the right in administering the Plan to rely upon information provided to them by the Union, the Association, Participants, Dependents, beneficiaries, alternate recipients or the representatives of any of them. Neither they nor the Fund shall be held liable for good faith reliance thereon.

No Eligible Employee, Former Employee, Eligible Retiree, Inactive Eligible Employee, Participant, or beneficiary, or any person claiming by or through any such person, will have any right, interest or title to any benefits under the Trust Agreement, the Plan or the Fund, except as such right, interest or title will have been specifically granted pursuant to the terms of the Plan. **There is no vesting of benefits.**

ALTERED OR FORGED CLAIMS

Any claim form or other materials submitted by or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Joint Board 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 in any manner.

FACILITY OF PAYMENT

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

for providing the Fund with any information and documentation regarding someone who has or may have authority to act in your place.

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.

NO EMPLOYMENT CONTRACT

The Plan shall not be deemed to constitute a contract between the Employer or the Joint Board of Trustees and any Eligible Employee or to be a consideration or an inducement for the employment of any Eligible Employee. Nothing contained in this Plan shall be deemed to give any Eligible Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Eligible Employee at any time regardless of the effect which such discharge shall have upon him or her as a participant in this Plan.

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, reimbursement 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 reimbursements will be provided subject to the same rules applicable to other medical and surgical benefits provided under this Plan.

If you would like more information on WHCRA benefits, contact the Fund Office at Edward W. Sparrow Hospital Association MNA Employees Health Reimbursement Arrangement, 6525 Centurion Drive, Lansing, MI 48917.

The Fund has provided reimbursement for mastectomies for a number of years. As part of this coverage, the Plan also provided reimbursement for the procedures necessary to effect reconstruction of the breast on which the mastectomy was performed, as well as the cost of prostheses and physical complications of all stages of mastectomy, including lymph edemas, as recommended by the attending physician of any patient receiving Plan benefits in connection with the mastectomy and in consultation with the patient. The Plan also provides reimbursement for any surgery and reconstruction of the other breast to achieve a symmetrical appearance.

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).

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 Edward W. Sparrow Hospital Association MNA Employees Health Reimbursement Arrangement ("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 EDWARD W. SPARROW HOSPITAL ASSOCIATION MNA EMPLOYEES HEALTH REIMBURSEMENT ARRANGEMENT 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.

In the case of a conflict, the Plan, and not this Summary Plan Description, will govern.

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 Edward W. Sparrow Hospital Association MNA Employees Health Reimbursement Arrangement 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 Edward W. Sparrow Hospital Association MNA Employees Health Reimbursement Arrangement should be made in writing to the Fund's Privacy Officer. The Edward W. Sparrow Hospital Association MNA Employees Health Reimbursement Arrangement 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, Edward W. Sparrow Hospital Association MNA Employees Health Reimbursement Arrangement, 6525 Centurion Drive, Lansing, Michigan 48917-9275 – (517) 321-7502.

GENERAL PLAN INFORMATION

INTERNAL REVENUE SERVICE EMPLOYER AND PLAN IDENTIFICATION NUMBERS

The Plan has been assigned an Employer Identification Number by the Internal Revenue Service. It is 26-0655485. The Plan Number is 501. The EIN of the associated Trust Fund is 26-0583605.

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.

The Board of Trustees are well aware of these advantages and will take whatever steps are necessary to keep your Fund tax exempt under Internal Revenue Service rules.

TYPE OF ADMINISTRATION

The Board of Trustees of the Edward W. Sparrow Hospital Association MNA Employees Health Reimbursement Arrangement ("Joint Board") is the Plan Administrator and Plan Sponsor and is responsible for overall Plan administration. There are four Union Trustees appointed by the Michigan Nurses Association (the "Union") and four are appointed by the Edward W. Sparrow Hospital Association (the "Association"). The Board of Trustees has retained TIC International, the Administrative Manager, to fulfill the day-to-day responsibilities for contract administration.

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 Joint Board. With respect to claims processing for participants and beneficiaries, the Joint Board has delegated responsibility to TIC International, but has retained final authority to review those determinations and hear appeals. Any determination or interpretation made by the Joint Board is binding on the Participant and Fund unless it is demonstrated that the determination or interpretation was arbitrary and capricious.

PLAN NAME

The Plan's name is: The Edward W. Sparrow Hospital Association MNA Employees Health Reimbursement Arrangement.

TYPE OF PLAN

The Plan is a Group Health Plan, more specifically, a retiree only health reimbursement arrangement. It is an employee welfare benefit plan providing reimbursement of substantiated reimbursable medical expenses. 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 Fund, you are

entitled to certain rights and protections under ERISA, as described in the ERISA RIGHTS section of this booklet.

PLAN MODIFICATION, AMENDMENT AND TERMINATION

The Joint Board may modify or amend the Plan at any time in its sole discretion; so may the bargaining parties. 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, or eligibility required for any benefit. The benefits provided by the Plan are limited to the assets of the Trust that are available to pay for such benefits. ***No person has <u>any</u> vested rights to any benefit provided by the Fund, now or at any time in the future.***

Although the Joint Board does not foresee that the Plan will be terminated, the Trust Agreement provides that termination may occur when:

1. The Joint Board unanimously votes to terminate the Trust.
2. No assets remain in the Trust.
3. All individuals who can qualify for benefits under the Plan and Trust have died.

The Joint Board is obligated to use the Trust assets for payment of administrative expenses incurred up to the date of termination and administrative expenses related to the termination as their first priority. Next, assets are used for benefit claims arising prior to the date of termination or such earlier date determined by the Joint Board. Remaining assets, if any, must be used in such manner as will, in the Joint Board's best judgment, best effectuate the purposes of the Trust.

Upon written request, you may examine the Trust Agreement at the Fund Office or other specified locations. Or you may request a copy of the Trust Agreement which may be provided for a reasonable charge.

COLLECTIVE BARGAINING AGREEMENTS

The parties to the collective bargaining agreement under which the Plan was created and maintained are the Professional Employee Council Sparrow Hospital (1200 E. Michigan Ave, Suite 730, Lansing, MI 48912), the Michigan Nurses Association (2310 Jolly Oak Road, Okemos, MI 48864), and the Edward W. Sparrow Hospital Association (1200 E. Michigan Avenue, Suite 235, Lansing, MI 48912). A copy of such agreement(s) may be obtained upon written request to the Fund Office or any of the bargaining parties, which may make a reasonable charge for copying. Copies are also available for examination by participants and beneficiaries at the Fund Office, which may make a reasonable charge for copying.

SOURCES OF CONTRIBUTIONS AND FUND INCOME

The Plan is funded through employer contributions and investment earnings. All income is held in trust by the Joint Board pending the payment of benefits and administrative expenses.

The collective bargaining agreement between the Association and the Union specifies the amount of contributions, due date of employer contributions, and type of work for which contributions are payable. Contributions are generally required to be made on an annual basis pursuant to the terms of the agreement.

METHOD OF FUNDING BENEFITS

Benefits payable under this Plan are self-funded (i.e., not covered through an insurance policy). The Fund is responsible for the payment of these claims, changes in Plan benefits and enrollment.

Fund assets are also allocated for reserves to meet future liabilities to carry out the objectives of the Plan.

Benefits payable are limited to Fund assets available for such purposes.

PLAN YEAR/FISCAL YEAR

The Plan Year, for purposes of maintaining the Fund's fiscal records, begins on the first day of January and ends on the last day of December of each calendar year. The Benefit Year, for purposes of administration of the Fund, also begins on the first day of January and ends on the last day of December of each calendar year. The Plan Year is used for Fund accounting and for filing annual reports required by the Internal Revenue Service and the United States Department of Labor.

ELIGIBILITY AND BENEFITS

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

Generally, you (the employee) are entitled to participate in the Fund if you meet the benefit eligibility provisions (retirement or disability) after working under the collective bargaining agreement that requires your employer (the Association) to make, and the employer does make, contributions to the Fund on your behalf.

The Joint Board may change the eligibility rules and/or benefit provisions of the Plan at any time; so may the bargaining parties. 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 a vested right to any benefit provided by the Fund, now or at any time in the future.**

SOCIAL SECURITY NUMBER PRIVACY POLICY

The Social Security Number Privacy Act makes it unlawful, with respect to all or any more than four sequential digits of an individual's social security number, to do any of the following:

- Publicly display more than 4 sequential digits of the Social Security number. The term "publicly display" is broadly defined to mean exhibit, hold up, post or make visible such as on a computer screen, network, or other electronic medium.

- Use a person's social security number as an individual account number,

- Print a Social Security number on the outside of any envelope or package mailed or sent to an individual,

- Require use or transmission of more than 4 sequential digits of a Social Security number over the internet or a computer network, unless the connection is secure or the transmission is encrypted, or

- Require use or transmission of more than 4 sequential digits of a Social Security number to gain access to a website or computer system or network, unless the connection is secure and the transmission is encrypted, or protected by a password or other unique personal ID number or authentication device.

The statute also prohibits including all or more than 4 sequential digits of a Social Security number in any document or information mailed to a person, unless certain conditions, including the following, apply:

- A state or federal law or rule or court order authorizes, permits or requires the Social Security number's use,

- The document sent is part of an application or enrollment initiated by the individual,

- The document is sent to establish, confirm service, amend or terminate an account, contract, policy, or employee or health insurance benefit; or

- The document is mailed by a public body in certain circumstances.

The restrictions do not apply to use of a Social Security number that is "authorized or required by state or federal statute, by court order, or pursuant to legal discovery or process."

It is not a violation of the Act to use a Social Security number to "verify an individual's identity, identify an individual, or do another similar administrative purpose related to," proposed employment or employment. Use of Social Security numbers to provide or administer health insurance, membership benefits, or retirement programs is also permissible. An entity may also use all or part of a Social Security number to "lawfully pursue or enforce a person's legal rights," which may include "audit, collection, investigation, or transfer of a tax, employee benefit, debit, claim" or account.

To comply with the Social Security Number Privacy Act, to protect the confidentiality of the Fund's participants' and beneficiaries' social security numbers, and to prevent to the extent

possible their disclosure to persons who would use them unlawfully, the Joint Board hereby adopts the following Social Security Number Privacy Policy:

- All Fund service providers and their agents and employees are hereby directed to ensure to the extent practicable the confidentiality of all Social Security numbers.

- All Fund service providers and their agents and employees are hereby prohibited from making any disclosure of Social Security numbers contrary to the provisions of the law as set out above.

- All Fund service providers and their agents and employees are directed to limit who has access to information or documents that contain the Social Security numbers strictly to those individuals for whom such information is necessary for the provision and administration of the Fund's benefit program. Information in any form, written or electronic, which contains Social Security numbers will be handled only by those persons whose job duties require them to have access to that information for the provision and administration of the Fund's benefit program. If such information is contained in documents, the documents will be securely stored, with access limited to those persons whose job duties require them to have access to that information. If such information is in electronic form, access to any computer or computer files will be limited, through the use of passwords and/or other technology, to those persons whose job duties require them to have access to that information.

- Documents which contain Social Security numbers and which are no longer needed will be disposed of, whether by shredding or otherwise, in a manner which will insure that the numbers are protected. Each Fund service provider shall be responsible for supervising this process.

- Fund service providers who violate this privacy policy will be subject to disciplinary action, up to and including termination.