

**LABORERS'
METROPOLITAN
DETROIT
HEALTH CARE
FUND**

**SUMMARY
PLAN
DESCRIPTION
and
PLAN DOCUMENT**

Effective July 2009

www.metrodetroitlaborers.org

Laborers' Metropolitan Detroit Health Care Fund

Table of Contents

	Page #
TABLE OF CONTENTS	i
THE BOARD OF TRUSTEES	iv
FUND OFFICE/AGENT DESIGNATED FOR LEGAL PROCESS	v
OTHER CONTACTS	vi
A MESSAGE FROM THE BOARD OF TRUSTEES ABOUT THE PLAN	vii viii
I. GENERAL DEFINITIONS – Terms You Should Know	1
II. ELIGIBILITY	
A. ACTIVE EMPLOYEES	15
1. Initial Plan Eligibility Requirements	15
2. Continuation And Reinstatement Of Plan Eligibility	16
B. ACTIVE EMPLOYEES AND/OR THEIR SPOUSES WHO ARE AGE 65 OR OLDER	17
ACTIVE EMPLOYEE WITH DEPENDENT ELIGIBLE FOR MEDICARE	17
D. ELIGIBILITY DURING PERIODS OF UNEMPLOYMENT (SELF- PAYMENT PROVISIONS)	19
1. The Self-Payment Program	19
2. The COBRA Continuation Coverage	19
E. RETIRED PARTICIPANT BENEFITS	26
A. GENERAL	26
1. Schedule Of Benefits For Early Retirees	27
2. Method Of Payment For Coverage	27
3. Provisions For Continued Participation	27
4. Special Provisions	28
B. TOTALLY & PERMANENTLY DISABLED PARTICIPANT SELF-PAYMENT PROGRAM	29
1. Eligibility Provisions	29
2. Schedule Of Benefits For Totally And Permanently Disabled Participants	30
3. Method Of Payment For Coverage	33
4. Provisions For Continued Participation	31
5. Special Provisions	32

Laborers' Metropolitan Detroit Health Care Fund

	33
C. SURVIVING SPOUSE SELF-PAYMENT PROGRAM	
ELIGIBILITY PROVISIONS	
1. Schedule Of Benefits	33
2. Method Of Payment	34
3. Termination Of Coverage	34
4. Special Provisions	35
D. SUPPLEMENT TO MEDICARE PROGRAM	35
1. Eligibility Provisions	36
2. Schedule Of Benefits	36
3. Method Of Payment For Coverage	38
4. Provisions For Continued Participation	38
5. Special Provisions	39
E. RETIREE DEATH BENEFITS	40
F. SPECIAL ELIGIBILITY PROVISIONS	41
1. Health Insurance Portability & Accountability Act (HIPAA)	41
2. Military Service	42
3. Employment Outside the Jurisdiction	42
4. Disability Hour Credit	42
5. Family and Medical Leave	43
6. Qualified Medical Child Support Orders	43
7. Both Spouses Eligible As Employees	44
8. Claims Incurred in Foreign Countries	44
9. Automatic Assignment of Benefits	45
III. BENEFITS	
A. HEALTH CARE BENEFITS	46
1. Summary Of Benefits	46
2. Preferred Provider Program (PPO Program)	48
B. EXPLANATION OF BENEFITS	49
1. In-Hospital Comprehensive Confinement Benefit	49
2. Hospice Care, Home Health Care, And Convalescent Care	51
3. Out-Patient Surgical Benefits	52
4. Out-Patient Medical Benefits	54
5. In-Patient Hospital Bill Review Program	55
6. Prescription Drug Program	55
7. Smoking/Tobacco Use Cessation Benefits	56
8. Chiropractic Benefit	56
9. Hearing Aid Benefit	57
10. Dental And Orthodontic Benefits	58
11. Special Benefit Provisions	61
a. Acupuncture treatment	61
b. Ambulance Service	61

Laborers' Metropolitan Detroit Health Care Fund

c. Birth Control	61
d. Cosmetic Surgery	62
e. Diapers	63
f. Durable Medical Equipment	63
g. Infertility	63
h. Maternity / Obstetrical Related Services	64
i. Mental Health & Substance Abuse Benefits	66
j. Obesity Treatment	69
k. Out-Patient Chemotherapy & Cancer Treatment	70
l. Physical Therapy	71
m. Podiatry Treatment	71
n. Preventive Health Care Program	72
o. Prosthetic and Orthotic Devices	72
p. Second Surgical Opinion	73
q. Speech Therapy	73
r. Temporomandibular Joint Dysfunction Treatment (TMJ)	73
s. Transplants	73
t. Vision Care	74
C. COORDINATION OF BENEFITS	75
D. DEATH BENEFITS – ACTIVE PARTICIPANTS	77
E. LIMITATIONS & EXCLUSIONS	79
IV. CLAIMS PROCEDURE	83
A. How to File for Claim Payments	83
B. Claim Review and Appeal Procedures	84
C. Claims Procedure is Mandatory	84
D. Medical Benefit Claim Review Procedure	85
VI. GENERAL INFORMATION	
A. AMENDMENTS	89
B. BASIC PLAN INFORMATION	89
1. Type Of Plan	89
2. Name Of Plan Administrator	89
3. Plan Year	89
4. Identification Numbers	90
5. Type Of Administration	90
6. Collective Bargaining Agreements	90
7. Plan Sponsors	90
8. Source Of Contributions	90
9. Fund Medium For The Accumulation Of Fund Assets	91
10. Right To Receive And Release Necessary Information	91
C. ERISA RIGHTS AND PROTECTIONS	91

Laborers' Metropolitan Detroit Health Care Fund

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FUND OFFICE/AGENT DESIGNATED FOR LEGAL PROCESS

(The Plan's Administrative Manager)

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FARMINGTON HILLS, MI 48333
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www.cofinity.net

THREE RIVERS PROVIDER **NETWORK (TRPN)**

1620 5TH AVENUE, SUITE 900
SAN DIEGO, CA 92101
1-866-393-0966
www.trpnppo.com

HINES AND ASSOCIATES

115 E. HIGHLAND AVENUE
ELGIN, IL 60120
1-888-236-2652 (precertification)
1-800-735-1200 (general questions)
www.hinesassoc.com

EXPRESS SCRIPTS

P.O. BOX 66583
ST. LOUIS, MO 63166
1-800-692-5263
www.express-scripts.com

HEALTH MANAGEMENT SYSTEMS **OF AMERICA (HMSA) or** **LABORERS' ASSISTANCE** **PROGRAM**

20811 Kelly Road
Eastpoint, MI 48021
1-877-366-5552
www.my-life-resource.com

DELTA DENTAL

P.O. Box 30416
LANSING, MI 48090-7916
1-800-524-0149
www.deltadental.com

Laborers' Metropolitan Detroit Health Care Fund

A Message from the Board of Trustees

Dear Participant,

This booklet describes the benefits available to you and your family through the Laborers' Metropolitan Detroit Health Care Plan (Plan). In it, you'll find information on eligibility for benefits, covered services, how to file a claim and your rights under the Plan, etc.

Read this booklet carefully. Use it for quick reference. As periodic changes are made in the Plan, we'll provide you with written updates.

This booklet, called the "summary plan description" (SPD), summarizes the Plan's key features. ***This booklet is also the Plan document.***

Additional Plan details are also contained in the other official Plan documents, including the Plan's Agreement and Declaration of Trust. Together, these Plan documents govern the Plan's operation.

All Plan documents are available for your inspection at the Administrative Manager's Office during normal business hours. All statements made in this booklet are subject to the provisions and terms of the complete Plan documents.

We've made every effort to make the Plan responsive to your needs. But, the ability to maintain a high level of benefits ultimately depends on ***you***. By complying with the Plan rules and following the booklet instructions, you can help the Plan deliver the best benefits possible in the most efficient and cost-effective manner.

NO BENEFITS ARE GUARANTEED

No Plan benefit is guaranteed. We may modify or eliminate (without prior notice to you) any Plan benefits and/or change the Plan's eligibility requirements.

We also have the sole authority and discretion to interpret all Plan documents, and all of the Plan benefits, and make final determinations regarding them.

If this booklet does not answer your specific questions, call the Administrative Manager's Office at (800) 228-0048 Toll Free or (517) 321-7502.

Sincerely,

**THE BOARD OF TRUSTEES
LABORERS' METROPOLITAN DETROIT
HEALTH CARE FUND**

Laborers' Metropolitan Detroit Health Care Fund

About the Plan

In 1973, your Union and several Employer Associations created this Plan through collective bargaining. The Plan's current sponsors are Laborers' Locals 1076 and 1191, the Michigan Laborers' District Council and several Employer Associations – The AGC of Michigan, the Detroit Mason Contractors' Association, the Mason Contractors' Association, Inc., and the Michigan Infrastructure & Transportation Association. The Plan provides health and related benefits to you and your family.

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

The Plan is a "jointly-trusted" fund. That is, it is administered by a twelve (12) member joint Board of Trustees. This Board consists of six (6) Union-appointed Trustees and six (6) Employer-appointed Trustees. This Board establishes the Plan's benefits, policies, rules and regulations related to the Plan's operation. The Plan's third-party administrator, *TIC International, Inc.*, administers the Plan's day-to-day operations.

The Board of Trustees and TIC are assisted by professional consultants and advisors who provide necessary expertise in their respective areas. These professionals include a Plan attorney, an investment consultant and investment managers, health benefit experts, auditors, actuaries and certified public accountants.

CAUTION

No one has the authority to speak for the Trustees on any matter related to the Plan except the full Board of Trustees or the Plan's Administrative Manager to whom such authority has been delegated. The Administrative Manager's decisions are subject to review by the Board of Trustees.

INFORMATION YOU MUST PROVIDE THE PLAN

Health Care Enrollment Form

You must provide the Plan office with a current Health Care Enrollment Form. This Health Care Enrollment Form contains your current mailing address, a list of your current dependents and your designated beneficiaries.

You may obtain a Health Care Enrollment Form from the Fund Office. All of your dependents must be accurately listed on the Health Care Enrollment Form. Your failure to file a Health Care Enrollment Form or to keep it current will certainly cause delays in the processing of your claims. It could prevent you from exercising certain rights.

Changes In Your Dependents

If you add or lose a dependent for **any** reason, *e.g.*, marriage, divorce, birth, adoption, death, etc., you must advise the Plan Office promptly in writing. So, for example, contact the Plan Office immediately if you marry or divorce or if your child reaches age 25 and is no longer a full-time student. It's important that you notify the Plan office whenever there is a change in your dependents because it may trigger your dependent's rights to continuation coverage (**COBRA**) under the Plan.

All changes in your dependents must be in writing and supported by appropriate documentation (birth certificate, marriage certificate, etc.).

A Change in Mailing Address

Notify the Plan Office immediately, **in writing**, of any change in your address. (**Remember:** this Plan and the Union are separate entities. A change of address must be submitted to both).

A Change in Beneficiary

If you wish to change the beneficiary of your Death Benefit, complete a new Health Care Enrollment Form and send it to the Plan Office. You can obtain a new Health Care Enrollment Form by contacting the Plan Office at (517) 321-7502 or, toll free in Michigan, 1-800-228-0048.

Laborers' Metropolitan Detroit Health Care Fund

Eligibility for Other Coverage

If you or your dependents are covered under any **other** group, or any individual health insurance plan(s), you must inform the Plan Office and provide, in writing, the name(s) of the other group health plan(s), the carrier(s), the policy number(s), the coverage effective dates and the address(es) of the other health insurance plan's claims paying office(s). Please submit a copy of the front and back of the other group health plan (s) participant identification card. This information is required so that benefits can be properly coordinated with other health Plans.

Providing Information – Your Responsibility

You must provide accurate and current information to the Plan. When inaccurate information and/or proof is provided, this ultimately can result in the improper use of Plan assets.

So, for example, if you or a dependent fail to submit the requested information or proof, make a false statement, or furnish fraudulent or incorrect information, you or your dependent's Plan benefits (and participation in the Plan) may be denied, suspended or discontinued at any time and for any length of time (including permanently) by the Trustees.

Excess Benefit Payments

If the Plan mistakenly pays benefits that exceed the expenses actually incurred or exceed the Plan's allowable amounts, due to error (including, for example, a clerical error), or fraud or for any other reason (including, for example, your failure to notify the Plan Office regarding a change in family status), the Plan reserves the right to recover such overpayment through whatever means are necessary. This includes, without limitation, the right to pursue legal action and/or the right to deduct the excess payment amounts from any of your or your dependent's future benefit claims.

I. GENERAL DEFINITIONS – Terms You Should Know

To better understand your Plan, you should know the meaning of certain terms. These terms, when they appear in this booklet, are highlighted because they are specially defined terms.

1. **Accident** means an incident that contains some degree of unexpected violence, such as a fall, blow or a laceration.
2. **Accidental Bodily Injury and Sickness** means physical damage or illness caused by an action, object, or substance outside the body. For example, strains, sprains, cuts, bruises, allergic reactions, frostbite, sunstroke, swallowing poison, or the inhalation of smoke, carbon monoxide or fumes are all a form of **Accidental Bodily Injury and Sickness**. But, this term does *not* include physical damage or illness that arises out of or in the course of your employment or a motor vehicle accident or incident.
3. **Acute Care Facility** – A facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days. The facility is not primarily for:
 - Custodial, convalescent, rest care or care of the aged
 - Skilled nursing care or nursing home care
 - Substance abuse treatment
4. **Allogeneic (Allogenic) Transplant** – A procedure using another person's bone marrow or peripheral blood stem cells to transplant into the patient (including syngeneic transplants when the donor is the identical twin of the patient).
5. **Ambulatory Surgical Facility** means a separate outpatient facility that is not part of a hospital, where surgery is performed and care related to surgery is given. The procedures performed in an **Ambulatory Surgical Facility** can be performed safely without overnight inpatient hospital care.
6. **Approved Amount** – The PPOM (COFINITY) or TRPN maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copayments are deducted from the approved amount if applicable.

Laborers' Metropolitan Detroit Health Care Fund

7. **Approved Facility** – A hospital or clinic that provides medical and other services, such as substance abuse treatment, rehabilitation, skilled nursing care, or physical therapy. Approved facilities must meet all applicable local and state licensing and certification requirements. Approved facilities must be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association. These facilities must also meet all applicable local and state licensing and certification requirements.
8. **Approved Hospital** means any legally constituted institution that meets all applicable local and state licensure and certification requirements and is accredited as a hospital by state or national medical or hospital authorities or associations. The term **Approved Hospital** does not include any institution, or part thereof, that is used principally as a rest facility, nursing facility, convalescent facility or facility for care of the aged.
9. **Alternative Self-Payments** means active participant self-payments that participants remit when they lose their coverage due to a reduction in hours.
10. **Autologous Transplant** – A procedure using the patient's own bone marrow or peripheral blood stem cells for transplantation back into the patient.
11. **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1986 and continuation coverage required under this Act.
12. **Collective Bargaining Agreement** means a negotiated, written contract between the Union and an Employer that requires the Employer to make contributions to the Plan on your behalf.
13. **Continuation Coverage** means the coverage available to you and your family in the event you lose eligibility due to a Qualifying Event. If you elect Continuation Coverage, the Plan must provide coverage which, as of the time such coverage is provided, is identical to the coverage provided for other similarly situated beneficiaries for basic hospital, medical, and surgical benefits. But, Burial Benefits and Accidental Death and Dismemberment Benefits are **not** provided.
14. **Coordination of Benefits (COB)** means the Plan's program to coordinate you, and your family's health care benefits when either you or your dependents have coverage under more than one health plan.

Laborers' Metropolitan Detroit Health Care Fund

15. **Co-payment** means the designated portion of the approved amount you must pay for **Covered Services** or prescription drugs. This can be either a fixed dollar or percentage amount. (In the case of prescription drugs, your co-payment amount is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.)
16. **Covered Services** means services, treatment or supplies payable under the terms of the Plan. These services must be medically necessary to be payable.
17. **Custodial Care** means care, services or supplies, which are furnished mainly to assist a person with the activities of daily living, such as walking, bathing, dressing, eating, taking medication and getting in and out of bed. This **Custodial Care** may be given with or without:
- ❑ Routine nursing care;
 - ❑ Care supervised by a physician.
- Custodial Care** does not, however, include therapeutic treatment.
18. **Deductible** means a specified amount that you pay for **Covered Services**, during each benefit period, before the Plan begins to pay.
19. **Dental Hygienist** means a person who is currently licensed (if licensing is required in the State) to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of dental hygiene and who works under a **Dentist's** direct supervision.
20. **Dentist** means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.
21. **Durable Medical Equipment** means equipment that is prescribed by a physician, can withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness and injury.

Equipment, which primarily serves as a comfort or convenience for the patient or the patient's caregiver (for example, a wheelchair ramp or vehicle lift device) is not **Durable Medical Equipment**.

Laborers' Metropolitan Detroit Health Care Fund

21. ***Educational Institution*** means a university, college, junior or community college, trade or vocational school.
22. ***Elective Voluntary Sterilization*** means sterilization not medically required but voluntary elected by the patient. This includes, but is not limited to, vasoligation, vasectomy, salpingectomy, and tubal ligation.
23. ***Eligible Dependents*** mean:
- a. your legal spouse;
 - b. your unmarried children to the end of the calendar year in which they reach the age of 18;
 - c. unmarried children, over the age of 18, who are full-time students at an Educational Institution. Your child(ren), who is over age 18, remains eligible until they are no longer a full-time student or until the end of the calendar year in which they reach age 23, whichever is earlier;
 - d. unmarried children over age 23 and under age 25 who are full-time students, who reside with you for at least one-half of the year and are not eligible as "qualifying children" under another parent's health care plan; and
 - e. unmarried children of any age who are, and who have been prior to reaching age 19, incapable of self-sustaining employment by reason of a medically determinable physical or mental impairment and are primarily dependent on you for financial support and maintenance. You must provide proof, in writing (i.e. social security disability award, physician's or school verification) of such incapacity to the Plan at least thirty (30) days prior to the date that your child reaches age 19.

Throughout this definition children must be unmarried and primarily dependent upon you for financial support and maintenance to qualify as ***Eligible Dependents***. (You must provide proof of dependence in a form acceptable to the Plan.) ***Eligible Dependents*** include your biological children, legally-adopted children (including a child placed with you during the adoption waiting period), stepchildren, and children for which you have full legal guardianship. It does **not** include foster children, children on whose behalf you have power of attorney or limited guardianship.

Laborers' Metropolitan Detroit Health Care Fund

Also, for the purpose of this definition, a full-time student is one who is attending an **Educational Institution** and taking at least twelve (12) credit hours per term or semester and who is primarily dependent upon you for financial support and maintenance.

Dependent children also include your unmarried child who meets the requirements of b, c, d, or e above, even if they are *not* primarily dependent on you for financial support or maintenance, provided the child is recognized under a qualified medical child support order (QMCSO) as having Plan rights.

24. **Eligible Participant** means any person who: (1) is working within the jurisdiction of and covered under the terms of a Collective Bargaining Agreement and (2) is eligible for Plan benefits based upon the eligibility provisions of the Plan.
25. **Eligible Person** means either the eligible Employee or the eligible Employee's Dependents.
26. **Employee** means a person, actively employed by an Employer, on whose behalf an Employer must make contributions to the Plan.
27. **Employer** means any employer that has signed a collective bargaining agreement, Participation Agreement, either individually or through the **Employer's** affiliation with an employer association, and is required to make contributions to the Plan on behalf of its **Employees**.
28. **End Stage Renal Disease (ESRD)** means permanent and irreversible kidney failure that can no longer be controlled by medication or fluid and dietary restriction and, as such, requires a regular course of dialysis or a kidney transplant to maintain the patient's life.
29. **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.
30. **Expense Incurred** includes only those charges made for services and supplies, which are reasonably priced and reasonably necessary for treatment of the injury or sickness.
31. **Experimental or Investigational** – a service, procedure, treatment, device, or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. The Plan makes this determination based on a review of established criteria such as:

Laborers' Metropolitan Detroit Health Care Fund

- Opinions of local and national medical societies, organizations, committees, or governmental bodies;
 - Accepted national standards of practice in the medical profession;
 - Scientific data such as controlled studies in peer review journals or literature
32. ***Freestanding Facility*** – A facility separate from a hospital that provides outpatient services, such as substance abuse treatment, rehabilitation, skilled nursing care, surgical or physical therapy.
33. ***Freestanding Outpatient Physical Therapy Facility (OPT)*** – An independently owned and operated facility, separate from a hospital, that provides outpatient physical therapy services and occupational or functional occupational therapy or speech and language pathology.
34. ***Homatopoietic Transplant*** – A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.
35. ***High-Dose Chemotherapy (HDC)*** – A procedure that involves giving a patient cell destroying drugs in doses higher than approved by the FDA for therapy.
36. ***High Risk Patient*** – An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.
37. ***Hines & Associates*** – Provides Case Management and Utilization Review services related to inpatient hospital admissions.
38. ***HIPAA*** means the Health Insurance Portability and Accountability Act of 1996, as amended.
39. ***Illness*** means a sickness, disorder, or disease.
40. ***Independent Physical Therapist (IPT)*** – A licensed physical therapist that is not employed by a hospital, physician, or freestanding outpatient physical therapy facility and who maintains an office, separate from a hospital or freestanding outpatient physical therapy facility, with the equipment necessary to adequately provide physician-prescribed physical therapy.
41. ***In-patient*** means a person who is a resident patient using and being charged for an ***Approved Hospital's*** room and board facilities.

Laborers' Metropolitan Detroit Health Care Fund

42. ***Intensive Care Unit*** ("ICU") means a dedicated area of a hospital, exclusively reserved for critically ill patients requiring constant observation, which in its normal course of operation provides:
- a. Personal care by specialized registered professional nurses and other nursing care on a twenty-four (24) hour per day basis;
 - b. Special equipment and supplies which are available on an immediate and emergency basis; and
 - c. Care required, but not rendered, in the general surgical or medical nursing units of the hospital. ***Intensive Care Unit*** shall also include an area of the hospital designated and operated exclusively as a Coronary Care Unit or as a Cardiac Care Unit.
43. ***Medical Emergency*** means a condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately.
44. ***Medically Necessary*** means any service, supply, treatment or ***Approved Hospital*** confinement, which is:
- a. Essential to the treatment of the injury of illness;
 - b. Based on valid medical need according to the accepted standards of medical practice;
 - c. An appropriate level of care provided in the most appropriate setting, based on the diagnosis and condition, and that could not have been omitted without an adverse effect on the Participant's or Dependent's condition or quality of medical care;
 - d. Not primarily for the comfort, convenience or administrative ease of the licensed doctor or other health care provider or for the Participant or covered Dependents; or

Laborers' Metropolitan Detroit Health Care Fund

- e. Ordered by a physician, (except where the treatment is rendered by a medical provider and is generally recognized to not require a physician's order).
45. **Medicare** means the government Health Insurance Program for people 65 or older, certain disabled people under 65, and people who have permanent kidney failure. As referred to in this document, **Medicare** means both Parts A & B of **Medicare**. Medicare Part D which is the prescription drug portion of Medicare is not required by the Plan.
46. **Network Pharmacies** means pharmacies that have been selected for participation and have signed agreements to provide covered drugs through the Laborers' RX – Express Scripts network. Network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.
47. **Network Providers** – Hospitals, physicians and other licensed facilities or health care professionals who have contracted with PPOM (COFINITY) or TRPN to provide services to PPOM (COFINITY) and TRPN. Network providers have agreed to accept the PPOM (COFINITY) or TRPN approved amount as payment in full for covered services provided under these Plans.
48. **Non-Network Pharmacies** – Pharmacies that are **not** in the Laborers' RX – Express Scripts network. Non-network pharmacies have not agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.
49. **Nonparticipating Providers** – Providers that have not signed participation agreements with any or all of the Plan's participating networks agreeing to accept the **PPOM (COFINITY) or TRPN** payment as payment in full.
50. **Occupational Therapy** – A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:
- Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury, or following surgery;
 - Help the patient learn to apply the newly restored or improved function to meet the demands of daily living; or
 - Design and use splints, orthoses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raised toilet seats).

Laborers' Metropolitan Detroit Health Care Fund

51. ***Optician, Optometrist and Ophthalmologist*** means any person who is qualified and currently licensed (if licensing is required in the State) to practice each such profession by the appropriate government agency or authority having jurisdiction over the licensing and practice of such a profession, and who is acting within the usual scope of their practice.
52. ***Out-of-Network Service*** means a service **not** performed or referred by a network provider.
53. ***Out-patient*** means a person who receives hospital services and treatments, but is not an ***in-patient***.
54. ***Participating Providers*** – Providers that have signed agreements with ***PPOM (COFINITY)*** or ***TRPN*** to accept the ***PPOM (COFINITY)*** or ***TRPN***-approved amount for covered services as payment in full.
55. ***Peripheral Blood Stem Cell Transplant*** – A procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.
56. ***Period of Disability Confinement*** means that when an ***Eligible Employee*** is confined to an ***Approved Hospital*** within six (6) months after a previous confinement, it shall be considered as one (1) period of disability unless:
- a. the current or most recent confinement is due to entirely different causes from those which caused the first confinement; or
 - b. after the previous confinement, the attending physician has certified that the Employee was available to return to work; or
 - c. the Employee did, in fact, return to active employment with a contributing **Employer** for at least five (5) consecutive working days.
57. ***Pheresis*** – Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets, and stem cells).
58. ***Physical Therapy*** means treatment that is intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination and general mobility.

Laborers' Metropolitan Detroit Health Care Fund

59. **Physician** means a medical doctor (MD), a doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), psychiatrist, or doctor of medical dentistry (DMD).
60. **PPOM (COFINITY)** means the Preferred Provider Organization of Midwest which is a state-regulated PPO with whom the Plan has contracted to provide Plan participants with Plan benefits at a substantial savings.
61. **Pregnancy** means resulting childbirth, miscarriage, and any complications of pregnancy.
62. **Protected Health Information** means information maintained by a health care provider, health plan, employer, or health care clearinghouse which relates to past, present, or future physical or mental health or condition of an individual that identifies the individual or to which there is a reasonable basis to believe the information can be used to identify an individual.
63. **Purging** means a process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.
64. **Qualified Beneficiary** – means an individual who is covered under the Plan on the day before a Qualifying Event, as well as a newborn child or child placed for adoption with you during the period of Continuation Coverage. Qualified Beneficiaries are you, your spouse or your dependent child(ren).
65. **Qualifying Event** – means an event that causes you and/or your family to lose Plan coverage. The specific events, which are Qualifying Events for you, your spouse and/or your children, are explained in detail in the following sections. Depending on the Qualifying Event, COBRA Continuation Coverage is available for up to either 18, 29 or 36 months.
66. **Reasonable and Customary Charge** means charges that are determined by uniform reference standards as adopted by the Board of Trustees. To be considered reasonable and customary, the charge by any provider for a service must be similar to the charges generally incurred for cases of comparable nature and severity by a physician of similar training and experience in that geographical area. The geographic area considered is the metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of providers rendering such service or furnishing such supplies.

With respect to medical equipment, a charge will be considered "reasonable" only if the following requirements are met:

Laborers' Metropolitan Detroit Health Care Fund

- a. The expense of the equipment must be clearly proportionate to the therapeutic benefits ordinarily derived from its use;
- b. The equipment may not be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and
- c. The equipment may not serve essentially the same purpose as equipment already available to the patient.

67. *Routine Physical Examination* means an examination performed by a physician for screening purposes. If there is no diagnosis or symptoms presented on a claim form or itemized bill by the physician, the care will be considered routine.

68. *Self-Management Training* means an interactive, collaborative process involving patients with diabetes, their physicians and certified diabetes instructors. The training provides individuals with the knowledge and skills needed to care for themselves on a day-to-day basis, manage diabetic crises and make any lifestyle changes needed to manage the disease successfully.

69. *Sickness* means a deviation from a healthy condition which:

- a. Alters the state of the body;
- b. Interrupts or disturbs the performance of vital functions; and
- c. Tends to undermine or weaken the body.

Sickness does not include a limitation on or a loss of body function or a temporary illness, which does not progressively undermine or weaken the body. Illness caused alcoholism or intentional overdose of drugs are generally subject to special limitations and may not be considered a ***Sickness*** for which benefits are available. As such, these illnesses may be excluded from Plan coverage entirely.

70. *Skilled Nursing Care Facility* means an institution, or that part of any institution, which operates to provide convalescent or nursing care and:

Laborers' Metropolitan Detroit Health Care Fund

- a. Is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services for injured, disabled or sick persons;
 - b. Requires that each patient be under the supervision of a physician;
 - c. Has a physician available to furnish necessary medical care in case of emergency;
 - d. Has policies, which are developed by one (1) or more physicians and one (1) or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;
 - e. Has a physician, a registered professional nurse or a medical staff responsible for the execution of such policies;
 - f. Maintains clinical records on all patients;
 - g. Has at least one (1) registered nurse employed full time;
 - h. Provides twenty-four (24) hour nursing services;
 - i. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals; and
 - j. In appropriately licensed and certified to provide skilled nursing care.
- 71. *Specialty Hospital*** means a hospital, such as a children's hospital, a chronic disease hospital, or a psychiatric hospital, that provides care for a specific disease or population group.
- 72. *Speech Therapy*** means active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.
- 73. *Stem Cells*** means primitive blood cells originating in the marrow but also found in small quantities in the blood. These cells development into mature blood elements including red cells, white cells and platelets.
- 74. *Substance Abuse*** means the taking of alcohol or other drugs in amounts that can:
- a. Harm a person's mental, social and economic well-being;

Laborers' Metropolitan Detroit Health Care Fund

- b. Cause a person to lose self-control; and
 - c. Endanger the safety or welfare of others because of the substance's habitual influence on the person.
75. ***Surgical procedure*** means invasive and/or cutting procedures, as well as reduction of fractures or dislocations.
76. ***Syngeneic Transplant*** – A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient's identical twin to transplant into the patient.
77. ***T-Cell Depleted Infusion*** – A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.
78. ***TRPN (THREE RIVERS PROVIDER NETWORK)*** - PPO with whom the Plan has contracted to provide Plan participants with Plan benefits at a substantial savings.
79. ***Total Body Irradiation*** – A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.
80. ***Totally Disabled and Total Disability*** means disability resulting solely from a sickness or accidental bodily injury which prevents you from engaging in any occupation or employment for compensation or profit or prevents a Dependent from engaging in substantially all the normal activities of a person of like age and sex in good health. A copy of the Social Security Administration Award Letter is required for proof of total disability, if applicable.
81. ***Trust Agreement*** means the Agreement and Declaration of Trust establishing the Laborers' Metropolitan Detroit Health Care Fund, as may be amended from time to time.
82. ***Trust Fund or Fund*** means the Laborers' Metropolitan Detroit Health Care Fund.
83. ***Trustee*** means the Employer Trustees and the Union Trustees, collectively, as selected under the Trust Agreement, and as constituted from time to time in accordance with the provisions of the Trust Agreement.

Laborers' Metropolitan Detroit Health Care Fund

84. ***UCR*** means the amount approved as the usual, customary and reasonable fee for medical services.
85. ***Union*** means those Unions, which have signed a collective bargaining agreement with an Employer who, in accordance with such agreement, participates in and contributes to the Laborers' Metropolitan Detroit Health Care Fund.

III ELIGIBILITY

FAST FACTS:

- **Initial Plan Eligibility** – You must work a specific number of hours in a seven (7) month period to establish your initial Plan eligibility.
- **Continued Plan Eligibility** – You must work a specific number of hours to continue or maintain your Plan eligibility.
- **Plan Eligibility During Unemployment** – If you're unemployed, you can maintain your Plan eligibility, for a limited time, through self-payment or COBRA continuation coverage.
- **Plan Eligibility During Retirement** – When you retire and if you meet the Plan's eligibility requirements, you may purchase Plan coverage under several different programs.

The Plan provides benefits for you, your spouse and your eligible dependents. This section describes the Plan's eligibility rules.

A. ACTIVE EMPLOYEES

Your eligibility as an *active* employee is determined by **Employer** contributions made on your behalf for work you perform within a specific number of months.

1. Initial Plan Eligibility Requirements

To become initially eligible for Plan benefits, you must work **and have contributions made on your behalf** for at least seven hundred (700) hours within six (6) consecutive months or less.

If this occurs, you and your dependents become eligible for Plan benefits ***on the first day of the month that immediately follows*** the **Employer's** contribution of the seven hundred (700) hours. Based on this seven hundred (700) hours of contributions, you and your dependents remain eligible for benefits for one (1) month.

Below are some examples of how you become eligible for Plan benefits:

Example 1: If you work and an **Employer** contributes a total of seven hundred (700) hours on your behalf for the months of January, February, March, April, May and June six (6) consecutive months), you and your eligible dependents become eligible for Plan benefits on July 1. You and your eligible dependents remain eligible for these benefits through the month of July **only**.

Laborers' Metropolitan Detroit Health Care Fund

Example 2: If you work and an **Employer** contributes a total of seven hundred (700) hours on your behalf for the months of January, February, March, April, May (five (5) consecutive months), you and your eligible dependents become eligible for Plan benefits on June 1. You and your eligible dependents remain eligible for these benefits for the month of June **only**.

How your contribution hours are earned during the six (6) or less consecutive months is **not** important to establishing of your initial eligibility. Instead, what's important is that an **Employer** contributes a total of seven hundred (700) hours in contributions that are made on your behalf **within** a period of six (6) consecutive months or less.

If you are ineligible for thirteen (13) or more consecutive calendar months, you must again satisfy the Initial Eligibility Requirements to again be eligible for Plan benefits. But, if during this period, you were eligible for benefits under the **Michigan Laborers' Health Care Fund**, you don't have to satisfy the Initial Eligibility Requirement to again be eligible for Plan benefits.

2. Continuation And Reinstatement Of Plan Eligibility

If you've satisfied the Initial Eligibility Requirements, you remain eligible for the first and second months following any period of three consecutive months for which contributions have been made on your behalf to the Fund by a contributing employer for at least 300 hours.

Example: If you had previously satisfied the Initial Eligibility Requirements and have at least 300 hours of contributions paid on your behalf by a contributing employer for the months of June, July and August, you will be eligible for benefits for the months of September and October.

If you fail to meet the 300 hour test for continuing eligibility, you may be reinstated or continue your eligibility for the first and second months following a period of 12 consecutive months (or less) in the previous 13 months for which at least 1200 hours of employer contributions were made to the Fund on your behalf.

Example: If you have at least 1200 hours of contributions paid to the Fund on your behalf for the months of January through the following December, you will be eligible for the two (2) months immediately following January and February.

ELIGIBILITY CHART

This eligibility chart demonstrates the month(s) an Employee will be eligible if sufficient employer contributions are received for work performed in any given month. The chart is an example for the 2009 year only.

Eligibility Month	Requires at least 300 Hours in Months Shown	At least 1200 hours in Months Shown
01/09	09/08, 10/08, 11/08 or 10/08, 11/08, 12/08	12/07 through 11/08 or 01/08 through 12/08
02/09	10/08, 11/08, 12/08 or 11/08, 12/08, 01/09	01/08 through 12/08 or 02/08 through 01/09
03/09	11/08, 12/08, 01/09 or 12/08, 01/09, 02/09	02/08 through 01/09 or 03/08 through 02/09
04/09	12/08, 01/09, 02/09 or 01/09, 02/09, 03/09	03/08 through 02/09 or 04/08 through 03/09
05/09	01/09, 02/09, 03/09 or 02/09, 03/09, 04/09	04/08 through 03/09 or 05/08 through 04/09
06/09	02/09, 03/09, 04/09 or 03/09, 04/09, 05/09	05/08 through 04/09 or 06/08 through 05/09
07/09	03/09, 04/09, 05/09 or 04/09, 05/09, 06/09	06/08 through 05/09 or 07/08 through 06/09
08/09	04/09, 05/09, 06/09 or 05/09, 06/09, 07/09	07/08 through 06/09 or 08/08 through 07/09
09/09	05/09, 06/09, 07/09 or 06/09, 07/09, 08/09	08/08 through 07/09 or 09/08 through 08/09
10/09	06/09, 07/09, 08/09 or 07/09, 08/09, 09/09	09/08 through 08/09 or 10/08 through 09/09
11/09	07/09, 08/09, 09/09 or 08/09, 09/09, 10/09	10/08 through 09/09 or 11/08 through 10/09
12/09	08/09, 09/09, 10/09 or 09/09, 10/09, 11/09	11/08 through 10/09 or 12/08 through 11/09

B. ACTIVE EMPLOYEES AND/OR THEIR SPOUSES WHO ARE AGE 65 OR OLDER

If you're an Active Employee and continue to work, or remain eligible through annual hours or self-payments, beyond the date you or your spouse become eligible for Medicare at age 65, you may either have the Fund or Medicare as your primary payer of benefits. If you elect Medicare as the primary payer, your out-of-pocket expenses will generally be greater than they would be if the Fund is the primary payer.

Because of the additional costs to you if Medicare is the primary payer of benefits, the Trustees have decided that the Fund should be the primary payer of benefits for all **ACTIVE EMPLOYEES AND THEIR SPOUSES WHO ARE OVER AGE 65 AND ELIGIBLE FOR MEDICARE**. That is, whenever Medicare and the

Laborers' Metropolitan Detroit Health Care Fund

Fund cover the same items or services, the Fund will pay first and then Medicare will supplement the Fund's coverage up to the Medicare limits.

In most cases, the Fund's benefits are more generous than Medicare benefits. Where they are not, you have the right to file your claim with Medicare for whatever supplemental coverage is available. Your combined benefits from Medicare and the Fund will remain unchanged.

Any time after the age of 65 that an Active Employee ceases to meet the definition of an Active Employee, Medicare automatically becomes the primary payer.

If, for some reason, you or your spouse would prefer Medicare as your primary payer, you may state this preference in writing to the Fund Office when you become eligible for Medicare. Regardless of your election, you should not forget to pay the Part "B" Medicare premium for medical services for your own protection. Failure to pay the Part "B" premium on time will result in the loss of Medicare protection for medical services.

C. ACTIVE EMPLOYEE WITH DEPENDENT ELIGIBLE FOR MEDICARE

The Fund *must* act as the primary payer of benefits for any ACTIVE EMPLOYEE and/or his covered family members who are eligible for Medicare due to a disability. But, this requirement ends when you cease to meet the definition of an ACTIVE EMPLOYEE.

Claims for the Covered Persons affected by this provision MUST be submitted to the Fund for payment first. Any portions not paid should then be submitted to Medicare for payment. In those cases where Medicare and the Fund cover the same items or services, the Fund will pay first up to its limits and then Medicare will supplement the Fund's coverage up to the Medicare limits. In some instances, only the Fund will provide coverage for some items.

Covered Persons affected by this provision are advised to pay the premium for Part B (Medical) coverage through Medicare. This assures the most complete coverage for medical expenses and is required in order to qualify for participation in certain programs available through the Fund.

D. ELIGIBILITY DURING PERIODS OF UNEMPLOYMENT (SELF-PAYMENT PROVISIONS)

1. The Self-Payment Program

If you're an Eligible Active Employee, who would otherwise lose eligibility because you have insufficient Employer contributions made on your behalf, you may maintain your eligibility through the Self-Payment Program. (You could also extend your coverage under the **COBRA** provisions explained on pages 19 - 25).

The Self-Payment Program is available for only 18 consecutive months after each period when you've been eligible through **Employer** contributions as an active employee. That is, you may make self-payments to the Plan to remain eligible for benefits only for 18 consecutive months. But, to make self-payments you must remain available for work within the jurisdiction of one of the participating Local Unions. You can also make self-payments if you are temporarily disabled.

The Self-Payment Program has certain election periods and requirements for timely payments. When you become ineligible for Fund benefits, the Fund office will notify you of your self-payment rights and the applicable self-payment rate.

The Board of Trustees establishes the self-payment rates. These rates are adjusted periodically. All self-payments must be made timely. You must pay by check or money order made payable to the "Laborers' Metropolitan Detroit Health Care Fund" and mailed to the Fund Office, at 6525 Centurion Drive, Lansing, MI 48917.

NOTE: Please make your self-payment when due, EVEN IF YOU THINK you should be eligible by way of **Employer** contributions.

If, after your self-payment is made, the Fund receives late **Employer** contributions on your behalf, which would have been sufficient to continue your eligibility, the Fund will make the appropriate refund of your self-payment to you.

Aside from the Self-Payment Program, if you or your dependents lose Fund eligibility you can participate in the **COBRA** program below.

2. The COBRA Continuation Coverage

If you and/or your dependents become ineligible for Fund benefits, you can temporarily extend your health care coverage under certain circumstances. This section explains your *rights/obligations* under **COBRA** Continuation Coverage.

Laborers' Metropolitan Detroit Health Care Fund

The Plan's **COBRA** coverage available to you is identical to the coverage provided to other similarly situated participants for basic hospital, medical, and surgical benefits. Loss of Time (Disability) Benefits, Death Benefits and Accidental Death and Dismemberment Benefits are **not** provided.

You don't have to demonstrate that you're insurable to purchase this **COBRA** coverage. But, you must immediately notify the Plan office about a divorce, death, legal separation, or if your children lose **Eligible Dependent** status. You are also required to notify the Fund Office if you and/or your **Eligible Dependents** become eligible for social security or obtain coverage under another health care plan.

You or your **Eligible Dependents** must pay to the Fund Office the required monthly payments in a timely fashion to start and maintain your **COBRA** coverage. The amount due and the due date for payment are shown on the **COBRA** election form.

a. Your Right to Elect COBRA Coverage

You may choose Continuation Coverage if you lose Plan eligibility because of insufficient employer contributions. This is called a **Qualifying Event** for you. This Qualifying Event entitles you and/or your family to elect up to eighteen (18) months of Continuation Coverage.

The Fund determines when a Qualifying Event occurs as a result of insufficient employer contributions. It does this based on the information provided by your Employer or former Employer.

The Fund Office will determine when the **COBRA** Qualifying Event has occurred within one-hundred and twenty (120) days following receipt of the Employer contribution form. The Fund Office will mail you the **COBRA** election notice within sixty (60) days after it has determined that you or a qualified beneficiary has lost eligibility for coverage. You then have sixty (60) days from the date you receive the Election Notice to elect Continuation Coverage.

If you don't make an election for coverage within sixty (60) days, you no longer have a right to receive Continuation Coverage.

You can purchase either **COBRA** Coverage, or you may purchase **Alternative coverage** which provides health care coverage equal to **COBRA** coverage **plus other benefits** for a premium that is less than the **COBRA** premium. The details of the **Alternative** coverage appear on your **COBRA** Election Notice.

Laborers' Metropolitan Detroit Health Care Fund

The right to **COBRA** Continuation Coverage is individual. That is, if you personally don't elect such coverage, your spouse and/or dependent children are still entitled to individually elect **COBRA** Continuation Coverage for themselves.

b. Your Spouse's and Dependent Children's Right to Elect COBRA Continuation Coverage

Spouses of eligible employees or Retired Participants are Qualified Beneficiaries. So, they have the individual right to choose **COBRA** Continuation Coverage if they lose their group health care coverage under the Plan for any of the following reasons:

- A reduction in the hours worked by you which results in your losing Fund eligibility;
- Your death;
- Divorce or legal separation from you; or
- You become entitled to Medicare and are not eligible to continue coverage for your spouse under another portion of the Plan or choose not to continue such coverage.

These are Qualifying Events for your spouse. The first Qualifying Event (loss of your eligibility because of insufficient hours) entitles your spouse to elect eighteen (18) months of **COBRA** Continuation Coverage. The other Qualifying Events listed above entitles your spouse to elect thirty-six (36) months of Continuation Coverage.

Dependent children covered under the Plan are Qualified Beneficiaries. So, they have the individual right to **COBRA** Continuation Coverage if they lose their Plan coverage for any of the following five reasons:

- A reduction in the number of hours worked by their parent, who is the covered Employee under the Plan;
- Death of the parent, who is the covered Employee under the Plan;
- Divorce or legal separation of their parents;
- You become entitled to Medicare and either are not eligible to continue coverage for the children or choose not to continue such coverage; or

Laborers' Metropolitan Detroit Health Care Fund

- The child or children cease to satisfy the Plan's definition of a "dependent child."

These reasons are Qualifying Events for your dependent children. The first Qualifying Event (loss of a parent's eligibility because of insufficient hours) entitles your dependent child(ren) to elect eighteen (18) months of Continuation Coverage. The other Qualifying Events entitle your dependent child(ren) to elect thirty-six (36) months of Continuation Coverage.

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

c. Continuation Coverage for Disabled Persons

If you, as a covered employee, your spouse, or any dependent child, as Qualified Beneficiaries, are eligible for Social Security disability benefits when a Qualifying Event occurs, or any time during the first sixty (60) days after you lose coverage due to a Qualifying Event, you may purchase an additional eleven (11) months of **COBRA** for a total of twenty-nine (29) months of **COBRA** Continuation Coverage.

This additional eleven (11) months of **COBRA** Continuation Coverage (18 months + 11 months = 29 months) can be purchased not only for the disabled person but also for other family members who are not disabled (subject to the applicable premium). **But, to qualify for this additional COBRA coverage, you must be eligible for Social Security Disability Benefits before the end of the eighteen (18) month continuation coverage period and you must notify the Fund Office during this eighteen (18) month period and within sixty (60) days after the Social Security Administration awards you disability benefits.**

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

Laborers' Metropolitan Detroit Health Care Fund

Eligibility for extended **COBRA** Continuation Coverage because of disability ends the first day of the month that is more than thirty (30) days after the date that the person is deemed, by the Social Security Administration, to be no longer disabled. A disabled person must notify the Fund within thirty (30) days of a final Social Security Administration determination that they no longer are disabled.

Under **COBRA**, you or a family member must notify the Fund Office **immediately** about a divorce, legal separation, or a child losing dependent status under the Plan. If such an event is not reported to the Fund Office **within sixty (60) days** after it occurs, **COBRA** Continuation Coverage is not available. Your surviving spouse (or dependent child) should contact the Fund Office **immediately after your death**. This assures that **COBRA** Continuation Coverage is offered to your surviving spouse and child(ren) at the earliest possible date.

COBRA election notices will be sent to the **last known address** on file at the Fund Office. If the election notice is sent to the wrong address because you failed to notify the Fund Office about a change in address, the sixty (60) day time limit for selecting **COBRA** Continuation Coverage will not be extended. And, you may lose the opportunity to elect **COBRA**.

You must also notify the Fund Office **if you or any family members are covered under another group health care plan** when you received a Fund **COBRA** election notice (*e.g.*, if you are covered as a dependent under your spouse's plan). You must also notify the Fund if, while you're receiving **COBRA** Continuation Coverage, you or a covered family member later become covered under another group health plan, including Medicare.

The Fund Office will likely require that you provide information about your coverage under another group health care plan. And, the Fund may seek reimbursement directly from you if it pays because you or your dependents did not notify the Fund of other health care coverage.

d. Second Qualifying Events

Under certain circumstances, you may purchase **COBRA** Continuation Coverage for a total of thirty-six (36) months. Specifically, you may purchase this extended **COBRA** Continuation Coverage if 1) a second Qualifying Event occurs within the eighteen (18) months after a first Qualifying Event that is a result of a reduction in hours, and 2) you are already covered under **COBRA** Continuation Coverage when the second qualifying event occurs.

Laborers' Metropolitan Detroit Health Care Fund

Below is an example of a second Qualifying Event that would trigger your right to purchase **COBRA** Continuation Coverage for up to thirty-six (36) months:

EXAMPLE 1: You die while covered under **COBRA's** eighteen (18) month coverage. At the time of your death, you have nine (9) months of your **COBRA** coverage remaining from your initial eighteen (18) months of **COBRA** coverage. In this case, your family may purchase additional **COBRA** coverage for up to thirty-six (36) months or twenty-five (25) more months of **COBRA** coverage. (Nine (9) months of remaining **COBRA** + twenty-five (25) more months of **COBRA** = thirty-six (36) total months of **COBRA**. $9 + 25 = 36$).

You **must** notify the Plan Administrator within sixty (60) days of the second Qualifying Event or this additional **COBRA** Coverage is not available.

e. Procedure for Obtaining COBRA and Your Duty to Notify Plan Office

Once the Fund Office learns that a Qualifying Event has occurred which entitles you to such **COBRA** Continuation Coverage, the Fund Office will notify you of your individual right to elect **COBRA** Continuation Coverage. Once you receive this Election Notice, you have sixty (60) days within which to notify the Fund Office of your decision. If you don't elect the **COBRA** coverage within this sixty (60) day time period, your right to **COBRA** Continuation Coverage ends.

f. Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may be cancelled by the Fund for any of the following reasons:

1. The Fund no longer provides group health care coverage to any Employees;
2. Your required self-payment for **COBRA** Continuation Coverage is not paid or not paid on time;
3. The person covered under the **COBRA** Continuation Coverage becomes covered under any group health care plan that does not include a pre-existing condition exclusion; or

Laborers' Metropolitan Detroit Health Care Fund

4. The person covered under the **COBRA** Continuation Coverage becomes entitled to Medicare.

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

Upon retirement, provided the qualifications are met, a Retired Participant is eligible to continue coverage for himself and his eligible dependents under one of the following Retired Participant Self-Payment Programs:

1. Early Retiree Self-Payment Program;
2. Totally & Permanently Disabled Self-Payment Program;
3. Supplement to Medicare Self-Payment Program;
4. Surviving Spouse Self-Payment Program; or
5. **COBRA** Continuation Coverage.

Descriptions and qualifications for each of the Programs (except for **COBRA** Continuation Coverage) are shown on the following pages.

Self-payments are required to provide coverage under all of these Programs. The self-payment rates are established by the Trustees and are changed periodically. For the current self-payment rates, call the Fund Office.

NOTE:

COBRA continuation payments do **not** provide coverage for Death, Accidental Death and Dismemberment Benefits or Disability Hour Credit.

III. RETIRED PARTICIPANT BENEFITS

A. GENERAL RETIREE PROGRAM

1. Schedule Of Benefits For Early Retirees

The schedule of benefits for Early Retirees and their dependents (who are not eligible for Medicare) is the same as the schedule of benefits for Active (Non-Retired) Participants, with the exception of Death Benefits and Disability Hour Credit. No Accidental Death and Dismemberment Benefits or Disability Hour Credit are available for Early Retirees or their spouses. Refer to Pages 40-41 for explanation of Retiree Death Benefits.

B. EARLY RETIREE SELF-PAYMENT PROGRAM

If you retire prior to age of 65, you're considered an Early Retiree until such time as you attain age 65 or become eligible for Medicare.

1. Eligibility Provisions

To continue Fund coverage as an Early Retiree, you must be receiving monthly pension benefits from the Laborers' Pension Trust Fund — Detroit & Vicinity or the Laborers' International Pension Fund and have been eligible under the Fund at least once by way of employer contributions in at least 5 of the last 10 years preceding your retirement.

If, due to disability, you can become eligible for Medicare, your coverage is provided under the Supplement to Medicare Program. Participants must obtain both Parts A & B of Medicare.

Your dependent(s) may also be covered through the Early Retiree Self-Payment Program.

Claims incurred in foreign countries by Covered Persons who are eligible for Medicare are payable only if such claims are **approved** for payment by Medicare and are adequately documented as "Emergency Services."

You must be eligible by either employer contributions or self-payments on the date of your retirement to participate in the Early Retiree Self-Payment Program. And, participation in this Program must begin immediately upon termination of coverage under the Active Program.

Laborers' Metropolitan Detroit Health Care Fund

2. Method Of Payment For Coverage

Self-payments are due in the Fund Office on the 1st day of the month for which payment is being made. For example, the self-payment to provide coverage for the month of September is due in the Fund Office no later than September 1. Self-Payments are to be made by either check or money order made payable to "Laborers' Metropolitan Detroit Health Care Fund."

You may elect to have self-payments deducted from your Laborers' Pension Trust Fund — Detroit & Vicinity monthly benefit check, or Direct Debit a personal bank account such as a checking or savings account. But, the appropriate authorization for deduction form must be executed by the 15th day of the month preceding the month such deductions are to begin. Cancellation of the deductions must be made in writing at least sixty (60) days prior to the effective date of cancellation.

You may remit self-payments for up to six (6) months in advance. Upon receipt of the self-payment, the Fund Office will send only one notification to you of the due date and amount of your next self-payment. You must remit your next self-payment in a timely manner because no additional notifications will be sent.

The Trustees establish the amount of the monthly self-payment and may change this amount periodically. For current self-payment rates, call the Fund Office at (517) 321-7502 or, toll free in Michigan 1-800-228-0048.

3. Provisions For Continued Participation

You may continue your coverage under the Early Retiree Self-Payment Program until one of the following occurs:

- Failure to remit timely self-payments or failure to pay the proper amount;
- Failure to remain a member in good standing with his Local Union;
- You attain Age 65 or becomes eligible for Medicare

You must provide the Fund Office with a copy of your Medicare Card as soon as you obtain such card. You must obtain both Parts A & B of Medicare when you are eligible;

(Coverage may be continued under the Supplement to Medicare Self-Payment Program.)

Laborers' Metropolitan Detroit Health Care Fund

- The Plan terminates the Early Retirement Self-Payment Program

You may continue coverage for your spouse and/or eligible dependent children under this Early Retiree Self-Payment Program until one of the following events occurs:

- You fail to remit timely self-payments or fail to pay the proper amount;
- Failure to remain a member in good standing with his Local Union;
- You become eligible for Medicare;
- Your child no longer meets the definition of Dependent Child;
- The Plan terminates the Early Retiree Self-Payment Program;
- You die;
- Your spouse is eligible or becomes eligible for Medicare; and
- Your spouse no longer meets the definition of "Spouse."

4. Special Provisions

- a. If you discontinue remitting self-payments or are untimely in your self-payments, Plan coverage will automatically terminate on the first (1st) day of the month following the month for which the final payment was made. This termination of coverage is ***automatic*** and no notification will be sent to you prior to this termination.
- b. This termination is significant because you will not later have an opportunity to participate in the Plan under the Supplement to Medicare Program at the age of 65, even if he meets the qualifications of that Program because your Plan coverage must be continuous to qualify for the supplement to Medicare Program.
- c. If you are single and remitting self-payments, and then marry, you may begin to cover your new spouse, effective with the date of marriage provided that proof of your marriage is submitted to the Fund Office within thirty (30) days from the date of such marriage along with the additional self-payment amount, if any. The current self-payment rates can be obtained from the Fund Office.

Laborers' Metropolitan Detroit Health Care Fund

- d. If you acquire dependent children, notification and proper documentation (for example, marriage license, birth certificates, adoption papers, legal guardianship papers, etc.) must be submitted to the Fund Office within thirty (30) days along with the additional self-payment amount, if any, for such coverage. The dependent children will be covered effective with the date the child meets the definition of Dependent Child provided the Fund Office has received proper documentation of such status.
- e. If you return to work, at the trade, you must remit self-payments at the "Active" self-payment rate, effective with the 1st month that you receive thirty-nine (39) hours or more of employer contributions.

B. TOTALLY & PERMANENTLY DISABLED PARTICIPANT SELF-PAYMENT PROGRAM

If you become totally & permanently disabled prior to age 65, you are considered a Totally & Permanently Disabled Participant with the Health Care Fund until you become *eligible* for Medicare Benefits.

1. Eligibility Provisions

To continue Plan coverage as a Totally & Permanently Disabled Participant, you must be receiving monthly pension benefits from Laborers' Pension Trust Fund — Detroit & Vicinity or the Laborers' International Pension Fund and:

- a) have been eligible under this Fund at the time your disability began and have been continuously disabled for a period of twenty-six (26) weeks; and
- b) have been eligible at least once by way of employer contributions in at least five (5) of the last ten (10) years preceding your disability

Generally, you are considered totally and permanently disabled if you are no longer able to perform the duties of your job or occupation.

If you have been declared totally and permanently disabled by the Social Security Administration for two years, you are eligible to receive Medicare Benefits. You may still continue to remit self-payments under the Totally &

Laborers' Metropolitan Detroit Health Care Fund

Permanently Disabled Participant Self-Payment Program until you attain the age sixty-five (65). Once you're age 65, you may continue to provide coverage for your spouse and any eligible dependents under the appropriate self-payment program until your spouse reaches age 65 and/or you no longer have any eligible dependents.

If the Social Security Administration determines that you have been disabled for a period of twenty-four (24) consecutive months, you are eligible for Medicare coverage. Then, you must obtain both Parts A and B of Medicare. You must make timely application for Disability Benefits from Social Security and Medicare. The benefits available to the Totally & Permanently Disabled Participants who are eligible for Medicare are payable under the Supplement to Medicare Program.

You must be eligible by either employer contributions or self-payment on the date of retirement to participate in the Totally & Permanently Disabled Participant Self-Payment Program. Coverage under this Program must begin immediately upon termination of coverage under the Active Program.

1. Schedule Of Benefits For Totally And Permanently Disabled Participants

The schedule of benefits for Totally & Permanently Disabled Participants and their dependents (who are not eligible for Medicare) is the same as the schedule of benefits in effect for Active (Non-Retired) Participants, with the exception of Death Benefits and Disability Hour Credit. No Accidental Death and Dismemberment Benefits or Disability Hour Credit are available for Totally & Permanently Disabled Participants and their spouses. Refer to Pages 40-41 for explanation of Retiree Death Benefits.

3. Method Of Payment For Coverage

Self-payments are due in the Fund Office on the 1st day of the month for which payment is being made. For example, the self-payment to provide coverage for the month of September is due in the Fund Office no later than September 1. Self-Payments are to be made by either check or money order made payable to "Laborers' Metropolitan Detroit Health Care Fund."

If you're totally & permanently disabled, you may elect to have self-payments deducted from your Laborers' Pension Trust Fund — Detroit & Vicinity monthly benefit check, or Direct Debit from your personal checking or savings account through your bank. You must sign the appropriate authorization form by the 15th day of the month preceding the month such deductions are to begin. The

Laborers' Metropolitan Detroit Health Care Fund

authorization form is available from the Fund Office. Cancellation of the deductions must be made, in writing, at least 60 days prior to the effective date of cancellation.

If totally and permanently disabled, you may remit self-payments for up to six (6) months in advance. Upon receipt of the self-payment, the Fund Office will send only one (1) notification to you of the due date and amount of your next self-payment. It is your responsibility to remit your next self-payment in a timely manner. After the one (1) notification is sent to you, no additional notification will be sent.

The amount of the monthly self-payment is established by the Trustees and is periodically changed. Current self-payment rates can be obtained from the Fund Office.

4. Provisions For Continued Participation

If you're totally and permanently disabled, you may continue his coverage under the Totally & Permanently Disabled Participant Self-Payment Program until one of the following occurs:

- Failure to remit timely self-payments or payments in the proper amount;
- Failure to remain a member in good-standing with his Local Union;
- You reach age 65;
- It is your responsibility to provide the Fund Office with a copy of your Medicare Card as soon as you obtain such card. You must obtain both Parts A & B of Medicare when you are eligible to receive them; or
- Termination or modification of the Totally & Permanently Disabled Self-Payment Program

(You may continue coverage for your spouse and/or eligible dependent children under this Program until one of the following events occurs;)

- Failure to remit self-payments on time or in the proper amount
- Failure to remain a member in good-standing with his Local Union

Laborers' Metropolitan Detroit Health Care Fund

- Totally & Permanently Disabled Participant attains age 65 or becomes eligible for Medicare
- Child or children no longer meet the definition of Dependent Child
- Termination or modification of the Totally & Permanently Disabled Participant Self-Payment Program
- Death of the Totally & Permanently Disabled Participant
- The Spouse no longer meets the definition of Spouse

5. Special Provisions

- a. If the Totally & Permanently Disabled Participant decides to discontinue remitting self-payments or fails to remit his self-payments in a timely manner, coverage will terminate on the first day of the month following the month for which the final payment was made. Such termination of coverage is automatic and no notification is sent to the Totally & Permanently Disabled Participant. The Totally & Permanently Disabled Participant will not have an opportunity to participate in the Plan under the Supplement to Medicare Program when eligible for Medicare, even if he meets the qualifications of that program since coverage must be continuous.
- b. If the Totally & Permanently Disabled Participant is single and remitting self-payments, and then marries, he may begin to cover his new spouse effective with the date of marriage provided that proof of his marriage is submitted to the Fund Office within 30 days from the date of such marriage along with the additional self-payment amount, if any. The current self-payment rates can be obtained from the Fund Office.
- c. If the Totally & Permanently Disabled Participant acquires dependent children, notification and proper documentation (marriage license, birth certificates, adoption papers, legal guardianship papers, etc.) must be submitted to the Fund Office within 30 days along with the additional self-payment amount, if any, for such coverage. The dependent children will be covered effective with the date as of which the definition of Dependent Child is met, provided proper documentation of such status has been

Laborers' Metropolitan Detroit Health Care Fund

received by the Fund Office. The current self-payment rates can be obtained from the Fund Office.

- d. If the Totally & Permanently Disabled Participant returns to work, he will be required to remit self-payments under the "Active" self-payment program until such time as he satisfies the eligibility provisions of the Active Program. It is the responsibility of the Totally & Permanently Disabled Participant to notify the Fund Office, in writing, if he returns to work so that a complete review of his status, can be completed. It is also his responsibility to notify the Fund Office, in writing, when he again retires.

C. SURVIVING SPOUSE SELF-PAYMENT PROGRAM ELIGIBILITY PROVISIONS

The Surviving Spouse and/or Surviving Dependent Children of a deceased Employee or deceased Retired Participant may be eligible for continued coverage under the Plan provided both the deceased Employee and the Surviving Dependents were covered under the Fund on the date of the Employee's death. Coverage is also available under the **COBRA** Continuation Provisions. Refer to Pages .

If the surviving spouse is not yet eligible for Medicare, she may remit self-payments for continued coverage under the Fund for herself and/or surviving Dependent Children. The amount of self-payment is established by the Trustees and may be changed from time to time. Benefits will be available under the Regular Medical Schedule of Benefits. Death Benefits and Disability Benefits are not included.

If the surviving spouse is eligible for Medicare at the time she qualifies to remit self-payments under this provision, she may remit monthly self-payments for herself under the Supplement to Medicare Program at the applicable self-payment rate.

However, this program may include Dental and Vision benefits if elected, for an additional fee. If there are also surviving Dependent Children, an additional self-payment will be required to provide such children with continued coverage under another portion of the Plan.

Self-payments are not required from a Surviving Spouse and/or Surviving Dependent Children until the first day of the month eligibility based on employer contributions or disability hours ends.

Laborers' Metropolitan Detroit Health Care Fund

1. Schedule Of Benefits

The schedule of benefits is the same for the Surviving Spouse and dependents (who are not eligible for Medicare) as the schedule of benefits in effect for Active (Non-Retired) Participants, with the exception of Death benefits. Dental and Vision benefits are available if elected, for an additional fee for the Surviving Spouse and/or dependent children.

If the Surviving Spouse and or dependents are eligible for Medicare Benefits, the plan will only pay those charges that are **approved** by Medicare. No Death benefits are provided and Dental & Vision benefits are only provided if an additional fee is paid.

2. Method Of Payment

Self-payments from a Surviving Spouse under this Program must be made by the 1st day of the month for which such self-payments is providing coverage. For example, the self-payment for coverage for the month of September is due in the Fund Office no later than September 1. Self-payments will only be accepted in the form of a check or money order made payable to the "Laborers' Metropolitan Detroit Health Care Fund." Self-payments may be mailed or delivered to the Fund Office, and must be received on or before the established due date. If the Surviving Spouse is receiving monthly benefits from the Laborers' Pension Trust Fund — Detroit & Vicinity, she may authorize a deduction of her self-payment from her monthly benefit check, or Direct Debit from your personal checking or savings account through your bank.

The amount of the monthly self-payment is established by the Trustees and may be changed from time to time. Current self-payment rates can be obtained from the Fund Office.

3. Termination Of Coverage

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

- Remarriage of the Surviving Spouse
- Failure to remit a self-payment in the correct amount by the specified due date

Laborers' Metropolitan Detroit Health Care Fund

- Termination or modification of the Surviving Spouse Self-Payment Program

Coverage for the Dependent Children will terminate on the first day of the month following one of these events:

- Termination or modification of the Surviving Spouse Self-Payment Program
- Failure to remit a self-payment in the correct amount by the specified due date
- Failure to meet the definition of Dependent Child as defined in the Plan

4. Special Provisions

Once coverage is elected under this Program, continuous coverage must be maintained through self-payments. If coverage is terminated for any reason, the Surviving Spouse and/or Surviving Children will not be permitted to make self-payments at any future time.

This coverage is subject to the *Coordination of Benefits* provision as provided on Pages 75 & 76. No duplication of benefits will be paid by the Fund if the Surviving Spouse and/or Surviving Dependent Children are eligible for benefits under any other insurance program or Medicare.

No Death Benefits or Accidental Death and Dismemberment Benefits are provided for persons covered by this Program.

Those not eligible for Medicare will have the same benefits as the Active Employees, except for the Death Benefits, Dental, Vision and Disability Hour Credit, and Accidental Death and Dismemberment Benefits.

All provisions, limitations, qualifications, exclusions, etc., as described in this booklet will apply to persons covered under this Program.

D. SUPPLEMENT TO MEDICARE PROGRAM

1. Eligibility Provisions

This coverage is available to those retired participants and/or spouses who are 65 and/or eligible for Medicare. Coverage is provided through Self-Payments

Laborers' Metropolitan Detroit Health Care Fund

under the Supplement to Medicare Program. In order to participate in this Program, the Retired Participant must meet the qualifications shown below:

- a. Have been eligible as an Active Participant at least once in five (5) of the ten (10) years immediately preceding the date of retirement
- b. Must be receiving monthly benefits from the Laborers' Pension Trust Fund — Detroit & Vicinity or the Laborers' International Pension Fund
- c. Must have both Parts A (Hospital) and B (Medical) coverage under Medicare. A copy of the Retiree and/or Spouse's Medicare Card must be submitted
- d. Must be a member in good standing with his Local Union
- e. Coverage based upon employer contributions has terminated
- f. The Retiree and/or his spouse is eligible to be added on the first day of the month following the month he/she becomes eligible for both Parts A & B of Medicare
- g. Spouse is eligible to be added to this program only if the Retiree meets provision A through E as shown above. In addition, the Retired Participant must be maintaining coverage for himself under one of the Retired Participant Self-Payment Programs. The spouse must have both Parts A and B of Medicare
- h. The Retiree and/or his spouse are required to obtain both Parts A and B when they are eligible for such coverage through Medicare

2. Schedule Of Benefits

This Program provides coverage as follows:

Hospitalization — The Fund will pay the difference between the Medicare approved amount and what Medicare pays. The Fund also pays the difference between the Medicare approved amount and what Medicare pays during the 60 lifetime reserve days. No coverage is available for services not paid by Medicare.

When utilizing a non-PPO facility, the out-patient Medicare deductible is not covered, the in-patient deductible will be reimbursed at 80%. When a PPO facility is utilized, the Fund will pay 100% of both Medicare deductibles.

Laborers' Metropolitan Detroit Health Care Fund

Skilled Nursing Facility — The Fund pays the difference between the Medicare approved amount and what Medicare pays for the 1st through 100th day. No coverage in these facilities is paid beyond the 100th day.

Out-Patient Care — The Fund will pay the difference between the Medicare approved amount and what Medicare pays.

Major Medical expenses not covered by Medicare may be considered for payment by the Fund. Approved benefits will be considered in accordance with the Plan schedule for Out-Patient Medical Care.

Home Health Care — The Fund pays the difference between the Medicare approved amount and what Medicare pays.

Doctor's Care — The Fund pays the difference between the Medicare approved amount and what Medicare pays including charges for x-rays, anesthesia, oxygen, surgery, wheelchairs and artificial limbs and other prostheses.

Out-patient Surgery, Radiology, Pathology — The Fund pays the difference between the Medicare approved amount and what Medicare pays.

The Fund will pay the difference between what Medicare approves and what Medicare pays. If the provider accepts Medicare assignment your bill will then be paid in full since the health care provider is not entitled to receive more than the Medicare approved amount.

If your physician or health care provider does not accept Medicare assignment you may owe the difference between the charged amount and the amount paid.

Neither Medicare nor the Fund will pay for the following:

- Cosmetic surgery
- Private hospitals or private duty nurses
- Custodial Care
- Chiropractic X-Rays
- Orthopedic shoes
- Items and services not necessary for the treatment of illness or disease

If Medicare does not cover a specific service or supply, with the exception of pap smears, and immunizations, the Fund will not cover such service or supply either.

Laborers' Metropolitan Detroit Health Care Fund

Non-military service related treatment provided by a Veterans Administration facility to participants and/or dependents *who are also covered by Medicare* is not covered by the Plan because Medicare does not provide any payment for these services. Any charges incurred by the participant and/or dependent for such non-military service related treatment will be the responsibility of the participant.

All benefits provided under the Supplement to Medicare Program are subject to the ***Coordination of Benefits*** Provisions as described, and in the section entitled Limitations and Exclusions.

The above is a summary of benefits. Medicare benefits are subject to final interpretation by the Department of Health and Human Services.

3. Method Of Payment For Coverage

Self-payments are due in the Fund Office on the 1st day of the month for which payment is being made. For example, the self-payment to provide coverage for the month of September is due in the Fund Office no later than September 1. Self-Payments are to be made by either check or money order made payable to "Laborers' Metropolitan Detroit Health Care Fund."

The Retired Participant may elect to have self-payments deducted from his Laborers' Pension Trust Fund — Detroit & Vicinity monthly benefit check, or Direct Debit from your personal checking or savings account through your bank. The appropriate authorization form must be executed by the 15th day of the month preceding the month such deductions are to begin. Authorization forms are available from the Fund Office. Cancellation of the deductions must be made in writing at least 60 days prior to the effective date of cancellation.

The Retired Participant may remit self-payments for up to six (6) months in advance. Upon receipt of the self-payment, the Fund Office will send only one notification to the Retired Participant of the due date and amount of his next self-payment. It is the responsibility of the Retired Participant to remit his next self-payment in a timely manner since no additional notifications will be sent.

The amount of the monthly self-payment is established by the Trustees and may be changed from time to time. Current self-payment rates can be obtained from the Fund Office.

4. Provisions For Continued Participation

The Retired Participant may continue his coverage under the Supplement to Medicare Program until one of the following occurs:

Laborers' Metropolitan Detroit Health Care Fund

- Failure to remit self-payments on time or in the proper amount
- Failure to remain a member in good standing with his Local Union
- Termination or modification of the Supplement to Medicare Program
- Death of the Retired Participant
- Retired Participant loses his Medicare coverage

The Retired Participant may continue coverage for his spouse and/or eligible dependent children under this Program until one of the following events occurs:

- Failure to remit self-payments on time or in the proper amount
- Failure to remain a member in good-standing with his Local Union
- Dependent no longer qualifies for Medicare
- Children no longer meet the definition of Dependent Child
- Termination or modification of the Retired Participant Self-Payment Program
- Death of the Retired Participant
- The Spouse no longer meets the definition of Spouse

5. Special Provisions

- a. If the Retired Participant decides to discontinue remitting self-payments or fails to remit his self-payments in a timely manner, coverage will terminate on the first day of the month following the month for which the final payment was made. Such termination of coverage is automatic and no notification is sent to the Retired Participant.
- b. If the Retired Participant is single and remitting self-payments, and then marries, he may begin to cover his new spouse effective with the date of marriage provided that proof of his marriage is submitted to the Fund Office within 30 days from the date of such marriage along with the additional self-payment amount, if any.

Laborers' Metropolitan Detroit Health Care Fund

The current self-payment rates can be obtained from the Fund Office.

- c. If the Retired Participant acquires dependent children, notification and proper documentation (marriage license, birth certificates, adoption papers, legal guardianship papers, etc.) must be submitted to the Fund Office within 30 days along with the additional self-payment amount, if any, for such coverage. The dependent children will be covered effective with the date as of which the definition of Dependent Child is met, provided proper documentation of such status has been received by the Fund Office. The current self-payment rates can be obtained from the Fund Office.

E. RETIREE DEATH BENEFITS

Retiree death benefits are payable to the beneficiary upon the death of a Retired Participant, Retired Participant's Spouse or Retired Participant's eligible children at least 30 days of age according to the following schedule:

Participant — \$4,000.
Spouse — \$2,000.
Dependent Children — \$2,000.

**NOTE: Widows do not qualify for Death Benefits

The Retired Participant's responsibilities include:

1. Remain a member in good standing with his local union. Status will be checked upon retirement and once each year thereafter.
2. Remit self-payments under either the Early Retiree Self-Payment Program, the Supplement to Medicare Program, the Retiree Self-Payment Program or the Totally and Permanently Disabled Participant Self-Payment Program to provide her with coverage in order for their spouse to be covered for the Retiree Spouse's Death Benefit.
3. Make sure that a Participant Data Card has been completed by the Retired Participant. This card is used to designate his beneficiary. The Retired Participant is automatically the beneficiary for his spouse. His spouse cannot designate a beneficiary.

Laborers' Metropolitan Detroit Health Care Fund

4. Benefits will be paid to the Beneficiary designated on the latest Participant Data Card on file in the Fund Office on the date of death. In the event the Retired Participant has not filed a Participant Data Card, benefits will be paid to his surviving legal spouse. If he is not survived by a spouse, benefits will be paid, equally, to his surviving children. If he is not survived by either a spouse or children, benefits will be paid to his surviving parents. If he is not survived by a spouse, children or parents, benefits will be paid to his estate or any individual determined by the Board of Trustees to be equitably entitled to receive the Death Benefits.
5. Benefits may be assigned, by the designated beneficiary, directly to the Funeral home. Assignment of benefits by any individual(s) other than the designated beneficiary will not be honored.
6. A written claim for benefits must be made within one (1) year from the date of death.
7. The designated beneficiary for receipt of Death Benefits will also be the beneficiary for any medical expenses that had not been paid prior to the date of death.

E. SPECIAL ELIGIBILITY PROVISIONS

1. HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for your preexisting medical conditions. Under HIPAA, a pre-existing condition exclusion generally may not be imposed for more than twelve (12) months (eighteen (18) months for late enrollees). These exclusion periods are reduced by your prior health coverage.

You are entitled to a Certificate of Creditable Coverage from your group health plan that will show evidence of your prior health coverage. A Certificate of Creditable coverage may help you obtain coverage under another health plan without a pre-existing condition exclusion should you lose coverage under this Plan. To obtain a certificate of creditable coverage, contact the Fund Office at (800) 228-0048 Toll Free, or (517) 321-7502.

If you have questions about your Continuation Coverage rights under ERISA, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, which is listed in your telephone

Laborers' Metropolitan Detroit Health Care Fund

directory or the division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C., 20210.

2. Military Service

You may continue your Fund health care coverage for up to eighteen (18) months if you stopped working in covered employment to enter the "uniformed services." Uniformed services include the Armed Forces or in active duty for training, inactive duty for training, or full-time duty in the National Guard, the Air National Guard, or the commissioned corps of the Public Health Service. You may be required to pay a monthly fee to continue Fund coverage.

To assure that this Fund coverage is provided on a timely basis, notify the Fund Office immediately within thirty (30) days, either when you enter the uniformed services, or, once you leave the uniformed services. You must resume working in covered employment to maintain Fund coverage.

3. Employment Outside The Jurisdiction

Frequently, the Laborers' accept employment outside the jurisdiction of their Local Union, particularly when there is no work available locally. The Plan has entered into reciprocity agreements with many other Funds covering Laborers that provide for the transfer of contributions back to this Plan. In most instances, you may authorize the transfer of contributions, in writing, although the transfer between the Michigan Laborers' Health Care Fund and this Fund are automatic in some circumstance. Contact the Fund Office for more information.

4. Disability Hour Credit

If you are unable to work because of injury or illness, you will receive Disability Hour Credit during the period of your temporary disability, up to a maximum of 52 weeks at up to 100 hours per month, if your disability lasts that long. Periodic statements from your attending physician (MD or DO) or a Fund-selected physician will be required as documentation of your continuing disability.

5. Family And Medical Leave

You may be eligible for up to twelve (12) weeks of unpaid, job protected leave for certain family and medical reasons under the Family and Medical Leave Act of 1993 (FMLA).

Your employer determines whether you are eligible for such medical leave under the FMLA, *not* this Plan or its Trustees. Contact your employer regarding your eligibility for leave under the FMLA.

Both you and your employer must notify the Fund Office if you take a family or medical leave and must provide certain other information as required by the Trustees. Your Plan coverage 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 Trustees.

6. Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 requires that this Plan recognize and comply with "Qualified Medical Child Support Orders." This SPD establishes the Fund's procedure for processing medical child support orders.

a. Receipt of Order and Determination of Qualification

The Fund Office will promptly notify you and each alternate recipient (*i.e.*, a person to receive benefits according to the order) of the order's receipt and the Fund's procedures for determining whether the order is a Qualified Medical Child Support Order.

Alternate Recipients may designate a representative who is authorized to receive copies of all correspondence that is sent to the Alternate Recipient regarding the submitted medical child support order. The custodial parents or guardians of minor Alternate Recipients are considered their designated representatives absent an express written request of other representatives. Alternate Recipients are deemed Fund Participants for purposes of applicable reporting and disclosure requirements and shall be treated as Fund beneficiaries for all other purposes.

Within a reasonable period after receipt of the order, the Plan Administrator, with the assistance of the Fund Counsel, shall determine whether it is a Qualified Medical Child Support Order. The Fund will then notify you and each alternate recipient of this determination.

Laborers' Metropolitan Detroit Health Care Fund

The Fund will review the submitted medical child support orders pursuant to the criteria established by Section 609 of **ERISA** and any applicable regulation and administration actions by agencies charged to enforce Section 609.

b. Effect of National Medical Support Notices

The Fund recognizes as Qualified Medical Child Support Orders "National Medical Support Notices" that comply with the provisions of applicable final regulations effective March 27, 2001.

c. Status of Alternate Recipients

Alternate Recipients shall be deemed Fund participants for purposes of applicable reporting and disclosure requirements and shall be treated as Fund beneficiaries for all other purposes.

d. Direct Payments

Payments for benefits or claims for reimbursements made by Alternate Recipients under Qualified Domestic Child Support Orders shall be made to the Alternate Recipients or their legal guardians as applicable.

7. Both Spouses Eligible As Employees

The Fund will coordinate benefits for any claims incurred by either spouse or an eligible dependent child if both a husband and wife are employed as Laborers, and are both eligible, as employees.

8. Claims Incurred In Foreign Countries

The Fund does not pay for any claims incurred outside the United States, Puerto Rico, the American Virgin Islands or American Samoa unless the claim is the result of a covered ***Accident*** or illness, requires emergency treatment, and occurs while traveling outside such areas. You are required in these instances to submit your claims fully translated and converted into U.S. dollars, in order for payment to be remitted on your behalf.

9. Automatic Assignment Of Benefits

Benefits payable under the Plan are automatically assigned (payable to) the provider of service (hospital, physician, etc.) unless the claim is accompanied by a valid, receipted paid bill.

All benefits which may be payable to plan providers are payable to the provider of service.

II. BENEFITS

A. HEALTH CARE BENEFITS

1. Summary Of Benefits

BENEFIT	PPO	DESCRIPTION
In-Patient Comprehensive Confinement, Surgery & Medical	PPOM (COFINITY) TRPN	100% of PPOM (COFINITY) approved amount to maximum of \$400,000
In-Patient Comprehensive Confinement, Surgery & Medical	OUT-OF-NETWORK	95% of 1st \$5,000 balance paid @ 100% to maximum of \$400,000
PPOM (COFINITY) Office calls – Takes \$10.00 co-pay	PPOM (COFINITY) TRPN	Included in Out-patient Medical Benefit maximum
Heart Transplant Benefit	PPOM (COFINITY) TRPN	100% of PPOM (COFINITY) approved amount to a maximum of \$300,000 per person, per Lifetime
Heart Transplant Benefit	OUT-OF-NETWORK	95% of 1st \$5,000 balance at 100% to max of \$300,000 per person, per Lifetime
Hearing Aid		50% reimbursement up to lifetime maximum of \$1,000, per person
Chiropractic	PPOM (COFINITY) TRPN	100% of PPOM (COFINITY) approved amount to max \$400 per person, \$1,000 per family, per calendar year (no deductible)
Chiropractic	OUT-OF-NETWORK	90% of UCR amount to maximum of \$400 per person, \$1,000 per family annually (no deductible)
Prescriptions-Retail	EXPRESS-SCRIPTS	\$10 Generic Drug or \$20 Brand Drug co-payment to a max benefit of \$5,000 per family, per calendar year. No coverage is provided for prescriptions purchased at Sam's Club or Wal-Mart. (A 40% co-payment applies to impotence drugs.)
Prescriptions-Mail Order	EXPRESS-SCRIPTS	\$10 Generic Drug or \$20 Brand Drug co-payment to a max benefit of \$5,000 per family, per calendar year. (1-copayment for a 3 mth supply). No coverage is provided for prescriptions purchased at Sam's Club or Wal-Mart. (A 40% co-payment applies to impotence drugs.)

Laborers' Metropolitan Detroit Health Care Fund

BENEFIT	PPO	DESCRIPTION
Prescriptions-Retail Surviving Spouse	EXPRESS- SCRIPTS	\$10 Generic Drug or \$20 Brand Drug co-payment to a max benefit of \$5,000 per family, per calendar year. No coverage is provided for prescriptions purchased at Sam's Club or Wal-Mart. (A 40% co-payment applies to impotence drugs.)
Supplement to Medicare	PPOM (COFINITY) TRPN	100% of Medicare approved amount
In-patient Deductible	NON-PPOM (COFINITY)	80% of the Medicare In-Patient Deductible
In/Out Patient Supplement to Medicare	NON-PPOM (COFINITY)	100% of approved amount not covered by Medicare (Out-Patient deductible not covered)
Out-Patient Medical	PPOM (COFINITY) TRPN	100% of PPOM (COFINITY) approved amount. Maximum of \$15,000 per person, per year (\$10.00 co-pay for office calls)
Out-Patient Medical	NON-PPOM (COFINITY)	90% of UCR after \$250 yearly family deductible Maximum \$15,000 per person, per calendar year
Out-Patient Surgery	PPOM (COFINITY) TRPN	100% of PPOM (COFINITY) approved amount (no annual maximum)
Out-Patient Surgery	NON-PPOM (COFINITY)	90% of UCR after \$250 yearly family deductible. (no annual maximum)
Out-Patient Mental Health	HMSA	100% HMSA approved amount up to 30 visits per person, per calendar year; 90 visits per lifetime-Included in the yearly out-patient medical maximum. PRE-AUTHORIZATION BY HMSA REQUIRED.
In-Patient Mental Health	HMSA	100% of HMSA approved amount up to 30 in-patient days per LIFETIME up to maximum of \$350,000. PRE-AUTHORIZATION BY HMSA REQUIRED.
In/Out Patient Substance Abuse	HMSA	100% of HMSA approved amount up to lifetime maximum of \$7,500 for <u>all</u> charges (In & Out-patient charges combined). PRE-AUTHORIZATION BY HMSA REQUIRED.
Preventive Health Exam		One exam per 12 month period for eligible participant and spouse
Preventive Health Incentive		\$200 maximum reimbursement of out-of pocket expenses for dental, vision, Rx or self-payments. Items not

Laborers' Metropolitan Detroit Health Care Fund

BENEFIT	PPO	DESCRIPTION
Smoking Cessation		\$500 lifetime maximum for participant and spouse ONLY- Referral Required
Eye Exam, Eye Glasses or Contact Lenses		\$225 per person, per consecutive 12 month period
Dental Benefits	Delta Dental	\$2,000 maximum per person per calendar year
Orthodontic Benefits	Delta Dental	\$1,500 lifetime maximum - per person
Death Benefits	Active Participants Only	Self - \$8,000 Spouse - \$4,000 Dependents - \$2,000
Accidental Death & Dismemberment	Active Participants Only	Self only – \$8,000
Retiree Death Benefit		Self - \$4,000 Spouse - \$2,000 Dependents - \$2,000

PPOM (Cofinity) – Preferred Provider of Mid-West
 TRPN – Three Rivers Provider Network
 HMSA – Health Management Systems of America

2. Preferred Provider Program - PPOM (COFINITY) OR TRPN

The Fund has contracted with various Preferred Provider Organizations to provide you with benefits at a substantial savings.

If you're eligible for Fund health care coverage, you're automatically enrolled in PPO program. But, *you* decide whether or not to use a PPO provider whenever you or an eligible dependent seek medical attention.

This program is completely voluntary. That is, *you* decide whether to use a PPO participating provider.

There are clear advantages to using PPO provider. For example, if you use a PPO provider for an office visit, your only expense is a ten dollar (\$10.00) charge. Similarly, covered benefits are payable at 100% of the PPO approved amounts up to the individual Benefit maximums. All Plan limitations and exclusions apply.

Laborers' Metropolitan Detroit Health Care Fund

If you don't use a PPO provider, your benefits will remain as outlined in the preceding Schedule of Benefits. And, you're responsible for all applicable co-pays and deductibles as they apply.

B. EXPLANATION OF BENEFITS

1. In-Hospital Comprehensive Confinement Benefit

a. PPO Providers

The Plan pays 100% of the PPO approved amount up to an overall maximum of \$400,000.00, and this benefit applies per disability. You must contact Hines and Associates at (888) 236-2652 to pre-certify all hospital admissions. The telephone number for Hines and Associates is also on the back of your Fund ID Card.

b. Non-PPO Providers

The Plan pays 95% of the first \$5,000.00 of covered reasonable and customary expenses incurred and 100% thereafter to an overall maximum of \$400,000.00. This benefit applies per disability. You must contact Hines and Associates at (888) 236-2652 to pre-certify all hospital admissions. The telephone number for Hines and Associates is also on the back of your Fund ID Card.

c. Covered Expenses

If you are admitted to a ***Hospital*** prior to the date Fund coverage would otherwise begin, this will have no effect on your eligibility for coverage as long as the Plan's eligibility provisions are otherwise fulfilled.

Covered Expenses for this In-Hospital benefit include the following:

1. ***Hospital*** room and board (including charges for coronary care, intensive care and trauma care) provided that it is medically necessary for you to be confined as a resident bed patient;
2. Miscellaneous necessary services and supplies furnished by the ***Hospital***;
 - a. dressings, splints, casts;

Laborers' Metropolitan Detroit Health Care Fund

- b. all medically necessary drugs and medications;
 - c. the use of operating rooms, recovery rooms, delivery rooms, treatment rooms and equipment;
 - d. general nursing services;
 - e. special nursing services, provided they are not provided by your immediate relative and such services are prescribed by the attending physician and not for ***Custodial Care***;
 - f. laboratory exams of blood, urine and tissue;
 - g. x-ray or imaging examinations, including radiologist's services;
 - h. electrocardiograms;
 - i. speech or physical therapy;
 - j. oxygen, including oxygen administration and therapy;
 - k. anesthesia, including administration by a Physician or licensed nurse anesthetist;
 - l. blood and blood plasma, including administration;
 - m. intravenous injections and solutions;
 - n. therapeutic services and supplies;
 - o. expenses incurred by the donor of organs or tissue to you, provided the charges are included on your ***Hospital*** bill.
- 3. Surgery and other medical care and treatment by a qualified physician or surgeon including consulting physician charges;
 - 4. Professional ambulance service to and from a ***Hospital***, when medically necessary;
 - 5. Maternity and newborn child care. Refer to Special Benefit Provisions, for complete maternity and newborn child care benefits;

Laborers' Metropolitan Detroit Health Care Fund

6. Newborn well-baby care while you are hospitalized following the Child's birth;
7. Emergency room charges, provided that you were admitted to the **Hospital** directly from the emergency room of the same facility and were eligible on the date the services were provided in the emergency room; and
8. Services provided must be medically necessary for the diagnosis or treatment of an injury/illness. Services/supplies must be provided by a practitioner who is properly licensed in the State such service/supply is provided.

2. Hospice Care, Home Health Care, And Convalescent Care

Hospice Care, Convalescent Care, and Home Health Care are part of the In-Hospital Benefit. As such, they are included in the overall maximum In-Hospital Benefit. Eligibility for these benefits is determined on the date of admission to the **Hospital**, except as described below. The benefits paid are the same as if the patient was still **Hospital** confined.

a. Hospice Care

Hospice care is available only to those who are determined by their physician to be terminally ill and who have a projected remaining life-span of six (6) months or less. Your attending physician's written certification is required. The Hospice must be State licensed and must meet Medicare and/or Medicaid requirements.

Hospice care is subject to the normal **In-Hospital Benefit Maximum**. If hospice care immediately follows discharge from the **Hospital**, your eligibility is determined on the date of the original admission to the **Hospital**. If hospice care is not preceded by a confinement in a **Hospital**, your eligibility for this benefit is determined on the date the hospice care actually begins.

b. Convalescent Care

Convalescent Care must be provided by a licensed extended care facility which, while not being able to provide all the services of a **Hospital**, can provide all services required by the patient until he is released. The facility must meet Medicare and/or Medicaid eligibility requirements. Your attending physician's written certification of the medical necessity for this type of care is required. Convalescent care is subject to the normal **In-Hospital Benefit Maximum**; but, benefits may only be paid up to 120 days of such Convalescent Care.

Laborers' Metropolitan Detroit Health Care Fund

Convalescent Care must immediately follow discharge from a hospital and eligibility is determined on the original date of admission to the hospital.

c. Home Health Care

Home Health Care is rendered to the patient at home by a licensed agency or licensed representative of the agency, who is not directly related to the patient. No benefits are payable for ***Custodial Care***, housekeeping services, child care, cooking, or laundry services. All services must be ordered by a physician and are subject to the Fund's review and verification. Home Health Care is subject to the normal **In-Hospital Benefit Maximum**.

Normally, Home Health Care Benefits begin immediately following discharge as an in-patient in a hospital and eligibility is determined on the original date of admission to the **Hospital**.

Should your Home Health Care not immediately follow a period of In-Hospital Confinement, the benefits may be payable under the In-Hospital Benefits provided your physician confirms, in writing, that your Home Health Care is in lieu of admitting you to the hospital. The Fund Office must authorize this care. When this occurs, eligibility is determined on the date the Home Health Care actually begins.

Pre-surgical home visit or physical by a visiting nurse are not covered.

3. Out-Patient Surgical Benefits

a. PPO Providers

The Plan pays 100% of the PPOM (COFINITY) or TRPN approved amount for charges incurred on the date of the surgery.

b. Non-PPO Providers

The Plan will pay 90% of all reasonable and customary charges incurred on the date of surgery after satisfaction of a \$250 deductible per family. This deductible will be in combination with the deductible for all Out-Patient Benefits, including but not limited to Out-Patient Hospital Services.

c. Covered Expenses

This benefit provides for payment of charges incurred for a covered surgical procedure performed in the physician/surgeon's office, out-patient surgical department of a *Hospital*, free-standing surgical center or clinic, out-patient emergency room of a *Hospital* or clinic while you are NOT confined as a resident bed patient in any facility.

This benefit does not cover dental surgical procedures, except for the removal of impacted teeth and certain tumors or as the result of a covered accidental injury to the natural teeth that is incurred while coverage is in effect. Refer to Special Benefit Provisions for more detail.

Out-Patient Surgical services include the following:

1. Surgeon's and Assistant Surgeon's charges
2. Anesthesia administration by a physician or certified nurse anesthetist;
3. Hospital/facility charges including:
 - a) operating rooms, recovery rooms, treatment rooms
 - b) miscellaneous supplies, such as dressings, casts, splints
 - c) drugs and medications and surgical supplies
 - d) surgical nursing services
 - e) anesthesia and its administration
 - f) blood and its administration
 - g) laboratory testing/examination of blood, urine and tissue
 - h) x-ray and imaging examinations
 - i) radiologist's charges
 - j) intravenous injections and solutions
 - k) oxygen, including its administration

Laborers' Metropolitan Detroit Health Care Fund

Charges in connection with a covered surgical procedure that are incurred either preceding the date of surgery or following the date of surgery are payable under the OUT-PATIENT MEDICAL Benefits, provided you're eligible for benefits on the date of service.

A copy of the surgical report must be submitted for all surgical procedures when the surgeon's fee exceeds \$300.

4. Out-Patient Medical Benefits

a. PPO Providers

The Plan pays 100% of the PPOM (COFINITY) or TRPN approved amount for charges incurred by you, while not confined as a resident bed patient, up to a maximum total payment of \$15,000 per person, per calendar year.

b. Non-PPO Providers

For Out-of-Network services, you must first satisfy an annual per family \$250 deductible. After this is paid, the Plan will pay 90% of reasonable and customary charges incurred by you while not confined as a resident bed patient up to a maximum total payment of \$15,000 per person, per calendar year. This \$250 deductible is in combination with the deductible for all Out-Patient Surgical Benefits, including but not limited to out-patient hospital services.

c. Covered Expenses

You must be eligible on the actual date services are rendered. Eligibility for all charges incurred in the emergency room will be determined on the date treatment in the facility actually begins.

Services provided must be medically necessary for the diagnosis or treatment of an injury/illness. Services/supplies must be provided by a properly licensed practitioner.

The following types of services are covered under this benefit:

- Emergency room charges
- Office calls
- Diagnostic x-rays and imaging (including radiologist's charges)
- Diagnostic laboratory testing of tissue, blood, or urine
- Physician's charges (including consultations and follow-up care)
- Acupuncture treatment

Laborers' Metropolitan Detroit Health Care Fund

Ambulance service to and from a hospital
Immunizations
Routine physical examinations
Well baby/child care
Prosthetic devices
Allergy testing and injections
Physical therapy
Second surgical opinions
Durable medical equipment
Lancets and test strips
Initial Diabetic instruction classes

Limits apply to certain types of services such as Chiropractic Care, Psychiatric Care and Durable Medical Equipment. Refer to Special Benefit Provisions, Pages 61 - 74.

5. In-Patient Hospital Bill Review Program

All hospitals must provide you with a copy of the itemized hospital bill. Please review the hospital bill to confirm that the charges correspond to the services provided to you.

If you discover a hospital billing error, the Fund will pay you ten percent (10%) of the amount saved, up to a maximum of \$250. The Fund will provide you with a questionnaire each time you are hospitalized.

6. Prescription Drug Program

The Fund has engaged with Express Scripts, Inc., to provide prescription drugs to you in a cost effective manner. By using your prescription drug card at Express Scripts/NPA pharmacies, you will receive your prescriptions at discounted prices.

The prescription drug benefits covers federal legend drugs, compound medications containing at least one federal legend drug ingredient, insulin and syringes.

Your prescription drug program is structured to allow you to receive generic drugs for a \$10 co-payment, and brand name drugs for a \$20 co-payment. Mail order prescriptions for maintenance medications allows for one co-payment (of either \$10/\$20) for a ninety (90) day supply as long as your physician writes the prescription for ninety (90) days. This benefit is limited to \$5,000 per family, per calendar year.

Laborers' Metropolitan Detroit Health Care Fund

A forty percent (40%) co-payment applies to Impotence drugs
For more information regarding the mail order drug program, contact the Fund office.

COVERAGE IS NOT PROVIDED FOR PRESCRIPTIONS PURCHASED AT WAL-MART OR SAM'S CLUB PHARMACIES.

**NOTE: All regular Plan limitations and exclusions apply.

7. Smoking/Tobacco Use Cessation Benefits

The Fund pays a maximum lifetime benefit of five hundred dollars (\$500), per participant and their spouse only, for smoking/tobacco use cessation classes and treatment. This benefit includes:

- Smoking/tobacco use cessation classes sponsored by a licensed health care facility, *i.e.*, the American Lung Association, the American Heart Association or the American Cancer Society. You must show proof of completion of the classes before reimbursement will be made;
- Nicotine Replacement Therapy (NRT) products such as patches, gum, nasal spray and/or inhaler. Your physician must write a letter recommending the therapy and you must produce a dated cash register receipt to be eligible for reimbursement for NRT product; and
- Acupuncture treatment if performed by a person that has been certified by the National Certification Commission for Acupuncture and Oriental Medicine.

You must be eligible for Fund benefits at the time you take classes, purchase NRT products, or receive acupuncture treatment. This benefit requires a written referral from a Medical Doctor (M.D.)

8. Chiropractic Benefit

For PPO in-network services, the Plan will pay 100% of the PPO approved amount up to a maximum total of \$400 per person, per calendar year, or \$1,000 per family, per calendar year, with no deductible.

For non-network services, the Plan pays 90% of the reasonable and customary expenses incurred up to a maximum total of \$400 per person, per calendar year or \$1,000 per family, per calendar year, with no deductible. Chiropractic related expenses covered under this benefit include manipulations, initial office calls, examinations, and x-rays.

Laborers' Metropolitan Detroit Health Care Fund

Certain services and supplies furnished by Chiropractors and/or Chiropractic Centers are **not** covered or are limited by the Plan. The items **not** covered include:

1. Maintenance and preventative care;
2. Treatment for non-orthopedic conditions such as cancer or heart disease;
3. Vitamins, food supplements, liniments, etc.;
4. Hair analysis;
5. Moire Contourographic Analysis;
6. Neurodermo-thermograph (thermodeltameter or thermoscribe);
7. Treatment outside the scope of the license of the Chiropractor;
8. Charges incurred that you are not required to pay;
9. Examinations and/or office calls, with the exception of the initial visit are included in the manipulation fee;
10. Chiropractic services for dependents under the age of 3;
11. Hot and cold packs; and
12. Massage therapy.
13. Traction
14. Exercise therapy

9. Hearing Aid Benefit

The Plan provides for payment of hearing aids and/or hearing aid examinations at 50% up to a lifetime maximum of \$1,000 per participant and/or dependent. ***Widows are not eligible for this benefit.***

10. Dental And Orthodontic Benefits

Dental Benefits are provided under the Dental Schedule of Benefits through Delta Dental Plans of Michigan. All exclusions in effect for Medical Benefits apply to Dental Benefits also unless coverage is specifically provided for in this description of covered benefits.

You must be eligible on the date dental services are actually performed. In the case of Orthodontic Benefits, you must be eligible on the "banding" date. Contact the Fund Office to verify eligibility prior to having any dental work performed.

Dental Benefits are payable on a scheduled basis, with an annual maximum of \$2,000. Orthodontic benefits have a lifetime maximum benefit of \$1,500. You must be eligible on the banding date.

Cleanings, routine examinations and bitewing x-rays are limited to once every six (6) months.

Full mouth x-rays are limited to once every two (2) years.

Dentures and partials are provided only once every five (5) years.

Relining of dentures and partials is provided only once every two (2) years.

Occlusal Guards are limited to the coverage of treatment of Bruxism only.

There is no benefit for lost or stolen dental appliances. Bite splints for treatment are not payable.

Charges incurred for injuries to the natural teeth as the result of a covered accidental injury should be submitted under the medical portion of the Plan.

a. Delta Dental DPO and Premier Networks

Your Dental Plan includes Delta Dental Preferred Provider Organization (DPO), and Premier networks. This is a national network of dentists, including specialists. These dentists accept the Delta Dental contracted fee schedule as full payment for dental services. By using a Delta Dental participating provider, you save the Fund and yourself money.

Preventive dental services (called Class I benefits) are paid at one hundred percent (100%) of the allowed amount.

Basic Restorative dental services (Class II), which include fillings, extractions, root canals, and bridge and denture repairs, are paid at eighty percent (80%) of the allowed amount.

Laborers' Metropolitan Detroit Health Care Fund

Regular Restorative dental services (Class III), which include crowns, bridges, dentures, and implants, are paid at fifty percent (50%) of the allowed amount, and Orthodontic dental services

Orthodontics (Class IV), which includes braces, are paid at fifty percent (50%) of the allowed amount.

Payment for services will be based on the **lowest** of the following fees:

- a. the dentist's submitted fee; or
- b. Delta Dental's maximum allowed amount.

If you are eligible for Plan benefits, you automatically qualify for Delta Dental Benefits. You may choose any dentist and may change dental offices at any time. To use a participating Delta Dental dentist, select a dentist from the Delta Dental directory, call the office, identify yourself as a network Delta Dental patient and make the appointment. Confirm with your dentist before each appointment that he/she is participating in the network.

Because dentists are continually added to the Delta Dental network, you may want to call periodically to review network participation. If your dentist is not in the network, call Delta Dental at 1-800-524-0149 or visit the Delta Dental website at: www.DeltaDental.com. Delta Dental will invite your dentist to join the network.

b. Dental Related Services

1. Accidental Injury to Natural Teeth

If treatment, including dental surgery, is required because of a covered accidental injury to natural teeth, your benefits are paid under the appropriate medical benefits. Treatment or surgery expenses must be rendered within one hundred eighty (180) days following the date of the **Accident**. And, you must have been eligible on the date of the **Accident**.

No benefits are payable for repair or replacement of dental prosthetic devices including dentures, partial bridges and plates, crowns, caps and braces.

2. Surgical Removal of Impacted Teeth

The surgical removal of impacted teeth is covered under the Out-Patient Surgical Benefit. Proper documentation is required from the dentist/dental surgeon who performs the surgical procedure.

3. Other Dental/Surgical Procedures

Certain dental/surgical procedures are covered, if properly documented, as medically necessary. Such documentation will be reviewed by the Fund Office and/or the Medical Consultant. If coverage is approved, payments are made under and subject to the limitations of the appropriate medical benefit. The procedures requiring documentation of medical necessity are listed below:

ADA Codes	Description
D5900 – D5921	Extraoral prostheses
D5931 – D5935	Intraoral prostheses for acquired defects
D5951 – D5957	Intraoral prostheses for congenital defects
D5973 – D5976	Implants - facial, mandibular, cranial
D5982 – D5985	Special treatment prostheses
D7470 – D7490	Excision of bone tissue
D7510 – D7560	Surgical excision
D7610 – D7780	Treatment of fractures
D7910 – D7994	Repair procedures

Certain other dental/surgical procedures are covered under the Out-Patient Surgical Benefit. These procedures are listed below:

ADA Codes	Description
D7220 – D7241	Surgical extraction of impacted tooth
D7430 – D7441	Removal of tumors
D7460 – D7465	Removal of cysts, destruction of lesions

If a surgery in the mouth is contemplated, contact the Fund Office to determine whether it is a covered procedure *prior* to the surgery. If hospitalization is recommended or required for a dental/surgical procedure, the hospitalization may not be covered. If surgery in the mouth is contemplated, covered persons are advised to contact the Fund Office for a determination as to whether it is a covered procedure prior to the surgery being performed. If hospitalization is recommended or required for a dental/surgical procedure, the hospitalization may not be covered. Contact the Fund Office for a determination prior to incurring the expense.

11. Special Benefit Provisions

This section provides more information regarding available benefits, restrictions, requirements and limitations for the treatment of certain conditions.

If a specific service has not been identified as payable under a certain benefit of this Plan, the CPT-4 Codes for services will be used to determine under which type of benefit the service should be paid, subject to all the Plan's limitations and exclusions.

a. Acupuncture Treatment

The Plan pays for Acupuncture treatment provided by appropriately licensed persons for the treatment of injuries/illnesses that involve chronic pain. Benefits are provided under the Plan's OUT-PATIENT MEDICAL BENEFIT. The following additional limitations apply:

1. Long-term treatment is subject to periodic review by the Administrative Manager and/or the Medical Consultant;
2. Simultaneous treatment for more than one (1) type of chronic pain requires written documentation of medical necessity; and
3. Therapy that is performed concurrently with another type of therapy requires documentation of medical necessity and is subject to review by the Administrative Manager and/or the Medical Consultant.

b. Ambulance Service

Ambulance service to and from the *Hospital* is covered when medically necessary. If medically necessary, air ambulance charges to the nearest facility able to provide appropriate treatment will also be covered.

c. Birth Control

Coverage is provided for the following:

1. Surgical sterilization (vasectomies and tubal ligations);
2. Oral contraceptives (birth control pills);
3. Diaphragms, excluding the charge for fitting;

Laborers' Metropolitan Detroit Health Care Fund

4. Voluntary Abortions —voluntary abortions are covered for the member or the member's spouse however they are limited to one, per lifetime for their eligible daughter(s);
5. Norplant — coverage only for the employee or the legal spouse (1 every 5 years); and
6. Intra Uterine Device (IUD)
7. Depo Provera Injection

Coverage is *not* provided for the following:

1. Condoms;
2. Spermicidal jellies and creams;
3. Cervical caps;
4. Home pregnancy tests; or
5. Ovulation detection supplies.

d. Cosmetic Surgery

Surgery to correct a functional problem or repair damage caused by a covered injury or illness is covered by the Plan. (But, surgery to improve personal appearance is not covered. See the **Exclusions** and Limitations section for more detail.)

Breast reconstruction surgery is covered for:

- Reconstruction of the breast(s) on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; or
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The Fund has provided coverage for mastectomies for a number of years. As part of this coverage, the Plan also covered 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 lymphedemas, 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 covers any surgery and reconstruction of the other breast to achieve a symmetrical appearance.

Check with the Fund Office *prior* to undergoing ANY non-emergency surgical procedure to confirm whether the Plan provides coverage.

e. Diapers

The Plan covers the cost of "diapers" when certified as medically necessary as a result of bladder and/or bowel control. This is not a benefit for infants or children who are at the age diapers are normally worn.

f. Durable Medical Equipment

The Plan covers the purchase or rental of certain *Durable Medical Equipment*. Benefits are provided under the Out-Patient Medical Benefits of the Plan. Contact PPOM (COFINITY) or TRPN for a listing of preferred providers.

The equipment must be appropriate for home use, prescribed by a licensed physician and medically necessary for the treatment of an illness or injury or used to improve the functioning of the patient's body. See the *Exclusions and Limitations* section related to *Durable Medical Equipment for more detail*.

The Plan does *not* provide coverage of repairs to *Durable Medical Equipment*.

g. Infertility

Limited coverage is provided for the diagnosis and treatment of infertility, including charges in connection with surgical sterilization reversal. However, the Plan does not provide any Benefits for charges incurred for the following procedures:

1. In-vivo fertilization
2. In-vitro fertilization
3. Artificial insemination
4. Zygote intrafallopian tube transfer (ZIFT)
5. Gamete intrafallopian tube transfer (GIFT)

Laborers' Metropolitan Detroit Health Care Fund

6. Ovulation detection supplies
7. Fertility drugs

h. Maternity/Obstetrical Related Services

Expenses incurred for some Maternity/Obstetrical related services are paid under the In-Hospital Benefits of the Plan. You must be eligible on the date you enter the hospital for delivery of the child for any of the following charges to be payable under the Plan:

1. Pre-natal, post-natal and delivery (including C-Section) charges;
2. Services as listed under the In-Hospital Benefits of the Plan on Pages 49 - 51;
3. Labor and delivery rooms;
4. Birthing rooms;
5. Midwives, provided they are supervised by a physician; and
6. TermGuard and similar uterine monitoring devices.

Some Maternity/Obstetrical related services are paid under the Plan's Out-Patient Benefits, provided you are not hospitalized when these services are provided. You must be eligible on the date services are rendered for any of the following charges to be payable:

1. Laboratory examinations of tissue, blood or urine;
2. X-ray and imaging examinations, including radiologists fees;
3. Injections, such as RhoGam; and
4. Preconception/prenatal testing for congenital defects or hereditary disease if performed in connection with an injury or illness, or if a history of hereditary disease is present, or if either parent is at high risk for producing an abnormal infant. Elective testing is not covered.

The mother and baby receive one benefit. Eligibility for payment of the newborn child's incurred expenses requires that the Employee be eligible on the date the

Laborers' Metropolitan Detroit Health Care Fund

child is born. In addition to those items listed under the In-Hospital Benefits, the following expenses are payable under the Plan:

1. Nursery charges, including nursing care and miscellaneous necessary supplies as long as the mother is confined;
2. Well baby care, including the initial physical examination;
3. Routine procedures, such as circumcision;
4. Continued confinement of the newborn, following discharge of the mother, if due to a congenital defect, premature birth or illness; and
5. Neo-natal care units.

Planned home delivery or use of a freestanding birthing center is covered provided a physician is in attendance.

The Fund allows for the payment of maternity related expenses for a dependent daughter's first pregnancy only. But, no payment for baby charges will be made.

STATEMENT OF RIGHTS UNDER THE NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Under federal law, the Plan may not 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 delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, the Plan may not set the level of benefits or out-of-pocket cost so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not require that a physician or other health care provider obtain authorization of prescribing a length of stay of up to 48 hours (or 96 hours). But, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on pre-certification, contact the Fund Office.

i. Mental Health And Substance Abuse Benefits

LABORERS' ASSISTANCE PROGRAM (L.A.P.)

The Laborers' Assistance Program (L.A.P.) is a confidential counseling program designed to help the member and his dependents with personal problems that may be interfering with work and daily life. The L.A.P. can assist with problems related to alcohol and drug abuse, marital and family issues, depression, stress and job-related issues. The L.A.P. is available 24 hours a day, 7 days a week.

The L.A.P. is offered through Health Management Systems of American (HMSA). In order to receive mental health and/or substance abuse treatment, you must call the toll free number (1-877-366-5552). You **must** call this number prior to receiving any treatment to have that treatment reimbursed by the Fund. In case of emergency treatment, you must call L.A.P. within twenty-four (24) hours of the emergency treatment to have that treatment reimbursed by the Fund.

The L.A.P. can help you with:

Substance Abuse

- Problem Drinking
- Illegal Drug Use
- Drug Testing Concerns
- Prescription Drug Misuse

Family

- Parent-Child Conflicts
- Coping with serious illnesses
- Aging Parents
- Single Parenting
- Child Care
- Attention Deficit Hyperactivity Disorder (ADHD)

Marital

- Separation & Divorce
- Communication Problems
- Resolving Conflicts
- Domestic Violence

Work-Related

- Jobsite Conflicts
- Sexual Harassment

Laborers' Metropolitan Detroit Health Care Fund

- Pre-Retirement Concerns

Financial

- Problem Gambling
- Household Finances
- Over-Extended Credits

Emotional & Mental Health

- Stress, Anxiety & Depression
- Managing Anger
- Grief & Loss
- Life Transition
- Disability Adjustment

The L.A.P. also offers assistance regarding:

Child Care Issues

- Pregnancy Planning
- Parenting Seminars
- Summer Programs
- Infant/Toddler Child Care
- Nanny/In-Home Referral
- College Scholarship Information
- Parental Classes/Support
- Before and After School Programs
- Special Needs Services
- Temporary Illness/Emergency Care
- Pre-School Care
- Tutor Referrals

Elder Care Issues

- Nursing Home Facilities
- Homemaker Services
- Medicare/Medicaid Assistance
- Adult Day Care
- Friendly Visitor Programs
- Individual Assessment Consults
- Social Service Agencies
- Home-delivered Meals
- Home Health Care
- Assisted Living Facilities
- Hospice Care
- Self-Care Education

Laborers' Metropolitan Detroit Health Care Fund

IMPORTANT

To receive **any** benefit under the Plan's Mental Health and Substance Abuse Benefits, you must first contact the Laborers' Assistance Program, (LAP) and get **preauthorization** for your treatment. You can reach the LAP 24 hours a day, seven days a week at 1-877-366-5552

In case of an emergency, you must notify LAP within 24 hours of your treatment or confinement.

If you do not get LAP pre-authorization for your treatment, you will not receive any coverage.

Finally, LAP is a confidential counseling program designed to help you with personal problems that may be interfering with work and daily life, including problems related to alcohol and drug abuse, marital and family issues, depression, stress and job-related issues.

Contact the Fund Office for additional literature related to LAP's services.

1. In-Patient Mental Health Benefits

In-patient Mental Health Benefits are paid the same as all other **Hospital** admissions. But, there is a **lifetime maximum of thirty (30)** in-patient **Hospital** days per person for all Mental Health admissions.

Benefits are paid based upon the Usual, Customary and Reasonable (UCR) fee schedules.

2. Out-Patient Mental Health Benefits

Out-patient Mental Health Benefits are paid the same as all other out-patient services. But, there is an **annual limitation of thirty (30)** Mental Health Visits and a **lifetime maximum of (90)** Mental Health visits. Benefits are paid based upon the Usual, Customary and Reasonable (UCR) fee schedules.

Marital counseling, dyslexia and learning disabilities are not covered under the out-patient mental health benefit. Nor is nicotine dependence/withdrawal. For benefits related to nicotine dependence, see page 56.

3. Substance Abuse/Chemical Dependency Benefits

Substance abuse/chemical dependency charges (both in-patient and out-patient) are payable at 90% after a \$250 deductible. **The lifetime maximum payable per person is \$7,500.**

Whether charges are incurred as an inpatient or an out-patient, the provider of service must be licensed and meet the qualifications established by the Plan. Services provided by a psychologist or social worker are covered, provided such services are rendered under the direct supervision of, or are recommended by, a physician.

The changes for consultations with family members during the diagnosis or initial evaluation stage are payable under the benefits available for the person being treated. Subsequent consultations with family members are not paid by the Plan unless the necessity for such consultations is documented.

Treatment lasting longer than 30 days in an in-patient facility or six (6) months on an out-patient basis is subject to review by the Administrative Manager and/or Medical Consultant.

j. Obesity Treatment

Treatment for obesity is covered only if **all** of the following conditions of medical necessity are met:

1. You're at least 100 pounds or 100% over your ideal weight, according to a standard height/weight chart;
2. There is medical documentation of your inability to control weight by diet for a minimum period of five (5) years;
3. There is medical documentation that a medical condition exists that is aggravated by your obesity; and
4. There is documentation that no psychiatric conditions/problems exist.
5. Prior authorization from the Fund Office is required.

If determined to be medically necessary, the following obesity-related surgical procedures are covered:

Laborers' Metropolitan Detroit Health Care Fund

1. Gastric bypass;
2. Gastric stapling;
3. Gastric partitioning;
4. Gastric banding;
5. Vertical banded gastroplasty;
6. Gastrogastrostomy; and
7. Dental Occlusion (Jaw Wiring), in certain instances. Prior approval by the Fund Office is needed.

If medically necessary, the following non-surgical obesity-related services rendered by physicians are also covered, provided these services are rendered by a physician:

1. Office visits;
2. Diagnostic testing;
3. Psychologic counseling; (approved through the LAP Program)

The following services are not covered by the Plan:

1. Food supplements
2. Weight loss program membership fees
3. Dietary supplements
4. Special foods/drinks
5. Exercise programs
6. Exercise equipment

k. Out-Patient Chemotherapy and Cancer Treatment

Reimbursement for out-patient chemotherapy charges is payable under the **In-patient Schedule of Benefits**.

If you use a PPOM (COFINITY) provider, your out-patient chemotherapy charges are paid at 100%. But, if you use a non-PPOM (COFINITY) provider, your charges are paid at 95% of the first \$5,000 of covered reasonable and customary expenses incurred then 100% thereafter.

Laborers' Metropolitan Detroit Health Care Fund

All related charges are subject to the overall benefit maximum of \$400,000 per disability. Charges for cancer drugs are included within this benefit.

I. Physical Therapy

The Plan requires that treatment be recommended by a physician/surgeon and performed by a licensed physical therapist. But, certain services and supplies are not covered or are limited by the Plan. These include:

1. Maintenance and/or preventative treatment is not covered;
2. Iontophoresis or iontotherapy without documented medical necessity is not covered;
3. Therapy that is performed concurrently with chiropractic therapy requires documentation of medical necessity;
4. Thermography is not covered;
5. Treatments that can easily and safely be performed at home are not covered, unless documentation of medical necessity for treatment being provided by a physical therapist exists. For example, moist or dry heat treatments, cold packs, exercise routines, use of exercise equipment, TENS therapy, and home traction, is not covered;
6. Aquatic and Equestrian Therapy

Charges are paid on a per visit basis when more than 3 types of service are provided. Treatment for chronic and/or long-term conditions is subject to periodic review by the Administrative Manager and/or the Medical Consultant.

m. Podiatry Treatment

The Plan covers certain types of treatment by a licensed podiatrist. The following types of services are NOT covered:

1. Routine foot care, unless certified as medically necessary;
2. Cost or the fitting of more than one (1) pair of orthotics per person per lifetime;

Laborers' Metropolitan Detroit Health Care Fund

3. Medicine or drugs *dispensed* by a podiatrist;
4. Electrodiagram (EDG); and
5. Excessive x-rays.

Long-term care/treatment is subject to periodic review by the Administrative Manager and/or the Medical Consultant.

n. Preventive Health Care Program

The Plan has a Preventive Health Care program. It includes an examination and comprehensive diagnostic services for you and your spouse with an emphasis on prevention and early detection of, and referral for treatment of occupationally related diseases. One (1) preventive health care examination per twelve (12) month period will be performed at no cost to you.

The facilities within the Providence Corporate Health Services participate in this program.

If you're interested in participating in this Program, contact the Fund Office for verification of your eligibility. If you're eligible for this examination, the Fund Office will send you a voucher, which you must present at either facility.

Once you've received your voucher, contact one of the participating providers to set up your examination date and time (the addresses and telephone numbers of the participating facilities is on the voucher).

The Plan may offer incentives, such as credit towards self-payments and/or claims co-payments, for those participants who receive a physical examination under this Preventive Health Care Program from one of the Fund's participating providers.

o. Prosthetic And Orthotic Devices

With certain limitations, the Plan provides benefits for prosthetic and orthotic devices.

The device must be medically necessary as documented by a physician and only those items for which coverage is provided by Medicare and/or Medicaid are covered by the Plan. Coverage for some prosthetic and orthotic devices is only

Laborers' Metropolitan Detroit Health Care Fund

provided one (1) time. Other devices are covered on a limited basis. Contact the Fund Office for information regarding these specific items.

p. Second Surgical Opinions

The Plan pays for Second Surgical Opinions under both the In-Hospital and Out-Patient Benefits. Obtaining a Second Surgical Opinion is not mandatory. But, the Plan urges you to obtain one for any elective, non-emergency surgical procedures. To avoid any unnecessary duplicate testing, you must arrange to have the physician/surgeon who recommends the surgery, forward to the physician consulted for a second opinion, all of your medical records and test results necessary to make a determination about the surgery.

q. Speech Therapy

The Plan provides benefits for Speech Therapy that is provided by a properly licensed professional, subject to the following conditions:

1. A physician must recommend such therapy;
2. Documentation of medical necessity following a covered injury/illness is required; and
3. Services available through the school system are not covered.

r. TMJ (Temporomandibular Joint) Dysfunction Treatment

The Plan only covers certain services in connection with TMJ treatment. The actual treatment of TMJ is not covered. But, certain services, such as x-rays used to diagnose TMJ, may be covered.

s. Transplants

The Plan provides benefits, under the regular Schedule of Benefits, for charges related to any of the following organs or tissues transplants.

1. Cornea
2. Kidney
3. Liver
4. Bone Marrow

Laborers' Metropolitan Detroit Health Care Fund

Heart transplants are treated separately by the Fund. They are subject to a \$300,000 per person lifetime maximum. The Fund will pay, where applicable, 100% of the PPOM (COFINITY) approved amount up to the \$300,000 maximum or, for services performed by non-PPOM (COFINITY) providers, 95% of the first \$5,000 and any balance at 100% up to the \$300,000 maximum.

t. Vision Care

The Plan provides vision care benefits. The Plan provides a benefit of \$225 per twelve (12) consecutive month period for you and each of your eligible dependents. Participants who maintain coverage via self-payments as well as eligible retirees are also eligible for this benefit.

Vision Care Benefits are up to the maximum of \$225 for the purchase of one pair of glasses (including lenses and frames) or contact lenses and related eye exam.

The Plan generally excludes all charges for treatment of vision problems deficiency that can be corrected by use of glasses or contact lenses. But, some vision problems are covered by the Plan, provided documentation of medical necessity is presented.

The covered procedures that are payable, provided documentation of medical necessity is presented, include:

1. Cataract and Strabismus Surgery;
2. Keratoplasty;
3. Repair of Detached Retinas;
4. Glaucoma treatment;
5. Orthoptics; and
6. Treatment following an injury

C. COORDINATION OF BENEFITS, OVERPAYMENT AND SUBROGATION PROVISIONS

1. Coordination Of Benefits

All Plan benefits, except Death and Accidental Death and Dismemberment Benefits, are subject to the Plan's Coordination of Benefit Provisions (COB). These provisions apply to any Covered Person who has coverage under any other group or individual insurance program. This includes, for example, a Blue Cross-Blue Shield Plan or Medicare.

Whenever other coverage is in effect under an *individual* program, the other coverage will be primary and the Plan secondary.

When coverage is in effect under another *group* program, COB will be applied as described below.

The Plan will pay the benefits, under its applicable Schedule of Benefits, if it is considered to be the primary plan. Otherwise, the other insurance must pay the benefits up to the maximum amount payable under its schedule of benefits. Thereafter, the Plan will then pay any remaining amounts not covered by such other plan but only consistent with the Plan's Schedule of Benefits.

Under no circumstances will more than 100% of your covered expenses be paid.

The following rules are applied to determine whether this Plan or the other health care plan pays first:

1. If the other plan has not adopted COB Provisions, it must pay first;
2. If the other plan has COB Provisions, then,
 - a) the plan in which the Covered Person is covered as an Employee shall pay first and in accordance with its schedule of benefits and the plan in which the Covered Person is covered as a Dependent shall pay any remaining balance up to its maximum amount according to its schedule of benefits;
 - b) if the Covered Person is covered as an Employee under both plans, the plan that has provided coverage for the longest

Laborers' Metropolitan Detroit Health Care Fund

continuous period of time will be considered the primary carrier and will pay first;

3. Where the claim is for a Covered Dependent child, the following procedure shall be followed in determining which plan shall pay first:
 - a) the plan covering the child's parent who has the earliest birthdate in the calendar year;
 - b) if both parents have the same birthdate, the plan which covered the child for the longer period of time;
 - c) if the child's parents are divorced, or legally separated, the plan covering the parent who is financially responsible for the child's health care pursuant to court decree. If there is no court decree, the plan which covers the custodial parent will be primary. If the custodial parent is remarried, the plan which covers the spouse of the custodial parent is primary over that which covers the non-custodial parent.

Complete copies of divorce decrees are necessary to determine the primary and secondary payers of benefits for dependent children of divorced parents.

To properly determine whether other plans may be involved in the payment of medical expenses, you must complete and submit a yearly ***Coordination of Benefits*** Form. You must promptly notify the Fund Office, in writing, whenever a change in available coverage occurs for you or your covered dependent.

2. Recovery Of Overpayment Procedure

If the Plan has mistakenly overpaid a claim on your behalf, the Fund will contact the provider of services for a refund of the overpayment. If the provider refuses to refund the overpayment, you must refund the overpaid amount.

The Plan has the right and authority to refuse payment of benefits to you and/or your family if you have failed to reimburse the Plan for an overpayment.

3. Subrogation Provisions

The Fund does not allow double recovery for health care benefits nor does it provide health care benefits for occupationally related diseases or conditions.

Laborers' Metropolitan Detroit Health Care Fund

The Fund is specifically entitled to subrogation if a participant, participant's spouse or dependent recovers money as reimbursement for medical expenses in any third party claim, suit or action, or if it is determined that a condition is occupationally related and covered by the Michigan Workers' Disability Compensation Act, Occupational Disease Act, similar federal or state statutes, or common law actions.

The obligation to repay the Fund is not limited to amounts recovered and the obligation to repay all such benefits to the Fund shall not be limited or reduced by reason of any attorney fees or expenses the participant, participant's spouse or dependent pay or agree to pay in connection with the prosecution of their claims.

The Fund is not bound by any settlement reached separately by the participant unless the Fund agrees to be bound by that settlement. The participant, participant's spouse and dependent must sign a subrogation agreement prior to payment of any benefit from the Fund. But, the Fund is subrogated to the participant's spouse or dependent's right to recover payments even if no subrogation agreement has been signed.

D. DEATH BENEFITS —ACTIVE PARTICIPANT

The Plan pays a Death Benefit upon your death, the death of your spouse, or the death of eligible children who are at least 30 days of age at the time of their death. The Death Benefit schedule is as follows:

Active Employee	\$8,000
Spouse	\$4,000
Dependent Children	\$2,000

No death benefits are payable if the Covered Person was engaged in a felonious activity or an aggravated assault that resulted in their death.

You must provide the Fund Office with written notice of the death of a Covered Person within one (1) year of the date of their death. If you miss this filing deadline, no death benefit is payable.

****NOTE:** Widows do not qualify for the Death Benefit

1. Accidental Death And Dismemberment Benefits (Active Participant Only)

The Plan provides an Accidental Death and Dismemberment Benefit for *active* employees only. When a bodily injury caused solely through external, violent or accidental means, on or off the job, occurs while your are an active employee,

Laborers' Metropolitan Detroit Health Care Fund

that is when you're eligible by either employer contributions or self-payments, the Plan will pay benefits for losses described in the following Schedule. This benefit is in addition to any other benefits that may be payable by the Plan. And, it is not subject to COB provisions:

LOSS OF

Life	\$8,000
Both Hands or Both Feet	\$4,000
One Hand and One Foot	\$4,000
One Hand or One Foot & Entire Sight of One Eye.	\$4,000
One Hand or One Foot	\$2,000
Entire Sight of One Eye.	\$2,000
Entire Sight of Both Eyes	\$4,000

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

No Accidental Death or Dismemberment Benefit is payable if the Covered Person was engaged in a felonious activity or an aggravated assault that resulted in their loss of a limb or death. Similarly, no Accidental Death and Dismemberment Benefit is payable for the suicide or attempted suicide of a Covered Person. All applications for Death Benefits must be submitted to the Fund Office within twelve (12) months of the date that death occurs.

2. Beneficiary

You must designate a Beneficiary when you complete and file a Beneficiary Designation Form with the Fund Office.

You may thereafter change your designated Beneficiary at any time, by filing a new, completed Beneficiary Designation Form with the Fund Office. Your change of Beneficiary is effective upon receipt in the Fund Office of your newly completed Beneficiary Designation Form.

If, for some reason, you've not designated a Beneficiary, any benefits payable upon your death will be paid to your surviving legal spouse, if you have one. If you have no surviving legal spouse, your Death Benefit is paid to your surviving child(ren). If you have no surviving child(ren), your Death Benefit is paid to your

Laborers' Metropolitan Detroit Health Care Fund

surviving parents. If you have no surviving parents, your Death Benefits are paid to your estate.

You are automatically deemed to be the Beneficiary for the payment of any benefits upon the death of your legal spouse, and dependent children. Your spouse is not entitled to designate a Beneficiary under the Plan.

A designated Beneficiary of your Death Benefit may direct payment of your Death Benefit to the funeral home.

Your Beneficiary must submit a written claim for your Death Benefit within one (1) year from the date of your death.

NOTE:

Your designated beneficiary for receipt of your death benefits is also the beneficiary for any medical expenses that had not been paid prior to the date of death.

E. LIMITATIONS AND EXCLUSIONS FOR IN-AND OUT-PATIENT SERVICES

The Plan does not cover the following:

1. Dental treatment, dental surgery or dental x-rays, except for the removal of impacted teeth and certain tumors or as the result of a covered accidental injury to the natural teeth which occurs while the person is eligible provided such treatment/surgery is performed within 180 days from the date of the ***Accident***. Refer to Special Benefits Provisions, Pages 57 - 60, for a complete list of covered dental/surgical procedures;
2. Periodic health examinations while confined as an in-patient, except for newborn well-baby care;
3. Travel expenses related to health care;
4. Cosmetic surgery, except for treatment of injury sustained in a covered ***Accident*** while coverage is in effect;
5. Maternity related expenses incurred by dependent daughters, except for the first pregnancy;

Laborers' Metropolitan Detroit Health Care Fund

6. Injuries/illnesses sustained as the result of a motor vehicular related **Accident**;
7. Injuries/illnesses sustained in the course of employment for wage or profit;
8. Any claims incurred outside the United States, Puerto Rico, the American Virgin Islands, or American Samoa unless the claim is the result of an otherwise covered **Accident** or illness, requires emergency treatment and occurs while traveling outside those areas.
9. Experimental treatment/surgical procedures;
10. Care rendered within any facility of, or provided by, the United States Veterans Administration for a service related injury or illness;
11. One elective abortion is payable for the eligible dependent daughter;
12. Expenses incurred as the result of an intentionally self-inflicted injury or injury incurred as the result of the Covered Person being the perpetrator of a felonious activity;
13. Surgery to correct a vision deficiency, where the visual deficiency could be corrected by eyeglasses or contacts;
14. Charges incurred for services rendered by a psychologist, (PhD) or social worker (MSW) unless the patient was referred to the psychologist by a physician or psychological treatment is under the direct supervision of a physician. Refer to Special Benefit Provisions, Page 68;
15. Injury or illness caused by war or any act of war (declared or undeclared) or suffered while in military or naval service of any country;
16. Memberships/usage fees for health clubs;
17. Air conditioning units, air filtering units, swimming pools, spas, exercise equipment, home heating units, whirlpools, elevators or

Laborers' Metropolitan Detroit Health Care Fund

fixed chairlifts, or any other device that is considered usable by other family members or becomes a fixed part of the home;

18. Rolfiging;
19. Chelation therapy;
20. Rare or obsolete diagnostic tests, procedures and surgeries;
21. Investigational drugs and treatment;
22. Treatment or supplies for which the Covered Person is not required to pay;
23. Any treatment or supply that is not considered medically necessary;
24. Temporomandibular Joint Dysfunction (TMJ) unless determined by the consulting specialist to be medically functional;
25. Paternity testing;
26. ***Custodial Care***;
27. Complications arising from cosmetic procedures;
28. Surgical stockings, when prescribed by a physician, are limited to 6 pair each calendar year, mastectomy bras are limited to two (2) per year;
29. Treatment rendered by family members;
30. Fertility drugs
31. Erectile dysfunction drugs unless the dysfunction is due to prostate cancer or prostate surgery (contact the Fund Office for prior approval);
32. In-vivo or In-vitro fertilization, artificial insemination, zygote intrafallopian tube transfer, (zift), Gamete intrafallopian tube transfer (Gift), or ovulation detection supplies.
33. Cotton swabs and alcohol;

Laborers' Metropolitan Detroit Health Care Fund

34. Thermography, maintenance and/or preventative physical therapy treatment, and physical therapy treatment that can be easily and safely performed at home unless, as the matter of documented medical necessity, the treatment must be provided by a physical therapist. This includes, for example, moist or dry heat treatments, cold packs, exercise routines, TENS therapy and home traction;
35. Medicine or drugs dispensed by a podiatrist, electrodiagnosis (EDG), routine foot care unless certified as medically necessary by your treating physician, excessive x-rays, and expenses related to more than one (1) pair of orthotics per person, per lifetime;
36. School System Speech Therapy;
37. The treatment of vision problem deficiencies that are correctable through the use of glasses or contact lenses, radial keratotomy, retinal transplants or cosmetic procedures; and
38. Court ordered treatment
39. Any convenience item including, but not limited to, guest trays, television, etc...for any inpatient hospital stay.
39. Durable Medical Equipment (DME) that is not medically necessary, and/or considered a luxury item. Specialized wheel chairs, electric hospital beds and lift chairs are not covered.

IMPORTANT REMINDER

The Plan totally and completely excludes coverage for any claim arising out of an auto or other vehicular related *Accident* or incident. "Vehicle" includes all usual forms of transportation on public highways, such as vans, pick-up trucks, motorcycles, etc.

To make certain that you're properly covered, check with your automobile insurance agent and/or insurance carrier to confirm that your automobile policy provides "first and completely" for any claim arising out of a vehicular-related ***Accident***.

Emphasize to your automobile insurance carrier that the Plan ***completely excludes*** such auto-related coverage from its schedule of benefits.

IV. CLAIMS PROCEDURE

A. HOW TO FILE FOR CLAIM PAYMENTS

When you incur a medical claim, you must submit a completed claim form to the Fund Office along with the itemized bills. Claim forms/envelopes can be obtained from either the Fund Office or your Local Union Offices.

All claims must be filed within one (1) year from the date the service or supply is provided. Faxed claim submissions will not be accepted.

All bills submitted for Out-of-Hospital Medical Expenses, Surgical procedures, and In-Hospital Physician/Surgeon services must contain the following information:

1. A written description of charges;
2. Procedure code for each charge;
3. The date(s) of service, by charge;
4. The amount charged for each service;
5. The diagnosis;
6. The patient's name and, if applicable, their relationship to you;
7. Your name;
8. Your Member Identification Number;
9. The surgical report, if surgery was performed and the charge exceeds \$300; and
10. A specific description of how the injury occurred, if charges pertain to an injury

B. CLAIM REVIEW AND APPEAL PROCEDURE

If your claim for benefits is denied, you may appeal that decision. The following sections outline the appeal procedure you must follow if you wish to appeal the denial (whether a partial or complete denial) of a claim.

PLEASE NOTE: The appeal procedure, and in particular the applicable time limits, differs according to whether your appeal relates to an "urgent care" claim, a "pre-service" claim, or a "post-service" claim.

TIC, the Plan's Third Party Administrator (TPA), makes the initial decision on your eligibility of claims. If your claim for benefits is denied, in whole or in part, and you're dissatisfied with that denial, you may ask that the TPA review the claim and the denial.

If, after the TPA's review and decision, you're still unsatisfied, you may appeal to the Trustees. This appeal to the Trustees **MUST** be in writing. A simple letter setting forth your objection is sufficient. Your appeal will be considered by the Trustees, or a Committee of Trustees, who will then provide a decision, in writing, within a reasonable time after receiving your appeal.

C. CLAIMS PROCEDURE IS MANDATORY

No legal action may be initiated against the Plan, the Administrator or the Trustees regarding a claim for benefits or eligibility under the Plan, or regarding any interpretation or administration of the Plan until you have followed and exhausted the Plan's Claims Reviews and Appeal Procedures.

1. Your Right To Receive An Explanation Of And To Ask For Review Of An Adverse Benefit Determination

You or your provider must file claims for Fund Benefits with the Fund Office.

If you have questions about any decision made on your claims or requests for Medical benefits, you can contact the Fund Office Customer Service Representatives by telephone at (800) 228-0048 Toll Free, or (517) 321-7502. This telephone number is also at the top of the Explanation of Benefits sent to you by the Fund Office and on the denial letter notifying you that your claim for benefits has not been approved.

Laborers' Metropolitan Detroit Health Care Fund

If you're dissatisfied with the Fund Office's denial of your claim for benefits, **ERISA** guarantees your right to request a review or appeal of an "adverse benefit determination".

An "adverse benefit determination" is a denial, reduction or termination of a benefit claim (in whole or in part), including any denial based on your eligibility to participate in the Plan. You may ask for review of or appeal an adverse benefit determination on a "pre-service claim", an "urgent care claim", or a "post-service claim". These terms are defined below.

A "pre-service claim" is a claim for a benefit conditioned, in whole or in part, on obtaining advance approval of medical care.

An "urgent care claim" is a claim for medical care or treatment where applying the normal time periods for claims determination could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician who knows your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that you are seeking.

A claim will be found to be an "urgent care claim" if either (1) a physician with knowledge of your medical condition determines that the claim is an "urgent care claim" or (2) the Plan using the judgment of a prudent layperson with average knowledge of health and medicine determines that it is an "urgent care claim".

A "post-service claim" means all other claims that are not a "pre-service claim" or an "urgent care claim".

You must follow the review procedure set forth below to appeal of an adverse benefit determination on pre-service, post-service and urgent care claims. Except for appeals of adverse benefit determinations involving "urgent care claims", **all** appeals or requests for review must be in writing. You must exhaust these review procedures before you request a review under ERISA.

D. MEDICAL BENEFIT CLAIM REVIEW PROCEDURE

1. Review Procedure – "Post-Service Claims"

The appeal procedure is triggered when the Plan provides you with a written adverse benefit determination, which it must do within thirty (30) days of the Plan's receipt of your claim.

Laborers' Metropolitan Detroit Health Care Fund

To start an appeal, you, or your authorized representative, must send a written statement to the Fund Office explaining why you disagree with the Plan's adverse benefit determination. You **must** request your review no later than 180 calendar days after you receive the Plan's decision on your claim for benefits.

Laborers' Metropolitan Detroit Health Care Fund
6525 Centurion Drive
Lansing, MI 48917

In your written appeal statement, you must include all documents, records or comments that you believe support your position.

You will receive a written determination of your appeal by the later of:

- a. the Plan's next regularly scheduled meeting which is at least 30 days after the date of your appeal request for review; or
- b. 30 days following your request for review unless the Trustees tell you that they need more time.

The Plan written determination of your review/appeal will be the final determination involving your claim for benefits.

If you disagree with the Plan's final determination, or a determination is not timely issued, or the Plan fails to follow the procedures for a review/appeal you may sue under ERISA Section 502 (a) to obtain the benefits that you have requested.

2. Review Procedure – "Pre-Service" Claims

- a. The review procedure for "pre-service" claims is identical to the review procedure for "post-service" claims, ***except that the Fund Office must provide you with written determinations within shorter time frames.*** The Plan's determination of pre-service claims must be issued within fifteen (15) calendar days of your written appeal.
- b. If you disagree with the Plan's final determination, or if the determination is not timely issued, or the review/appeal procedures are otherwise not complied with, you may sue under section 502(a) of ERISA to obtain your benefits.

3. Review Procedure – “Urgent Care” Claims

The review procedure for “urgent care” claims is as follows:

- a. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request orally, please call: (800) 228-0048;
- b. The Fund Office must provide you with their decision ***as soon as possible***, taking into account the medical emergency, ***but not later than seventy-two (72) hours after receipt of your request for review***;
- c. All necessary information, including the Plan’s decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile, or other available similarly expeditious method. If the decision is communicated orally, the Plan must provide you or your authorized representative with ***written confirmation*** of their decision within 2 business days;
- d. If you disagree with the Plan’s final determination, or if the Fund Office fails to issue a timely determination (72) hours, or otherwise fail to comply with the review procedures, you may sue under section 502(a) of ERISA to obtain your benefits. In addition to the information found above, the following requirements apply to review of “pre-service,” “post-service,” and “urgent care” claims:
 - You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal review procedure;
 - No fees or costs may be imposed as a condition to requesting review;
 - Although there are set timeframes within which you must receive the Plan’s final determination on all three types of claims, you may allow the Plan additional time to issue its determination;

Laborers' Metropolitan Detroit Health Care Fund

- You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claims for benefits;
- You may submit written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination;
- The person who reviews your adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The determination on review will be a new determination; the initial determination on your claim will not be afforded deference on review;
- If your request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted;
- Upon request, the medical experts whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination;
- You will be advised of the specific reason for an adverse determination with reference to the specific Plan provisions on which the determination is based;
- If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion free of charge upon request; and

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

VI. GENERAL INFORMATION

A. AMENDMENTS

The Trustees reserve the right to amend the Plan at any time and from time to time. If the amendment significantly changes the provisions of the Plan as outlined in this Summary, a new summary plan description or supplement will be furnished to Participants.

B. BASIC PLAN INFORMATION

1. Type Of Plan

The Plan provides hospitalization, medical, death, maternity, surgical, and other related health care benefits.

2. Name Of Plan Administrator

The Laborers' Metropolitan Detroit Health Care Fund is maintained and administered by a Board of Trustees of which labor and management are equally represented. There are five Labor Trustees and five Management Trustees on the Board. A list of the current Trustees appears at the front of this booklet.

The Board of Trustees has the primary responsibility for decisions regarding the eligibility provisions, type of benefits, administrative policies, management of Fund Assets, and interpretation of Fund provisions.

3. Plan Year

The Plan year operates on a fiscal year basis commencing on October 1st and ending on September 30th of the following year.

4. Identification Numbers

The Laborers' Metropolitan Detroit Health Care Fund has been assigned employer identification number 38-2026006 by the Internal Revenue Service and assigned to itself identification number 501 for the Department of Labor.

5. Type Of Administration

Although the Trustees are legally designated as the Fund administrator, they have delegated many of the day to day functions to a professional administrative manager. The administrative manager maintains the eligibility records, accounts for employer contributions, processes claims, keeps participants informed about Plan changes, files government reports and performs other routine activities under the direction of the Trustees.

6. Collective Bargaining Agreements

The Laborers' Metropolitan Detroit Health Care Fund was established and is maintained under the terms of collective bargaining agreements. The agreements set forth the conditions under which the participating employers are required to contribute to the Fund and the rate of contributions. Upon written request, Employees may examine the agreements at the Fund Office or at other specified locations. Employees may request a copy of the agreement which will be provided to them at a reasonable charge.

7. Plan Sponsors

The Fund is maintained under the terms of collective bargaining agreements negotiated by the Union with participating employers. Employers who agree in writing to make contributions to the Fund are considered "plan sponsors." If any employer is not a party to a written agreement then he has no legal obligation to contribute to the Fund on behalf of employees. Consequently, in order to obtain benefits under this Fund, employees must be working for a plan sponsor. If there is any uncertainty about whether or not an employer is a plan sponsor, the Union Office should be contacted.

8. Source Of Contributions

The primary source of financing for the benefits provided under this Fund and for the expenses of Fund operations is employer contributions. The rate of contribution is spelled out in the collective bargaining agreements negotiated by the Union with participating employers. No money is ever deducted from an

Laborers' Metropolitan Detroit Health Care Fund

employee's paycheck to pay for these benefits. However, under the terms of the Fund, a participant may make self-payments in order to maintain his eligibility if he is temporarily unemployed or does not work enough hours to satisfy the eligibility provisions. Participants in the Early Retiree, Total & Permanent Disability and Supplement to Medicare Programs are required to make self-payments in order to maintain their eligibility. A portion of Fund assets are invested and this also produces additional Fund income to help defray administration expenses.

9. Fund Medium For The Accumulation Of Fund Assets

All contributions and investment earnings are accumulated in a trust fund with benefits being provided by the Trust Fund.

10. Right To Receive And Release Necessary Information

To determine the applicability of and to implement the terms of this Plan or the similar terms of any other plan, the Fund will not, without consent, notice and signed authorization to any covered person, release to or obtain from any insurance company or other organization or individual, any information, with respect to any covered person which is considered individually identifiable protected health information unless such information is deemed necessary for payment of medical claims.

C. ERISA RIGHTS AND PROTECTIONS

Participants in the Laborers' Metropolitan Detroit Health Care Fund 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:

1. Examine, without charge, at the Fund Office and at other specified locations, such as worksites union halls, all plan documents including: insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U. S. Department of Labor, such as detailed annual reports and plan descriptions.

Laborers' Metropolitan Detroit Health Care Fund

2. Obtain copies of all plan documents and other plan information upon written request to the Trustees. Under ERISA, Trustees may make a reasonable charge for the actual cost of reproducing the documents and other information.
3. Receive a summary of the Fund's annual financial report. The Fund administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
4. In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate this Fund, called "fiduciaries" of the Fund, have a duty to do so with reasonable care and in the exclusive interest plan participants and other beneficiaries.
5. No one may take any action which would prevent a participant from obtaining a benefit to which he is entitled under the Fund or from exercising his rights under ERISA.
6. In accordance with Section 503 of ERISA and federal regulations, the Trustees have adopted certain procedures to protect the rights of participants who are not satisfied with the action taken on a claim. If a claim for benefits is denied, in whole or in part, the participant must receive a written explanation of the reason for denial. Then, if the participant is not satisfied with the action on the claim, he has the right to have the Trustees review and reconsider such claim in accordance with the Fund's claim review procedures.
7. If a participant has any questions about the Fund, he should contact the Trustees by writing to:

**BOARD OF TRUSTEES
LABORERS' METROPOLITAN DETROIT
HEALTH CARE FUND
6525 Centurion Drive
Lansing, MI 48917**

8. Under ERISA, there are steps participants can take to enforce their rights under the Fund. If materials are requested from the Fund and they are not received, or if the participant feels that the Trustees or employees are discriminating against him for asserting his rights under ERISA, he may seek assistance from the nearest

Laborers' Metropolitan Detroit Health Care Fund

Area Office of the United States Department of Labor or he may file suit in a Federal Court. However, the Fund provides appeal procedures, as set forth earlier in this Summary Plan Description, and normally it is advisable to exhaust the Fund appeal procedures before taking other steps.

9. If a participant has any questions about the foregoing statements or about his rights under ERISA, which have not been answered in this booklet or by the Fund Office, he should contact the nearest Area Office of the U. S. Labor Management Services Administration, Department of Labor.