



Laborers' Metropolitan Detroit Health Care Fund

Local #1076 and #1191

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LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND FREQUENTLY ASKED QUESTIONS

How are my benefits Funded?

The primary source of financing for the benefits provided under the Health Care Fund and for the expenses of Fund operations is employer contributions.

What are the Fund's eligibility requirements?

Initial eligibility requires 700 hours of contributions within six (6) months or less.

Continuing eligibility requires 350 hours of employer contributions within three (3) months or less. The participant is then eligible for the next two (2) months.

What do I do if my employer does not remit my fringes?

First call your employer. There may be a very good reason that the fringes have not been remitted. If your employer cannot explain the reason to your satisfaction, you should contact the Local Union.

How can I add my dependents to the Plan?

Complete a "Yearly Coordination of Benefits and Dependent Status Statement Form" and submit copies of marriage or birth certificates.

What do I do when I get divorced?

You must send a copy of your completed divorce decree otherwise coverage will be maintained for your ex-spouse. If the Fund pays for benefits that should not be paid because your spouse no longer meets the definition of a dependent, you will be held responsible.

When does coverage stop for my dependent children?

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend Adult child coverage up to age 26 effective June 1, 2011. Therefore, if you are eligible for benefits and you have a child that was previously covered in the Plan, and their coverage was terminated, you should complete a "Request for Extension of Dependent Coverage" and return it to the Fund Office. Coverage may continue until the last day of the month in which that adult child turns 26 years old or earlier if you do not maintain your eligibility under the Plan. This requires annual verification.

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Can I continue coverage when I retire?

Yes, provided you meet the retiree requirements for maintaining coverage.

What do I do if I am injured and cannot work?

The Fund provides disability credit which may continue your coverage for health care benefits. You should complete a disability form.

What are the self-payment rates?

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|-------------------------------|----------------------------------|----------|
| Active participant and family | (First through the 12th payment) | \$399.42 |
| | (13th through the 18th payment) | \$543.72 |

What is COBRA?

COBRA is the Consolidate Omnibus Budget Reconciliation Act of 1986. COBRA requires that the Fund provide coverage for participants and their dependents that may not otherwise be offered. COBRA is available for dependents who no longer meet the definition of a dependent as defined by the Plan. The rates are:

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|------------------------|-------------------|----------|
| Participant and Family | (NO DENTAL) | \$812.85 |
| Participant and Family | (INCLUDES DENTAL) | \$903.69 |

What is Coordination of Benefits?

Coordination of Benefits or COB coordinates benefits with other health benefits you may have such as coverage through your spouses' employer.

What are the Health Care Benefits?

The Fund has contracted with PPOM to provide participants and the Fund with discounts on medical services. If a PPOM participating provider is utilized the participant has no out of pocket expenses for hospitalization and only a \$15.00 co-payment for office calls. For further details regarding the medical benefits available, please refer to the Summary Plan Description (SPD).

What Vision Benefits are available?

The Plan will pay \$225 towards the exam, lenses and frames every 12 months.

What Dental Benefits are available?

Dental coverage is provided and processed through Delta Dental. Please call 1-800-877-7195 with any questions regarding coverage.