DETROIT & VICINITY TROWEL TRADES

HEALTH & WELFARE FUND

SUMMARY PLAN DESCRIPTION

Bricklayers and Allied Craftworkers (Non-Residential)

April, 2012

DETROIT & VICINITY TROWEL TRADES
HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

IMPORTANT NOTICE

This Summary Plan Description booklet describes the Plan of the Detroit & Vicinity Trowel Trades Health and Welfare Fund as it is in effect on April 1, 2012. If you have questions about the Plan or your rights under the Plan, contact the Fund Office.

One word of caution: NO ONE HAS THE AUTHORITY TO SPEAK FOR THE BOARD OF TRUSTEES IN EXPLAINING THE ELIGIBILITY RULES OR BENEFITS OF THE FUND, EXCEPT THE FULL BOARD OF TRUSTEES OR THE FUND'S ADMINISTRATIVE MANAGER, TO WHOM SUCH AUTHORITY HAS BEEN DELEGATED.

IN CASE OF CONFLICT, THE PLAN, NOT THIS SUMMARY, WILL GOVERN.

DETROIT & VICINITY TROWEL TRADES

HEALTH AND WELFARE FUND

IMPORTANT ADDRESSES AND PHONE NUMBERS

BOARD OF TRUSTEES

Union Trustees

Mark King
BAC Trowel Trades Local #1 of Michigan
21031 Ryan Road
Warren, MI 48091

Chuck Kukawka
BAC Trowel Trades Local #1 of Michigan
21031 Ryan Road
Warren, MI 48091

Paul Dunford
BAC Trowel Trades Local #1 of Michigan
21031 Ryan Road
Warren, MI 48091

Frank Rodriguez
BAC Trowel Trades Local #1 of Michigan
21031 Ryan Road
Warren, MI 48091

Employer Trustees

Charles Wilson (DMCA)
Monte Costella & Co.
P.O. Box 7119
Novi, MI 48375

Patrick Baker (MCA)
Construction Assoc. of Michigan
43636 S. Woodward Ave.
Bloomfield Hills, MI 48302.

Chuck Binkowski (AGC)
Barton Malow Concrete
26500 American Drive
Southfield, MI 48034

Marino Censoni (ACCM)
37244 Groesbeck, Suite C
ClintonTownship, MI 48036

The Board of Trustees is the legal Fund Administrator.

FUND OFFICE/ADMINISTRATIVE MANAGER

Detroit & Vicinity Trowel Trades Health and Welfare Fund
Office Address: 700 Tower Drive, Suite 350, Troy, Michigan 48098
Mailing Address: P.O. Box 99490, Troy, Michigan 48099-9490
Phone Number (local): (248) 828-6000; Phone Number (toll-free): (800) 435-4080
Fax Number: (248) 828-6001
Web Site Address: www.dvtt.org

OFFICE HOURS

Monday through Friday
7:00 a.m. to 4:00 p.m.

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INTRODUCTION

TO ALL PARTICIPANTS AND DEPENDENTS:

This Summary Plan Description is issued to describe and summarize your health care benefits. The full terms and conditions governing coverage under the Plan are stated in the Plan documents, which include the Trust Agreement, Collective Bargaining Agreements, Participation Agreements and contracts with service providers. The benefits as outlined in this Summary are effective only if you are eligible for coverage and remain eligible according to the provisions of the Plan.

The benefits payable in the event of your illness or a covered dependent's illness are provided by the Detroit & Vicinity Trowel Trades Health and Welfare Fund. Your claims will be processed by the Fund Office, whose personnel are trained in this type of work.

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

The Board of Trustees of the Detroit & Vicinity Trowel Trades Health and Welfare Fund reserve the right, at any time, to modify, amend or terminate any existing or future benefit or condition of eligibility or self-payment or any other term or condition of the Detroit & Vicinity Trowel Trades Health and Welfare Fund.

As you read the Summary, keep in mind that it is an effort to summarize, simply, the principal provisions of the Fund's coverage and eligibility rules. **It is not intended to cover every detail or every situation that might occur.** We have tried to make the Summary accurate and complete but it does not describe Plan changes that occurred after the book was printed. If any discrepancy exists between this Summary and the other formal documents governing the terms of the Fund's coverage and eligibility rules (including the contracts entered into by the Fund), the provisions of those documents will govern. This Summary Plan Description supersedes and replaces any Summary Plan Description previously issued by the Fund.

You should read this material carefully and keep it for reference. It will help you to understand how the Plan works, what rights and benefits it provides for you and your family, and how to obtain those benefits.

We hope the benefits available through the Fund will serve your needs and those of your family.

Respectfully yours,

THE BOARD OF TRUSTEES

April 2012

PLAN INFORMATION

DETROIT & VICINITY TROWEL TRADES HEALTH AND WELFARE FUND

Office Address: 700 Tower Drive, Suite 350, Troy, Michigan 48098
Mailing Address: P.O. Box 99490, Troy, Michigan 48099-9490
Phone Number (local): (248) 828-6000; Phone Number (toll-free): (800) 435-4080
Fax Number: (248) 828-6001
Web Site Address: www.dvtt.org

SUMMARY PLAN DESCRIPTION

General Information Applicable to Plan Number 001

Employer Identification Number: 38-2073681

TYPE OF ADMINISTRATION

The Board of Trustees of the Detroit & Vicinity Trowel Trades Health and Welfare Fund is the Plan Administrator and Plan Sponsor and is responsible for overall Plan administration. There are four Trustees appointed by the Unions and four Trustees appointed by the Employer Associations. The Board of Trustees has delegated the day-to-day responsibilities for Plan administration to the Administrative Manager.

UNION

BAC Trowel Trades Local #1 of Michigan, International Union of Bricklayers and Allied Craftworkers, AFL-CIO

EMPLOYER ASSOCIATIONS

Associated Concrete Contractors of Michigan
AGC of Michigan
Detroit Mason Contractors Association
Mason Contractors Association, Inc.

AGENT FOR SERVICE OF LEGAL PROCESS

The person designated as Agent for Service of Legal Process shall be:

Patricia J. Tarini, Esq., Legal Counsel
Sachs Waldman, Professional Corporation
1000 Farmer Street
Detroit, Michigan 48226

Legal process may also be served on any Trustee or on:

Detroit & Vicinity Trowel Trades Health and Welfare Fund
Office Address: 700 Tower Drive, Suite 350, Troy, Michigan 48098
Mailing Address: P.O. Box 99490, Troy, Michigan 48099-9490

ADMINISTRATIVE MANAGER

The Board of Trustees has delegated certain administrative functions to a professional administrative manager. The Administrative Manager is BeneSys, Inc.

NAMED FIDUCIARY

A Named Fiduciary is the person or persons who have the authority to control and manage the operation and administration of the Fund. The Named Fiduciary for the Fund is the Board of Trustees of the Detroit & Vicinity Trowel Trades Health and Welfare Fund.

PLAN NAME

Plan of the Detroit & Vicinity Trowel Trades Health and Welfare Fund.

TYPE OF PLAN

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

PLAN MODIFICATION, AMENDMENT AND TERMINATION

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

COLLECTIVE BARGAINING AGREEMENTS

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

SOURCE OF PLAN CONTRIBUTIONS

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

eligibility. Any participant, surviving spouse, or beneficiary may receive, upon written request to the Fund Office, information about whether a particular employer is contributing to the Fund and, if so, the employer's address. You have a right to receive a copy of a collective bargaining agreement or to read it at the Fund Office.

WELFARE TRUST ASSETS AND RESERVES

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses. The benefits provided by the Fund are self-funded (i.e., not covered through an insurance policy). Benefits payable are limited to Fund assets available for such purposes.

PLAN YEAR

The Plan Year, for purposes of maintaining the Plan's fiscal records, begins on the first day of May and ends on the last day of April of each calendar year. The Benefit Year, for purposes of administration of the Plan, begins on the first day of January and ends on the last day of December of each calendar year.

ELIGIBILITY AND BENEFITS

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

The Board of Trustees may change the eligibility rules and/or benefit provisions of the Plan at any time. The benefits provided by the Fund are limited to the assets of the Fund that are available to pay for such benefits. No participant, dependent or retiree has any vested right to **any** benefit provided by the Fund, now or at any time in the future.

SUMMARY PLAN DESCRIPTION

The Summary Plan Description is this booklet.

TRUSTEE AUTHORITY

The Board of Trustees has full discretion and authority to increase, reduce or eliminate benefits and to change the eligibility rules and all other provisions of the Plan at any time. However, the Board of Trustees intends that the terms of the Plan are legally enforceable while they are in effect, including those relating to coverage and benefits. The right to change or eliminate any and all aspects of benefits provided under this Plan to all participants, including retirees and their dependents is a right specifically reserved to the Board of Trustees.

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

Only the full Board of Trustees is authorized and has the discretion to interpret the Plan and the benefits described in this Summary Plan Description. The Board's interpretation is final and binding on all persons dealing with the Fund or claiming a benefit from the Fund. If a decision of the Board of Trustees is challenged in court, that decision will be upheld, under current law, unless it is determined by the court to have been arbitrary and capricious. No agent, representative, officer or other person from the Union, the Associations, or an employer has the authority to speak for the Board of Trustees or to act contrary to the written terms of the governing Plan documents.

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

DOING YOUR PART

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

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

Keep the Fund Office informed. One of your most important responsibilities is to make certain that the Fund Office always has current and accurate information about you and your dependents.

You must complete a Vital Information Form immediately and return it to the Fund Office if you are a new participant.

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

Marriage - To add a spouse to your coverage, your marriage must be reported to the Fund Office. If you report your marriage **within 30 days** of its occurrence, your spouse will be covered from the date of marriage - if your marriage is reported later, your new spouse's coverage may be delayed. A copy of the certificate of marriage must be filed with the Fund Office. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice.

Births - To add a newborn as an eligible dependent, the child's birth must be reported to the Fund Office. If you report your child's birth **within 30 days** of its occurrence, your child will be covered from birth – if the birth is reported later, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice. A copy of the birth certificate must be filed with the Fund Office. Upon review, further evidence of parentage may be required.

Adoptions, Step-Children and Legal Guardianship - To add a child as an eligible dependent, the adoption, marriage (for stepchildren) or guardianship must be reported **within 30 days** of its occurrence, and one or more of the following must be filed with the Fund Office: 1) a copy of the legal adoption or Court Order placing the child in your home for adoption; 2) certificate of marriage to the child's parent, proof of the child's birth and proof that adoption proceedings have commenced; and/or 3) order of legal guardianship. The child will be covered from the moment of adoption (or placement for adoption), marriage to the child's parent or establishment of guardianship, if the event is reported **within 30 days** of its occurrence. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice.

Change of Address - Any change of address, or name change, must be reported immediately, in writing, signed by you, to BAC Local #1. BAC Local #1 is responsible for informing the Fund Office of your new address.

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

Divorce - Divorce must be reported immediately and a complete copy of the Judgment of Divorce, and any amendments to the Judgment, must be filed with the Fund Office. If the Fund pays benefits for a former spouse because you did not notify the Fund of your divorce, you are personally liable to the Fund for the amount of those benefits.

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

Other Coverage - Notice of other coverage must be reported to the Fund Office **within 30 days** of the date you or your dependents obtain such coverage.

You should tell the Fund Office if:

- You are unable to work due to accident or illness;
- Your disability has terminated;
- Your employment with a contributing employer has terminated and you wish to continue your insurance by self-payment;
- You have applied for family or medical leave from your employer;
- A court has entered a qualified medical child support order directing that health care coverage be provided for your child(ren) through the Fund;
- You or your dependent(s) are eligible for or have received benefits under another health care plan, insurance contract, program or statute; or
- You or your dependent(s) enter the military or other uniformed services of the United States.

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

Carry your card. You should have a benefit card. Be certain to carry this benefit card and show it whenever you receive medical, hospital and surgical benefits, dental or vision care or get a prescription.

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

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

Keep track of your employer contributions submitted to the Fund on your behalf. Your eligibility depends on it.

Identify yourself. When you write to the Fund Office, please be sure to include your name, Subscriber ID number (or alternate ID) and trade in your letter. If you call, please be sure to have your Subscriber ID number handy. Please note that due to privacy concerns, the Fund Office will not release your protected health information to your spouse or dependents unless you have a signed authorization form on file with the Fund Office.

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

Notify the Fund Office if you are working outside the area covered by BAC Local #1. If your employer is making health care contributions on your behalf, check with this Fund Office to find out whether there is a reciprocity agreement with the health care fund in the area where you are working and what you must do to have those contributions transferred to this Fund.

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

ADMINISTRATIVE RESPONSIBILITIES AND BENEFIT PAYMENTS

ADMINISTRATIVE RESPONSIBILITIES

The Plan Administrator, as a legal matter, is the Fund's Board of Trustees. However, the Board of Trustees has divided the day-to-day operations of the Fund into three areas of responsibility, and has delegated those responsibilities among the Fund Office, your Primary Network and Sav-Rx.

The **Fund Office** is responsible for the following:

- Financial and record-keeping functions for the Fund.
- All matters pertaining to eligibility.
- Processing self-payments.
- Processing claims for benefits **other than** prescription drug benefits and dental benefits for participants who elect the Golden Dental Managed Care Program (see page 38 of this summary regarding Golden Dental Managed Care Program).
- Reviewing and presenting appeals to the Board of Trustees.

You will be assigned to a **Primary Network**, which is the COFINITY network for Michigan residents. The Primary Network for out-of-state residents will be a local network under the Premier Health Exchange (PHX) system. Your Primary Network is responsible for providing network discounts for medical, hospital and surgical services provided by in-network providers.

Sav-Rx is responsible for administering prescription drug benefits.

FREE CHOICE OF PROVIDER

You have the free choice of any provider. However, the amount of benefits paid by the Fund may vary and/or be limited based on the provider you choose and the provider's participation in a preferred provider organization utilized by the Fund.

PAYMENT OF BENEFITS

Benefits up to but not in excess of the maximum benefits shown in this Summary are payable individually for you and for each of your dependents according to the following provisions:

Medical, Hospital and Surgical Services Provided by In-Network Providers

The Fund has a contract with Cofinity, which is a physician and hospital network for medical, hospital and surgical providers in Michigan. Cofinity is the **Primary Network** for in-state residents. Claims for medical, hospital and surgical services provided by Cofinity-participating providers should be submitted by the provider directly to Cofinity, P.O. Box 2720, Farmington Hills, MI 48333. For more information about Cofinity, you can visit the Cofinity website at www.cofinity.net.

The Fund also has a contract with Premier Health Exchange (PHX), which provides access to physician and hospital networks for medical, hospital and surgical providers outside of the Cofinity service area. If you live outside of the Cofinity service area, you will be assigned a network in your geographic area through the PHX system, which will be your **Primary Network.** In-network claims from providers outside of the Cofinity service area should be submitted by the provider to the Fund Office.

Prescription Benefits Provided Through Sav-Rx

The Fund has a contract with Sav-Rx to administer all outpatient prescription drug benefits. Claims for prescription drug benefits that are covered by Sav-Rx are processed by Sav-Rx participating pharmacies. Any claims for prescription drug benefits that you may have that are not processed in this manner may be submitted to Sav-Rx.

For more information about Sav-Rx, you can visit the Sav-Rx website at www.savrx.com.

Other Benefits

Generally, bills from hospitals and doctors from out-of-network providers will be sent directly to you. You should forward those claims to the Fund Office. Please be sure to include the participant's name, Subscriber ID number (or alternate ID), trade, local union information (BAC Local #1) and the name of the person who received treatment, if different.

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

EXPLANATION OF BENEFITS

After you make a claim for benefits, you should receive an "Explanation of Benefits" ("EOB") from the Fund Office stating what has been paid. You are responsible for paying any amount remaining due, and you should contact the Fund Office with any questions regarding your EOB.

PAYMENT OF BENEFITS TO A PERSONAL REPRESENTATIVE

If a person is not mentally, physically or otherwise able to handle his/her business affairs, the Fund may pay benefits to the legally appointed guardian, conservator or person holding the power of attorney. You are responsible for providing the Fund with any information and documentation regarding someone who has or may have authority to act in your place.

ELIGIBILITY AND COVERAGE

INITIAL ELIGIBILITY REQUIREMENTS

To be initially eligible for benefits under this Plan, you must be employed by an employer who is obligated by a collective bargaining agreement to make contributions on your behalf to the Fund for covered work you perform in the geographic jurisdiction of BAC Local #1. You will be initially eligible for benefits on the first day of the month in which you have been credited with 360 hours of work and contributions within the immediately preceding six (6) consecutive months or less.

> **Example:** If the Employee works a total of 360 hours for a contributing Employer(s) in covered employment in April, May, June and July, and the contributions and hours reflecting this are received by the Fund on September 15, the Employee shall be eligible effective September 1 and his eligibility based on these hours will continue until November 30.

If the Fund receives employer contributions on your behalf from another Fund with which the Fund has a reciprocity agreement before you have become initially eligible, those contributions will be accepted and applied toward your reaching the initial eligibility requirements upon confirmation by the Fund Office that you are member of BAC Local #1. See page 19 for information regarding reciprocity.

When you become eligible, you will receive a Vital Information Form on which you can report all of your eligible dependents. This Form should be completed and returned to the Fund Office as quickly as possible. Be certain to report all changes (i.e., additions and deletions) among your dependents to the Fund Office immediately.

Employees of Newly-Organized Employers: An Employee of a newly organized Employer shall become eligible for benefits on the first day of the first full month for which that Employer is obligated to contribute to the Fund, if the Employer satisfies certain requirements. The Fund Office will notify you if your Employer satisfied those requirements.

Non-Bargaining Unit Employees: The eligibility provisions applicable to Owners and other Non-Bargaining Unit Employees, collectively ("NBUEs"), are set forth on page 14.

Special Rule for Employees Suffering a Work-Related Injury: If you suffer a work-related injury when you need 24 or fewer hours to meet the initial eligibility requirement, you will be credited with the number of hours necessary to be eligible for benefits, including Loss-of-Time benefits.

CONTINUING ELIGIBILITY REQUIREMENTS

Continuation by Working

Once you have established initial eligibility for benefits, you will continue to be eligible for benefits in any month (the "eligibility month") in which you were credited with 120 hours of work and contributions for the third calendar month prior to the eligibility month.

> **Example:** You will have coverage for the June eligibility month if you work (and contributions are received for) a total of at least 120 hours in March.

A three (3) month bookkeeping period has been instituted for accounting, reporting and notification of eligibility to Employees. Eligibility will be determined according to the following schedule:

Hours worked during the month below . . .	will determine eligibility for the Eligibility Month of . . .
June	September
July	October
August	November
September	December
October	January
November	February
December	March
January	April
February	May
March	June
April	July
May	August

Hour Bank

Once you have established initial eligibility for benefits, you can continue your eligibility based on months when you have **not** been credited with 120 hours of work and contributions through use of your **"hour bank."**

Your **"hour bank"** will be credited with the hours of covered work you perform (for which employer contributions are received) in excess of 120 hours in any month, and drawn upon to keep you eligible for benefits when you are credited with fewer than 120 hours in a later month or are out of work.

> **Example:** You are credited with employer contributions for 162 hours of work in June; 120 are applied to continue your eligibility for the month of September and 42 are deposited in your hour bank. By October, you have accumulated 157 hours in your hour bank. You work only 43 hours in October, so the Fund draws 77 hours from your hour bank (120 - 43 = 77) to continue your eligibility for January, which leaves a balance of 80 (157 – 77 = 80) hours in your hour bank.

If you have fewer than 120 hours in your hour bank, you can continue coverage for one month only by making a self-payment to the Fund equal to the hourly contribution rate multiplied by the number of hours needed to reach 120 hours for that month.

> **Example:** You have 100 hours in your hour bank, and you do not work in June at all. To continue coverage for September, you must make a self-payment equal to the hourly employer contribution rate multiplied by 20 (the number of hours by which your hour bank is short). Then, the 100 hours will be deleted from your hour bank and, with your payment, you will be eligible for September only on this basis.

No more than 480 hours can be accumulated in your hour bank, so it is possible for you to be eligible for a total of four (4) months if you have 480 hours in your hour bank, even if you have no work for four months.

> **Example:** If you have 480 hours in your hour bank and you do not work in September, October, November and December, the 480 hours in your hour bank will be used to keep you eligible for the months of December, January, February and March.

Continuation by Self-Payments

If you would otherwise lose your eligibility because you have not been credited with sufficient hours of work and contributions, you may continue your eligibility by making self-payments at a rate established by the Board of Trustees. That rate may change from time to time at the discretion of the Board of Trustees. You may make self-payments to continue your eligibility only if you have become ineligible and continue to be ineligible because of a lack of available employment or because you are not working sufficient hours to remain eligible, even though you are currently working for a contributing employer. While you are making self-payments, you must submit a certification letter to the Fund Office from BAC Local #1 every three months verifying that you are unemployed or underemployed but available for work. (You are not eligible for continuation by self-payments if you are a Retiree, unless you are working under the jurisdiction of the collective bargaining agreements that require contributions to the Fund.)

You may make self-payments for a period up to 12 consecutive months, provided that you are available for work and not working in non-covered employment. If you work outside the jurisdiction of the collective bargaining agreements that require contributions to the Fund, you will no longer be considered available for work and you will no longer be permitted to continue coverage by self-payments, unless you are working outside of your "home area" for an employer who participates in a fund that has entered into a Reciprocity Agreement with the Detroit & Vicinity Trowel Trades Health and Welfare Fund. (See page 12 of this Summary.)

If you are about to become ineligible, the Fund Office will mail a Monthly Status Report and a notice regarding self-payment rights to your last known address on file at the Fund Office. **Remember that you must report your change of address, in writing with your signature,**

to BAC Local #1. BAC Local #1 then informs the Fund Office of your new address. It is your responsibility to keep BAC Local #1 and Fund Office informed of your current address.

If you elect to continue coverage by self-payment, the required self-payment must be received in the Fund Office no later than the date indicated on the notice. You should make the required self-payment when due even if you think that you should be eligible by way of employer contributions. If, after the self-payment is made for a month, the Plan receives further contributions on your behalf for that month, and such contributions are sufficient to continue your eligibility, the self-payment will be held as credit toward future self-payments only if it is needed to continue your eligibility for the next eligibility month; a refund is issued to you if it is not needed to continue your eligibility for the next eligibility month.

If you have made self-payments for the 12 consecutive months permitted by the Fund **or** you elect not to make self-payments and, as a result, your eligibility is terminated, you will have the opportunity to continue coverage under COBRA (see page 21 of this Summary).

If your eligibility terminates, whether or not you elect to continue coverage under COBRA, and you remain ineligible for at least 12 consecutive months, you will not be eligible to make self-payments again until you once again establish eligibility under the initial eligibility requirements (see page 9 of this Summary).

Continuation While Working Outside of Your Home Area (Reciprocity)

The Board of Trustees has entered into Reciprocity Agreements with some other funds. These Agreements provide a way in which an Employee who performs covered work outside of his "home area" (the jurisdiction in which he regularly works) can have that work recognized by his "home fund". The "home fund" of an Employee is the Fund that handles health care coverage for the Local Union to which the Employee belongs.

If you are working outside of your home area and would like reciprocal coverage, you must contact the Fund Office or the Local Union to which you belong to determine your "home fund" and the procedures to follow in order to have work hours transferred to your "home fund." Thereafter, the "home fund" will determine your eligibility and right to benefits.

The final authority to determine the home fund of any Employee will rest with the Administrators of the funds involved. These Administrators may consider the home address of the Employee claiming benefits and other factors they consider relevant. Transfers will be made for the periods considered by each fund for purposes of maintaining eligibility.

The Board of Trustees has the exclusive authority to enter into this or any other type of reciprocity agreement that it believes will benefit participants.

Continuation During Short Term Disability (Loss-of-Time Credit)

You will be eligible to receive a Loss-of-Time Credit equivalent to 30 hours of work for each week you

- are eligible to receive Weekly Disability Benefits under this Plan (see page 40 of this Summary for an explanation of those Benefits) or
- are not eligible to receive Weekly Disability Benefits under this Plan because
  - your injury or illness was work related or
  - your injury was suffered in an auto/vehicular accident

provided you are eligible for benefits under this Plan at the time of the injury or illness.

Loss-of-Time Credits are applied to keep you eligible under the rules for Continuation by Working.

You must submit an application to the Fund Office for loss-of-time credits as soon as reasonably possible after the accident or sickness, but no later than 60 days after the accident or onset of sickness.

If you remain disabled after you have exhausted your eligibility for loss-of-time credits, then you will have six months of coverage from the Plan without any cost to you ("six-month extension"). If you remain disabled after you have exhausted the six-month extension, then you may exhaust the credits in your hour bank to continue coverage.

Finally, if you remain disabled after you have exhausted the credits in your hour bank, you may continue coverage one of two ways. If you meet the requirements for Permanent and Total Disability Coverage (see page 13 of this Summary), you may continue coverage by making self-payments at the rate for disabled employees. If you do not meet the requirements for Permanent and Total Disability Coverage, you may continue coverage by making self-payments at the rate for active employees for a period up to 12 consecutive months, as described on page 18 of this Summary.

If you elect not to make self-payments and, as a result, your eligibility is terminated, you will have the opportunity to continue coverage under COBRA (see page 21 of this Summary).

PERMANENT AND TOTAL DISABILITY ELIGIBILITY

Eligibility for Permanent and Total Disability Coverage

To qualify for Permanent and Total Disability coverage under the Fund, you must meet each of the following requirements, and make timely monthly payments in an amount established by the Board of Trustees from time to time, which amount is subject to change by the Board at any time:

1. You must have become disabled while covered under the Fund and be a member of a bargaining unit represented by BAC Local #1 or be an Employee of a contributing employer who has signed a participation agreement in effect with this Fund. You must submit a certification letter to the Fund Office from the Local Union every two years verifying that you are disabled. You must not be eligible for coverage as a Retiree. You must not have become disabled as a result of non-covered employment.
2. You must have a physical or mental condition which, on the basis of satisfactory medical evidence, permanently and totally prevents you from engaging in any regular occupation or employment in the bricklaying or cement mason trades for wages or profit (except for rehabilitation as approved by the Board of Trustees) and which is expected to be permanent and continuous during the remainder of your life. You will not be deemed to be permanently and totally disabled for purposes of the Fund if your incapacity was contracted, suffered, or incurred while you were engaged in a felony.
3. You must be credited with at least 500 hours of work and contributions prior to the date of application and must have been eligible for benefits as an active Employee for at least one month in the prior twenty-four consecutive month immediately preceding the date of application for Permanent and Total Disability coverage. In the alternative, if you have at least 10 years of service or more with the Pension Fund, or at least 10,000 hours of work with employer contributions to the Health and Welfare Fund, you must have received a Social Security Disability Award within 30 months of your last month of active employment, and maintained coverage with the Fund via self-payments and/or COBRA continuation coverage.

4. You must complete an application for Permanent and Total Disability coverage, accompanied by your Social Security Disability Award Letter, and all IRS Forms W-2, 1099 and 1040 received by or submitted by you, as applicable, from the date of your last covered employment through the date of application. Effective January 1, 2010, if you do not have a Social Security Disability Award, your eligibility is limited to twenty-four months. You are required to notify the Fund immediately in the event of any change in your status with respect to Social Security disability eligibility.

Termination of Permanent and Total Disability Coverage

Once you are granted Permanent and Total Disability coverage, your coverage will continue until the earliest date any of the following occur:

(a) you engage in an occupation or in employment (except for rehabilitation as determined by the Board of Trustees) which is inconsistent with the finding of total and permanent disability; or

(b) you refuse or fail to submit, upon request from the Board of Trustees which it shall make no more frequently than annually, proof of continuing receipt of Social Security Disability Benefits, and copies of all IRS Forms W-2, 1099 and 1040 received by or submitted by you, as applicable, from the date of commencement of your eligibility for Permanent and Total Disability Coverage through the date of the request; or

(c) you become employed in an effort at rehabilitation as allowed under paragraph (a) hereof, but fail to provide satisfactory evidence of income when requested by the Board of Trustees; or

(d) the Fund Office does not receive your monthly payment for coverage in the amount required, and when due; or

(e) you become eligible for coverage as a Retiree; or

(f) the Fund no longer provides Permanent and Total Disability coverage.

ELIGIBILITY FOR OWNERS AND OTHER NON-BARGAINING UNIT EMPLOYEES

Owners and other persons employed by a contributing Employer outside the bargaining unit ("non-bargaining unit employees" or "NBUEs") may participate in the Detroit & Vicinity Trowel Trades Health and Welfare Fund subject to the provisions of the Fund's Plan and the following rules:

- The contributing Employer must be an employer actively involved in the masonry business in the State of Michigan who
  1. is a party to a current collective bargaining agreement requiring contributions to the Fund and
  2. enters into a Participation Agreement (sometimes called a "Health Agreement") with the Fund.
- If an Employer chooses to contribute on NBUEs, it must contribute on all NBUEs it employs except the following:
  1. NBUEs participating in another collectively bargained health care plan;
  2. NBUEs with health care coverage through a family member's employer; and
  3. at the Employer's option, NBUEs who perform only clerical work for the Employer.
- If an Employer chooses to contribute on NBUEs who are Owners and the Owners are husband and wife, the Employer will be required to make contributions on only one of the

spouses. If one of the Owner-spouses is a tradesperson, the Employer must make contributions on the Owner-spouse who is a tradesperson.

- The Fund will not accept contributions or self-payments on behalf of a NBUE if the Employer is delinquent in paying contributions on bargaining unit employees, except where there is a payment schedule in effect that has been approved by the Fund or ordered by a court.
- All NBUEs to be covered by the Fund's Plan must be listed on the Participation Agreement at the time it is signed, and the Employer must notify the Fund Office of any change in NBUEs upon whom the Employer is contributing.
- NBUEs will be classified as follows:

  S-1 Owners who are not working with the tools ("Non-working Owners"), estimators, general superintendents, designated managing partners, and non-Owner non-bargaining unit employees, including, but not limited to, those who perform only clerical work for the Employer.

  Once an S-1 non-bargaining unit employee meets the initial eligibility requirements, that person will continue to be eligible for benefits if he or she is credited with Employer contributions based on at least 160 hours of work during a month according to the applicable continuation of eligibility schedule.

  S-1 non-bargaining unit employees will not have an "hour bank" or be eligible for Weekly Disability Benefits (including loss-of-time credits).

  S-2 Corporate Owners and non-managing partners who are working with the tools ("Working Owners").

  Once a Working Owner meets the initial eligibility requirements, that person will continue to be eligible based on actual hours worked, which must be reported, and/or on self-payments, provided that he or she is credited with Employer contributions and self-payments based on at least 160 hours of work during a month according to the applicable continuation of eligibility schedule.

  Working Owners will have an "hour bank" and will be eligible for Weekly Disability Benefits (including loss-of-time credits).

  S-3 Sole Proprietors.

  Once a Sole Proprietor meets the initial eligibility requirements, that person will continue to be eligible for benefits if he or she is credited with Employer contributions based on at least 160 hours of work during a month according to the applicable continuation of eligibility schedule.

  Sole Proprietors will not have an "hour bank", but they will be eligible for Weekly Disability Benefits (including loss-of-time credits).

TERMINATION OF ELIGIBILITY

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

- The date you are no longer eligible for coverage under the terms of the Plan;
- The date you fail to make self-payments, if required;
- The date the Plan terminates;

- The date you are inducted into the Armed Forces; or
- If you are a NBUE, the date you or your employer violates the terms of the Participation Agreement that provides for contributions on your behalf.

REINSTATEMENT OF ELIGIBILITY

The rules on reinstating eligibility by working after your eligibility has lapsed vary based on how long you were ineligible.

If you have been ineligible for fewer than 12 consecutive months: If you have not been eligible by working for fewer than 12 consecutive months, you will again become eligible on the corresponding eligibility month following three (3) or fewer consecutive months during which you are credited with 120 hours of work and contributions.

If you have been ineligible for 12 or more consecutive months: If you have not been eligible by working for 12 or more consecutive months, you must again satisfy the Initial Eligibility Requirements.

ELIGIBILITY OF RETIREES

If you retire, you will remain eligible for benefits from the Detroit & Vicinity Trowel Trades Health and Welfare Fund by making a monthly self-payment if you meet certain requirements. The type of benefits that you will receive is based on whether or not you are eligible for Medicare. If you are receiving an early retirement benefit from the Bricklayers Pension Trust Fund - Metropolitan Area, the requirements for eligibility for retiree coverage are described in the section below entitled “Eligibility for Early Retirees.” If you are age 65 or over, your eligibility requirements are described in the section below entitled “Eligibility for Medicare-Eligible Retirees.”

Retiree benefits do **not** include Accidental Death and Dismemberment Benefits, Weekly Disability Benefits or Loss-of-Time Credits under the provisions for Continuation of Eligibility During Short-Term Disability.

If you do not elect Retiree coverage when you become eligible, you will not have another chance to elect retiree coverage unless you return to covered employment and either reinstate or re-establish eligibility. However, if you did not elect retiree coverage because you had health coverage through your spouse’s employment and then you lose that coverage, you may elect retiree coverage under this Fund so long as you

- request to return to coverage within **30 days** after the date on which you lost coverage under your spouse’s employment-related health care coverage, and
- provide proof that you maintained your health care coverage continuously from the date you first became eligible for retiree coverage through the date you requested to elect retiree coverage under the Fund.

Eligibility for Early Retirees

To be eligible for benefits for yourself and your dependents as an Early Retiree, you must:

- Notify the Fund Office that you have applied for early retirement benefits from the Bricklayers Pension Trust Fund - Metropolitan Area and that you would like to receive Retiree coverage by completing an application;
- Be a participant in the Detroit & Vicinity Trowel Trades Health and Welfare Fund who has been eligible for benefits from the Fund based on work hours or self-payments at least once in each of the four rolling calendar years immediately preceding the date of your application; and

- Be receiving early retirement benefits from the Bricklayers Pension Trust Fund - Metropolitan Area or the Cement Masons Pension Trust Fund – Detroit & Vicinity.

When you become eligible for Retiree coverage, your hour bank will be exhausted, and then you will be required to make monthly self-payments in an amount determined by the Board of Trustees from time to time, which amount is subject to change by the Board at any time.

You must notify the Fund Office **immediately** if you return to work.

Eligibility for Medicare-Eligible Retirees

To be eligible for benefits for yourself and your dependents as a Medicare-Eligible Retiree, you must:

- Be at least age 65;
- Complete and submit an application for Retiree coverage to the Fund Office; and
- Be a participant in the Detroit & Vicinity Trowel Trades Health and Welfare Fund who has been credited with 500 hours of Employer contributions in the each of the five rolling years before you attained age 65 **and** who has been eligible for coverage under the Plan by work hours or self-payments in each of the two rolling calendar months immediately before you notified the Fund Office that you would like to receive Retiree coverage.

You do **not** have to be receiving retirement benefits from the Bricklayers Pension Trust Fund - Metropolitan Area to be eligible for benefits as a Medicare-Eligible Retiree.

When you become eligible for Retiree coverage, your hour bank will be exhausted, and then you will be required to make monthly self-payments in an amount determined by the Board of Trustees from time to time, which amount is subject to change by the Board at any time.

You must notify the Fund Office **immediately** if you return to work.

Eligibility for Dependents of Retirees

A Retiree may choose either to cover him or herself only or to cover dependents as well. This choice, once made, cannot be changed. The only exception is where a Retiree's spouse was covered by the spouse's employer-provided group health plan when the Retiree coverage started, and the Retiree chose not to cover dependents. In that case, the Retiree will be allowed to add his or her dependents when the spouse's employer-provided coverage ends, but only if the election to do so is made within 30 days of the date the spouse's coverage under her employer-provided group health plan ends. Satisfactory evidence that the spouse was in fact covered by his or her employer's group health care plan and the date such coverage terminated will be required.

Post-Retirement Marriage

If you get married after you retire, your new spouse will be eligible for coverage under the Plan on the first day of the month following your marriage, provided that an application is filed with the Fund Office within 30 days of your marriage with sufficient evidence of such marriage.

Medicare Notice

The Fund provides Medicare-eligible Retired Participants with medical benefits that are supplemental to Medicare. You (and your spouse) must enroll in Medicare Part A, Part B, and Part D as soon as you (and your spouse) are eligible. Benefits under the

Plan will be reduced to the extent payment is available under Medicare. The Fund will not pay any expense that would normally be paid by Medicare Part B.

Termination of Retiree Eligibility

Your coverage will terminate on the earliest date one of the following occurs:

- you fail to pay the monthly payment amount in full and when due; or
- you return to active employment and/or withdraw from retirement; or
- the Board of Trustees eliminates retiree coverage, which is within its discretion to do at any time.

If you return to active employment, you will continue your Retiree coverage, but you will not be required to make a self-payment during the period that you are eligible based on hours worked. However, if you work sufficient hours for which employer contributions are received to meet the initial eligibility requirements as an Active Employee, your coverage will be converted to that of an Active Employee.

ELIGIBILITY OF DEPENDENTS

Dependent coverage does **not** include Accidental Death and Dismemberment Benefits, Weekly Disability Benefits or Loss-of-Time Credits under the provisions for Continuation of Eligibility During Short-Term Disability.

Coverage of Spouses

Your legal spouse is eligible for coverage from the Fund when you are eligible. You must complete a Vital Information form with all required information within thirty days of your becoming eligible, listing your spouse, in order for coverage for your spouse to be retroactive to the date of your eligibility. If the Fund is notified later than that date, the Fund is not obligated to provide coverage effective any earlier than the first day of the month after the month in which you provide notice.

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

Coverage of Children

Your biological sons and daughters, adopted children (including children placed for adoption), and stepchildren are eligible for coverage from the Fund until the last day of the calendar month in which they reach age 26, regardless of their marital status.

Your biological sons and daughters, adopted children (including children placed for adoption), and step-children who have attained age 18 but have not yet attained age 26 will not be eligible for coverage from the Fund if the child is eligible to enroll in a health plan other than the health plan of a parent (for example, if the child is eligible to enroll in the health plan of either his employer or his spouse's employer).

Your disabled dependent children are eligible for coverage from the Fund, regardless of age, if the child is unmarried, incapable of self-sustaining employment by reason of mental retarda-

tion or physical handicap and became so prior to attaining age 26, and is chiefly dependent upon the Employee for support and maintenance. The Employee must furnish acceptable proof of such incapacity within thirty-one (31) days of the child's attainment of age 26.

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

If you or your spouse is named full legal guardian (other than a limited or temporary guardian) of a person who is not your child and who has not yet attained age 18, that person may be eligible for coverage from the Fund under certain circumstances. You should contact the Fund Office for additional information.

NOTE: It is the exclusive responsibility of the participant and any person claiming benefits through a participant to keep the Fund appraised of his or her current address and any change in marital/family status. All documents necessary for payment of benefits and identification of beneficiaries must be submitted to the Fund Office. Medical or other expenses, no matter when incurred, are subject to denial if the Fund Office has incomplete documentation of any nature.

Enrollment of New Dependents

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

If you do not enroll one or more of your eligible dependent(s) for coverage at the time of your initial eligibility, or when you acquire the dependent, if later, because the dependent(s) has coverage under another health plan, you may enroll such an eligible dependent(s) upon the subsequent loss of the other coverage if you do so within **30 days** of the loss of the other coverage.

Termination of Dependent Eligibility

Coverage of a dependent of an eligible Employee will terminate on the date the Employee ceases to be eligible as set out above, or when any of the following events occur

Termination of Coverage for Spouses

A spouse's coverage ends immediately upon divorce from the participant. Both you and your former spouse have an independent obligation to notify the Fund **immediately** upon your divorce. **If you delay in providing notice of your divorce to the Fund for any reason, and the Fund pays benefits on behalf of your ineligible former spouse, you are personally liable to the Fund for any amounts paid by the Fund.** The Fund reserves the right to recover that amount from you, your former spouse, and/

or both of you. It also reserves the right to recover through litigation, termination of your participation in the Fund, offsetting that amount from any future benefits payable to you, and any other lawful means.

Any coverage for a former spouse after the date of entry by the court of a judgment of divorce is available only under the terms of COBRA continuation coverage. If the Fund Office is not notified of a divorce within 60 days of the date of its entry, the Fund has no obligation to offer COBRA coverage. See page 21 for details on COBRA continuation coverage.

A spouse's coverage also ends on the date the spouse enters the Armed Forces of any country.

Termination of Coverage for Children

Children who qualify as your dependents under this Plan will be eligible for benefits until the last day of the month in which they reach age 26, unless the child became totally and permanently disabled by either a mental or physical condition which commenced prior to the end of the calendar month in which the child reaches age 26, and the child is chiefly dependent upon you for support and maintenance. You must be an eligible participant and submit proof of disability to the Board of Trustees within 31 days of the date the dependent child's coverage would otherwise have terminated.

Coverage may terminate on the earliest of the following:

- the child becomes eligible for benefits from the Fund as a result of hours worked by the child in covered employment as of the date of eligibility. However, he may be covered as a child under the Fund after losing eligibility as a participant if his parent is eligible for coverage, subject to all child coverage requirements; or
- for stepchildren only, you become divorced from the stepchild's parent as of the date of divorce; or
- for children who have attained age 18 but have not yet attained age 26, the date on which they are eligible to enroll in a health plan other than the health plan of a parent (for example, if the child is eligible to enroll in the health plan of either his employer or his spouse's employer); or
- the date the child enters the Armed Forces of any country.

ELIGIBILITY OF DEPENDENTS AFTER YOUR DEATH

The Fund offers coverage for dependents after your death that is an alternative to COBRA coverage. By law, the Fund must still offer COBRA continuation coverage. When the Fund Office is notified of the death of an Employee, and the surviving spouse is under age 65, the Fund will provide the surviving spouse with a choice between COBRA continuation coverage and the Fund's Surviving Spouse continuation coverage. The Fund's Surviving Spouse continuation coverage will be the same as the coverage for Early Retirees and Permanently and Totally Disabled Participants. The cost for the coverage for surviving spouses and eligible dependents is determined by the Board of Trustees, and can be changed by them from time to time. There is no time limit on the Fund's Surviving Spouse continuation coverage (as long as the payments are received in full and on time, and the Fund continues to offer this coverage); COBRA is limited to a maximum of 36 months.

The surviving spouse has sixty (60) days from the date on the Fund Office COBRA notification to decide which coverage to choose. Once this choice is made, it is final.

Remember, it is **the dependent's** responsibility to notify the Fund Office within 60 days of the participant's death. Failure to do so could result in the dependent forfeiting any rights to continuation of coverage **retroactive to the date of the participant's death.**

COBRA CONTINUATION COVERAGE

Introduction

This section of the Summary Plan Description contains important information about your right to COBRA continuation coverage. **It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

COBRA continuation coverage is a temporary extension of coverage under the Plan. COBRA continuation coverage does not include Life Insurance Benefits, Accidental Death and Dismemberment or loss-of-time credits during Short Term Disability. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This is only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office and/or get a copy of the Plan Document.

The Board of Trustees has delegated the day-to-day responsibilities for the administration of COBRA continuation coverage to the Administrative Manager. Both the Board of Trustees and the Administrative Manager can be contacted at 700 Tower Drive, Suite 350, Troy, Michigan 48098, (248) 828-6000 (local) or (800) 435-4080 (toll-free). Please use the following mailing address for the Board of Trustees and the Administrative Manager: P.O. Box 99490, Troy, Michigan 48099-9490.

COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced from your spouse.

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

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The child's parents become divorced (but see Qualified Medical Child Support Orders, page 19); or
- The child stops being eligible for coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is death of the Employee, the Employer must notify the Fund Office of the qualifying event within 30 days of any of these events.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce of the Employee and spouse or a dependent child's loss of eligibility for coverage as a dependent child), you must notify the Fund Office. The Plan requires you to notify the Fund Office within 60 days after the qualifying event occurs. The Fund Office may require that you provide evidence that a qualifying event has taken place, such as a copy of the Judgment of Divorce or a birth certificate. You must send notification to the Fund Office, P.O. Box 99490, Troy, Michigan 48099-9490

If any of these events is not reported to the Fund Office within **60 days** from the **later** of the date you would lose coverage because of the occurrence of one of the events described above **or** the date you were sent your COBRA election notice, continuation of coverage will **not** be permitted. Note that some qualifying events result in an immediate loss of coverage (such as divorce and loss of dependent status), and some are determined on a monthly basis (such as termination of employment and loss of hours). Therefore, you should **never delay** in notifying the Fund Office of any qualifying event, or you risk losing your rights under COBRA.

How is COBRA Coverage Provided?

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

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event (for divorce and loss of dependent status), and on the date that Plan coverage would have otherwise been lost (for termination of employment and reduction of hours).

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of his Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of continuation coverage**

  If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. **You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must send this notice to the Fund Office, P.O. Box 99490, Troy, Michigan 48099-9490.**

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

  If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children in your family can receive additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the Employee or former Employee dies, or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event's occurrence. You must send this notice to the Fund Office, P.O. Box 99490, Troy, Michigan 48099-9490.**

If you have a newborn child or have a child placed with you for adoption while your COBRA continuation coverage is in effect, you have the right to elect coverage for such child if the Fund receives notice of that birth, adoption or placement for adoption within 30 days of its occurrence. A child born or placed with you for adoption while you are receiving COBRA continuation coverage will have the same COBRA rights as your spouse or dependents who were covered by the Plan before the event that triggered COBRA coverage. Like all qualified beneficiaries with COBRA coverage, the child's continued coverage depends on the timely and uninterrupted payment of your COBRA payments.

Cost of COBRA Continuation Coverage

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you have to pay the full cost, including a 2% administrative surcharge, for your continuation coverage. If the Social Security Administration determines that you were

disabled at the time of termination or reduction of hours and you elect to continue coverage beyond the 18-month period, you may be charged an additional 50% surcharge beginning on the 19th month of coverage.

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

Termination of COBRA Continuation Coverage

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

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office, P.O. Box 99490, Troy, Michigan 48099-9490. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Fund Office Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of you and your dependents. You should also keep a copy, for your records, of any notices you send to the Fund Office.

FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act of 1993 provides for up to 12 weeks of unpaid, job protected leave for certain family and medical reasons. You are eligible for such leave if you have worked for your Employer for at least 12 months **and** for at least 1,250 hours in the 12 months before the leave starts, and if your Employer is both covered by the Act and has at least 50 employees within 75 miles of where you work.

Whether you are eligible for family or medical leave is determined by your Employer, not the Fund. Both you and your Employer are required to notify the Fund if you take family or medical leave and to

provide certain other information as required by the Board of Trustees. The Fund will continue coverage during the period of your family or medical leave, provided that your Employer makes contributions to the Fund at the same rate and in the same amount as if you were continuously employed during the period of your leave, and fully complies with all requirements established by the Board of Trustees.

ELIGIBILITY WHEN ENTERING MILITARY OR UNIFORMED SERVICE

If you enter the uniformed services of the United States ("Service") while you are eligible for benefits under the Plan, you may elect to continue coverage for all benefits under the Plan, except Death Benefits, Accidental Death and Dismemberment Benefits and Weekly Disability Benefits, for a period which is the lesser of

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

Unless you elect to use your hour bank first, as described below, continuation of coverage hereunder requires that you make a monthly payment, unless your period of Service is for less than 31 days, in which case you will receive coverage at no cost to you.

If you elect to maintain coverage during your Service by making monthly self-payments, your payment will be at the reduced, active rate for a maximum of 12 months. If you were eligible by self-payment immediately before your Service, those months will be included in this 12-month maximum. After you have made a maximum of twelve monthly self-payments at the reduced, active rate, you may continue coverage by self-payment at a rate of no more than 102% of the Fund's actual cost of coverage, until the end of the lesser of either the 24-month period beginning on the date on which your absence begins or the period of your Service plus 90 days.

You may choose to run out your hour bank first when you enter the Service to maintain coverage. When your hour bank becomes depleted, you can continue coverage by making self-payment at the reduced, active rate for a maximum of 12 months, and after that, at the self-payment at a rate of no more than 102% of the Fund's actual cost of coverage, until the end of the lesser of either the 24-month period beginning on the date on which your absence begins or the period of your Service plus 90 days. The Fund will not use the hours in your hour bank to maintain your coverage without your consent.

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

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

CREDITABLE COVERAGE FOR PRE-EXISTING CONDITIONS

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a Federal law, limits the amount of time that group health plans can exclude coverage for a new enrollee's pre-existing health conditions to 12 months (or 18 months for late enrollees). That waiting period (exclusion period) can be reduced by the number of months the individual was covered previously under another health plan, including COBRA coverage, so long as there has not been a gap of more than 63 days in the individual's coverage.

If your coverage under this Plan ends for any reason, you will receive from the Fund a "Certificate of Group Health Plan Coverage" which you should present to your new group health plan. That new group health plan will then "credit" your months of coverage under this Plan against any exclusion period for pre-existing conditions imposed by the new plan, provided you did not have a gap of more than 63 days in your coverage. Details regarding your rights under HIPAA's creditable coverage for pre-existing conditions are included on the Certificate.

BENEFITS

The following participants receive medical, hospital and surgical benefits as described in this Summary:

- Active Participants, including those whose eligibility is continuing as follows:
  - by working,
  - by drawing on the hour bank,
  - by self-payments with the exception of self-payments for COBRA continuation coverage, and
  - by use of loss-of-time credits during short-term disability.
- Those whose eligibility is continuing through COBRA continuation coverage.
- Early Retirees who are not eligible for Medicare.
- Those who are eligible under the Non-Bargaining Unit Employee provisions (NBUEs).
- Permanently and Totally Disabled Participants.
- Surviving Spouses.

Please note that, unless stated otherwise, a participant's dependent(s) will receive the same coverage, services, etc. that the participant receives.

Medicare-eligible Retirees (and their dependents) receive medical, hospital and surgical benefits through Health Alliance Plan's Medicare Complementary program. When you request Retiree coverage, and if you are over age 65, the Fund Office will provide you with information about the Health Alliance Plan program.

Retirees may also elect the **"Non-Medical Program for Retirees"** for a special reduced self-payment. That program is described on page 40 of this summary.

DEDUCTIBLE, CO-INSURANCE AND CO-PAYMENT AMOUNTS

Deductible: Your coverage requires an annual deductible of $250 per covered person before payment from the Fund will be made for any in-network or out-of-network services. In the alternative, once an annual total of $750 has been paid for a covered family, payments from the Fund will commence for all family members, whether or not the annual deductible of $250 has been met for any family member. In-network services are those services provided through your Primary Network.

> **Note:** The Fund Office will assign you to a **Primary Network.** If you live in Michigan, your Primary Network is with Cofinity. If you live outside of Michigan, you will be assigned to a local network under the Premier Health Exchange (PHX) system. Your Primary Network is responsible for providing network discounts for medical, hospital and surgical services provided by in-network providers.

The deductible is required each calendar year. When one person has met the deductible, benefits are payable for that person. Benefits for the remaining family members will be paid when their deductible has been met or when the full family deductible has been met.

Percent Co-Insurance – In Network Services: After the deductible has been met, the Fund will pay 80% of the in-network charges of your Primary Network-provider. You will be responsible for a co-insurance of 20%. After you have paid $1,000 in out-of-pocket co-insurance amounts per individual or $2,000 per family (for in-network services), the Plan will pay 100% of the approved charges.

Your Primary Network provides quality health care at reduced rates to the Fund. You should have received a listing of health care providers who participate in your Primary Network when you became eligible for coverage under the Plan. Please contact the Fund Office if you would like another copy of that listing. If you live in Michigan, your Primary Network is Cofinity and a listing of Cofinity-participating providers is available from both the Fund Office and Cofinity's website at www.cofinity.net.

Your Primary Network discounts the claims from participating providers and then sends them to the Fund Office for final processing and payment. If a participant is hospitalized in an in-network hospital, the total dollars paid by the Fund will be substantially less than in an out-of-network hospital.

The Board of Trustees strongly recommends that in the event you or your dependents require medical services, you consider using an in-network provider because the Fund generally experiences considerable savings when in-network providers are used. **It is your advantage to use in-network health care providers to minimize out-of-pocket expenses.**

Please note that your Primary Network does not pay benefits, or discount claims from out-of-network providers, or determine benefit coverage or eligibility.

Percent Co-Insurance – Out-of-Network Providers: After the deductible has been met, the Fund pays 60% of the Reasonable and Customary charge of an out-of-network provider. You and your dependents are responsible for a co-insurance of 40% of the Reasonable and Customary charges and 100% of any amount above the Reasonable and Customary charges. After you have paid $3,000 in out-of-pocket co-insurance amounts per individual (for out-of-network services) or $6,000 in out-of-pocket co-insurance per family (for out-of-network services), the Plan will pay 100% of Reasonable and Customary charges. You and your dependents will continue to be responsible for 100% of any amount **above** the Reasonable and Customary charge.

Multiple Surgical Procedures Performed at One Time: The maximum amount payable for all surgical procedures (inpatient or outpatient) performed at one time through the same incision or in the same operative field will be the largest payment provided for any one of the procedures performed. The maximum amount payable for two or more surgical procedures performed at one time through separate incisions or in separate operative fields will be the maximum allowed for each procedure.

Emergency Room Co-Payment: You will be charged a $250 co-payment for medical emergencies treated in an emergency room, whether in-network or out-of-network. The emergency room co-payment is waived if the emergency room visit directly arises from an accident or if the patient is admitted to the hospital as an inpatient.

Urgent Care Co-Payment: You will be charged a $50 co-payment for services rendered in an urgent care center, whether in-network or out-of-network.

Office Visit Co-Payment: You will be charged a $25 co-payment for office visits to in-network doctors. Office visits include annual routine physical examinations, "well baby" visits, "well child" visits and podiatry visits. Office visits to in-network providers are covered in full after the $25 co-payment (and the 20% co-insurance is not required). However, if any labs, X-rays, vaccinations, etc. are performed during the Office Visit, deductibles and co-insurance would apply. **Office visits are not covered where the doctor does not participate with your Primary Network.**

Prescription Co-Payment: You will pay a co-payment of $5 for a generic drug purchased at a retail pharmacy, $0 for a generic drug purchased via mail order, and 30% of the prescription cost for any other prescription.

REMEMBER: Co-Payments are not part of the Co-Insurance, and are not included in the annual out-of-pocket maximum. All Co-Payments continue to apply even after the annual out-of-pocket maximum is reached.

BENEFIT LIMITS

Except as provided below, "Essential Health Benefits" as defined by the Patient Protection and Affordable Care Act (the Affordable Care Act) provided by the Plan are subject to the following annual limits for the following periods:

May 1, 2011 – April 30, 2012: $750,000

May 1, 2012 – April 30, 2013: $1,250,000

May 1, 2013 – April 30, 2014: $2,000,000

May 1, 2014: unlimited.

Essential Health Benefits are the following:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

For May 1, 2011 to April 30, 2014, the following Essential Health Benefits provided by the Fund are subject to the following annual limits:

- Nuclear medicine (per calendar year): $4,000;
- Physical therapy (per calendar year): $1,000;
- Laboratory Diagnostic benefits (per calendar year):
  - Active Participants, COBRA Participants, and NBUEs $4,000;
  - Early Retirees, Permanently and Totally Disabled Participants and Surviving Spouses: $3,000;
- Hearing aids (one or more hearing aids every three years, Active Participants only): $500;
- Prescription drugs (per calendar year)
  - Active Participants, COBRA Participants, and NBUEs: $3,000;
  - Early Retirees, Permanently and Totally Disabled Participants who do <u>not</u> have a Social Security Disability Award, Surviving Spouses: $100;

- Pediatric* dental (per calendar year) (dental benefits are described on page 38 of this Summary)
  - Traditional dental benefits $ 400;
  - Golden Dental Managed Care Program dental benefits $1,500;
- Pediatric* vision (per calendar year) (vision benefits are described on page 39 of this Summary)
  - Eye examination $ 50;
  - Single lenses $ 75;
  - Bifocal lenses $ 90;
  - Trifocal lenses $ 100;
  - Frames $ 100;
  - Contact lenses (in lieu of frames and lenses) $ 140.

* "Pediatric" means dependent children who have not reached age 16.

Your dental and vision benefits are subject to other or further limitations, in addition to the above allowed amounts (see pages 38 to 39 of this Summary for details).

MEDICAL, HOSPITAL AND SURGICAL BENEFITS

1. Hospital and Surgical Benefits

When a covered person has incurred necessary expenses for hospital care that is recommended and approved by a Physician for the diagnosis and treatment of an illness or injury, the Fund will pay the Reasonable and Customary amount of the hospital's charge, subject to the Plan's benefit limits.

A. Hospitalization Management Program

If you (or your dependent) are admitted or scheduled for admission to the hospital, you must contact the Hospital Management Program, which is administered for the Fund by Alicare, at 1-800-848-9200 between the hours of 8 a.m. and 6 p.m., Monday through Friday. Have the alternate ID number of the person being admitted to the hospital, the name of the Plan, the hospital name and phone number, date and expected duration of hospital admission and reason for hospital admission. If you call after normal business hours, you will receive a recorded message instructing you to leave your name and phone number. Your call will be returned on the next business day.

When you (or your dependent) require an **urgent** admission, your doctor, the hospital or a family member should telephone Alicare at 1-800-848-9200 as soon as possible and provide Alicare with information so that it can assign an initial number of approved hospital days. When you or your dependent is hospitalized for an **emergency**, the doctor or a family member must call Alicare within 72 hours of the admission.

If you (or your dependent) become **pregnant**, you (or your dependent) should call Alicare as soon as possible. An initial number of days will be approved at that time, and you will be instructed to notify Alicare when admitted for delivery. See the Newborns' and Mothers' Health Protection Notice on page 32 for important information about the lengths of hospital stays related to childbirth.

Hospitalization Management requires you to have your proposed hospital stay reviewed by Alicare's professional staff prior to your hospital admission. Based on information provided by your doctor, Alicare will determine whether your hospitalization is medically necessary or if the treatment might be provided in a different setting. At the same time, Alicare will assign an initial number of approved hospital days and notify you, your physician and the hospital.

When the initially approved hospital days have expired, Alicare will contact your doctor to learn if you will be discharged. In cases where your doctor decides that an extension of your hospitalization is required, Alicare will approve additional days, subject to review and approval.

Hospitalization Management does not guarantee coverage for incurred services. Your hospital stay is still subject to all other Plan coverage rules.

B. Hospital Benefits

"Hospital" means an institution that meets all of the following requirements:

- is engaged primarily in providing medical care and treatment to ill and injured persons on an inpatient basis at the patient's expense;
- is constituted, licensed and operated in accordance with the laws that pertain to hospitals for the jurisdiction in which it is located;
- maintains on its premises all of the facilities necessary to provide medical and surgical treatment for the diagnosis of an illness or an injury;
- such treatment is provided for compensation by or under the supervision of Physicians, with continuous twenty-four (24) hour nursing services by Registered Graduate Nurses (R.N.);
- qualifies as a hospital, a psychiatric hospital, or a tuberculosis hospital under, and is accredited by the Joint Commission of the Accreditation of Hospitals (J.C.A.H.),
- is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital admissions must be medically necessary. Without a satisfactory showing of medical necessity, any such hospitalization for those days will not be considered covered treatment.

The Fund will pay the Reasonable and Customary amount of the hospital's charge for room, board, and general nursing care for a covered person who is hospitalized for at least 24 consecutive hours.

The Fund will pay the Reasonable and Customary amount of the hospital's charge for necessary services and supplies for the diagnosis and treatment of the illness or injury for which the covered person is hospitalized. Such charges may include (but are not limited to) the following:

- meals and special diet (patient only);
- use of operating, delivery, recovery, or other treatment room;
- anesthesia and its administration;
- drugs and medicines;
- dressings and casts;
- all hospital x-ray and laboratory services performed during confinement as an inpatient;
- use of iron lungs, respirators, incubators, oxygen tents, and similar hospital equipment;
- physical therapy performed during confinement as an inpatient;
- speech therapy performed during confinement as an inpatient;
- use of radium owned or rented by the hospital; radiation therapy performed during confinement as an inpatient;
- chemotherapy performed during confinement as an inpatient;
- hemodialysis performed during confinement as an inpatient; or

- treatment in special care units such as intensive care, cardiac care, critical care and isolation units.

The Fund will **not** pay for:

- dental treatment, other than as the result of injury;
- personal comfort or incidental items, such as television or telephone services;
- occupational therapy, except if such therapy is necessary following hospital confinement for a covered accident, surgery, stroke, cancer, or heart-related problems; or
- private rooms.

C. Surgical Benefits (Inpatient and Outpatient)

When a covered person has incurred necessary expenses for surgery that is recommended and approved by a Physician, the Fund will pay the Reasonable and Customary amount of the provider's charge for the following eligible surgical benefits, subject to the Plan's benefit limits:

- Charges made by a Physician for the pre-operative examination, the performance of the surgical procedure, and post-operative care;
- Charges made by a technical surgical assistant if the hospital does not provide interns, residents or house officers for that purpose, and provided that the procedure is such that the services of a technical surgical assistant are medically necessary;
- Charges made by a Physician for the administration of anesthesia in relation to a covered surgical procedure, provided that such anesthesia services are not also rendered by an employee of the hospital or the type customarily provided by the Physician in charge;
- Charges made by a Physician for plastic surgical (cosmetic) procedures performed to restore a functional bodily process if the loss of the process is the result of:
    - an accidental injury sustained while coverage under this Plan was in effect;
    - a congenital anomaly of a covered person or an eligible dependent child;
- Charges made by a Physician for plastic surgical (cosmetic) procedures performed post-mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These benefits are to be provided in a manner determined in consultation with the attending Physician and patient. These benefits are pursuant to the Women's Health and Cancer Rights Act of 1998 and are intended to comply in full with that Act.
- Charges made by a Physician for pre-natal care, delivery, and post-natal care.
- Charges for elective sterilization.

If multiple or bilateral surgical procedures are performed during the same operative session, the Fund will consider payment of the major surgical procedure to the Plan's benefit limits, plus 50% of the Reasonable and Customary amount of the charge for the lesser surgical procedure(s). All surgical procedures performed through the same incision during the same operative session will be considered one surgical procedure, and payment will be based on the Reasonable and Customary amount of the charge for only the major surgical procedure.

D. Second Surgical Opinion Program

If an operation is recommended to treat an illness or injury, the covered person may obtain additional opinions as to its necessity prior to the surgery. The Fund will pay the Reasonable and Customary amount of the charge for a surgical second opinion.

E. Physician Visit Benefit

When a covered person has incurred necessary expenses for treatment by a Physician during a period of hospitalization due to an illness or injury, the Fund will pay the Reasonable and Customary amount of the Physician's charge up to the limit stated in the Schedule of Benefits.

The Fund will pay the Reasonable and Customary amount charged for consultations between the attending Physician and other Physicians while the covered person is hospitalized.

2. Maternity Care

Maternity (including pre-natal care) benefits are covered and paid for subject to the same conditions, limitations and exclusions as defined under "Hospital Benefits." The Fund will pay benefits related to the pregnancy of a dependent daughter of a participant only once per daughter. The hospital and medical charges incurred by or on behalf of the child of the dependent daughter of a participant are not paid for by the Fund. (However, the Fund may cover the grandchild of a participant if the grandchild is a dependent of the participant subject to the requirements for Coverage for Dependents on page 18 of this Summary.)

Newborns' and Mothers' Health Protection Notice: Group health plan and health insurance issuers may not, under Federal law, restrict benefits for any hospital 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 caesarian section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the Fund may not, under Federal law, require that a provider obtain authorization from the Fund (or the insurer, if applicable) for prescribing a length of stay which does not exceed 48 hours (or 96 hours, as applicable).

3. Therapy Benefit

A. Physical Therapy Benefit

When a covered person has incurred necessary expenses for Physical Therapy, the Fund will pay the Reasonable and Customary amount charged, up to the Plan's benefit limits for physical therapy (see below). Benefits under this provision are payable only if the treatment is designed to improve muscle strength, joint motion, coordination, or general mobility, and the treatment:

- is prescribed by the covered person's attending physician;
- requires the assistance and supervision of an appropriate licensed therapist; and
- is for a condition that is capable of significant improvement in a reasonable and generally predictable period of time.

For example, Physical Therapy may be used to restore the use of leg(s) or arm(s), or to accelerate the healing of an acute injury or illness involving the muscles or joints in conjunction with a treatment program.

Benefit limits: Coverage for outpatient physical therapy is limited by $1,000 per calendar year. The Fund will cover an additional $1,000 outpatient physical therapy per calendar year for post-surgical therapy when medically necessary.

B. Occupational Therapy Benefit / Speech Therapy

When a covered person has incurred necessary expenses for Occupational Therapy and/or Speech Therapy, the Fund will pay the Reasonable and Customary amount charged, up to the Plan's benefit limits, but only when the Occupational Therapy and/or Speech Therapy is necessary following hospitalization for an accident (except accidents that are work or auto/vehicular related), stroke, cancer or heart-related problems. The Fund does not pay benefits for Occupational Therapy and/or Speech Therapy under any other circumstances.

4. Diagnostic Procedures Benefit

When a covered person has, upon the recommendation of a Physician, incurred necessary expenses for X-rays, diagnostic and laboratory tests solely for the diagnosis of an illness or injury, the Fund will pay the Reasonable and Customary amount of the charge up to the Plan's benefit limits. Diagnostic services must be directed toward determining a definite condition or illness and can include:

- X-ray and other radiology services
- laboratory and pathology services
- cardiographic, encephalographic, and radioisotope tests

5. Pre-Admission Testing

Pre-admission testing consists of routine laboratory tests and X-rays ordered by a Physician performed on a covered Person, on an outpatient basis, during the ten (10) day period immediately preceding a scheduled hospital confinement. The Fund will pay the Reasonable and Customary amount of the charges for pre-admission testing.

6. Extended Care/Rehabilitation Facility Benefit

The Fund will pay necessary expenses incurred by a covered person who has been hospitalized for at least three days for a period of extended care or rehabilitation that begins no more than 14 days after discharge from the hospital, up to the Plan's benefit limits for the following covered charges:

- Room and board, including regular daily services and supplies furnished by the facility.
- Other services and supplies ordered by a Physician and furnished by the facility for inpatient medical care.

An "Extended Care/Rehabilitation Facility" is either a skilled nursing facility, which is qualified to participate and eligible to receive payment under and in accordance with the provisions of Medicare (except for a skilled nursing facility which is part of a hospital), or an institution which provides 24-hour a day skilled nursing care of ill and injured persons operated in accordance with applicable laws under the full-time supervision of a physician or registered nurse who maintains a daily medical record of each patient, and is accredited by the Commission on Accreditation of Rehabilitative Facilities (C.A.R.F.).

The Extended Care/Rehabilitation Facility Benefit shall **not** be paid:

- after the 60th day of the Extended Care/Rehabilitation Facility confinement, during any one (1) occurrence;
- for care that is not certified as medically necessary by the attending physician (this applies to both 24 hour-a-day nursing care; and the entire period of extended care/rehabilitation facility confinement);
- for professional services such as private duty nursing or Physician's fees; or
- for an institution which is primarily a school, other institution for training, a nursing home or similar institution.

7. Hospice Care Benefit

The Fund will pay the Reasonable and Customary amount of the charges for necessary expenses incurred by a covered person for Hospice Care, up to the Plan's benefit limits. Benefits under this provision are payable only if the treatment is prescribed and supervised by a Physician under a written "Plan of Treatment" furnished to the Plan Administrator prior to the commencement of the Benefit Period. For purpose of this provision, a Plan of Treatment must include the following:

- a complete description of the palliative care and treatment to be provided to the terminally ill patient during a Benefit Period;
- a provision that such Plan of Treatment will be reviewed and approved every 60 days by the attending Physician;
- a prognosis of six months or less of life; and
- the concurrent opinion of the attending Physician and Hospice that the care and treatment to be provided will not exceed the cost of any other alternative treatment.

A "Benefit Period" begins on the date the Attending Physician certifies that a family member is terminally ill; it ends six months after commencement or upon the death of the terminally ill patient, if sooner. If the Benefit Period ends before the death of the terminally ill patient, a new Benefit Period may be established if the Attending Physician certifies that the Patient is still terminally ill, and the charges incurred for subsequent care and treatment do not exceed the overall lifetime maximum benefit stated in the Schedule of Benefits.

The following charges are covered under this Hospice Care Benefit:

- Inpatient Hospice care at the facility's standard Semi-Private Room Rate (Private room charges are limited to the facility's charge for a standard Semi-Private Room);
- Physicians' services;
- Drugs and medications administered by a Hospice Facility; and
- Home Health Care Services including:
    - Part-time nursing care rendered in the Covered Person's home by a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Public Health Nurse;
    - Physical therapy provided in the Covered Person's home;
    - Use of durable medical equipment; and
    - Rental of hospital-type beds and wheelchairs.

The following charges are **not** covered under this Hospice Care Benefit:

- services/items not ordered by the Attending Physician and not included in the Plan of Treatment;
- services/items for which the family unit would not legally have to pay if there were no coverage;
- care related to illness or injury due to any employment, automobile or other motor vehicle accident; or
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners, walkers, canes and bedside commodes, or similar appliances and devices.

8. Mental Health Treatment

The Plan provides benefits for the inpatient and outpatient care of mental health services, subject to the Plan's benefit limits.

- **Inpatient hospital benefits** for the treatment of mental and nervous disorders are paid in the same way as an illness or injury.
- **Outpatient care or treatment** of mental and nervous disorders must be provided by:
  - a psychiatrist (M.D. or D.O.); or
  - a certified or licensed psychologist (Ph.D., Ed.D. or M.A.);
  - a social worker or other professional counselor who is licensed as a Licensed Professional Counselor in the State of Michigan.

Eligible charges include:

- initial psychological testing
- initial evaluation
- individual visits.

9. Substance Abuse Treatment

The Plan provides benefits for the inpatient or outpatient care for substance abuse, subject to the Plan's benefit limits.

Inpatient hospital benefits for the treatment of substance abuse are paid in the same way as an illness or injury.

Outpatient care or treatment of substance abuse must be provided by:

- a psychiatrist (M.D. or D.O.); or
- a certified or licensed psychologist (Ph.D., Ed.D. or M.A.);
- a social worker or other professional counselor who is licensed as a Licensed Professional Counselor in the State of Michigan.

Eligible charges include:

- initial psychological testing
- initial evaluation
- individual visits.

10. Durable Medical Equipment

The Plan covers rental or purchase (whichever is most economical and at the option of the Plan) of medically necessary durable medical equipment designed for use, in lieu of a hospital confinement or continued confinement, if accompanied by a prescription and a Physician's statement verifying the medical necessity of the equipment and the duration for which it is expected it will be used. The Fund will pay the monthly rental of such equipment for up to 15 months for non-life sustaining needs and for as long as necessary for life-sustaining equipment. Note: In order for repairs to "purchased" durable medical equipment to be considered an eligible expense, prior authorization is required from the Fund Office.

11. Bariatric Surgery

Bariatric Surgery will be certified and covered by the Fund (subject to all deductibles and co-pays) where the person seeking coverage for Bariatric Surgery submits documentation that all of the following requirements have been met:

1) the patient has a Body Mass Index of 35 or greater with co-morbidities, **or** a Body Mass Index of 40 or greater without co-morbidities,
2) the patient has either
    a) completed an approved weight loss management program followed by a 12-month maintenance period,
    b) attempted but did not complete a weight loss management program because the patient was medically unable or because surgical intervention was recommended, or
    c) did not attempt a weight loss management program because the primary care physician did not support that as a treatment option based on presenting co-morbidities, and
3) the patient has undergone psychological assessment establishing his readiness and ability to comply with post-surgical dietary requirements.

All requests for bariatric surgery are reviewed by the Fund's case manager for medical necessity and appropriateness.

12. Other Covered Medical Benefits

When a covered person has incurred necessary expenses as a result of illness or injury, the Fund will pay the Reasonable and Customary amount of the charges for such eligible expenses, up to the limit(s) stated in Plan's benefit schedule.

Covered medical benefits include items listed below not otherwise payable under any other section of this Plan:

- Physician's services for office visits including **annual routine physical examinations** (in-network only), consultations (in-network only), "well baby" and "well child" examinations (in-network only), allergy testing, outpatient hospital treatment, skin conditions such as but not limited to acne and warts, and other medical care;
- Nuclear medicine;
- Outpatient treatment, services and supplies furnished by a hospital;
- Chiropractic office visit only in-network;
- Charges for ground ambulance service to and from a local hospital. A licensed ambulance must be used;
- Charges for the cost of anesthesia and its administration;

- Medical supplies, including but not limited to the following: surgical dressings, blood and blood plasma (except when replaced), electronic heart pacemaker, casts in lieu of surgery for fractures, splints, trusses, braces after surgery or in lieu of surgery, crutches, drugs and medicines ordered by a Physician and dispensed by a licensed pharmacist while hospital confined;
- Treatments by x-ray, radium or other radioactive substances; outpatient traditional therapy;
- Chemotherapy and hemodialysis rendered on an outpatient basis;
- Podiatric services rendered by a Doctor of Podiatric Medicine (D.P.M.), to the extent that benefits payable under this Plan do not exceed benefits that would have been payable to an M.D. or D.O. for treatment of the same condition;
- Ambulatory Surgical Facility service;
- Immunizations and vaccinations;
- Allergy treatments, including injections, testing and serum; and
- Hearing Aids for Active Employees (including NBUEs (Employee only) and those formerly Active Employees covered under COBRA continuation coverage), subject to the Plan's limitations.

13. Women's Health and Cancer Rights Act Notice

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the deductibles and co-payments applicable to other medical and surgical benefits provided under the Plan as set forth on page 31. If you would like more information on WHCRA benefits, call the Fund Office.

14. Case Management

Case Management is a special service designed to assist patients with serious illnesses or injuries. Many people who have used this kind of service have found that it provides valuable assistance and peace of mind during difficult periods of serious illness, such as chronic illnesses, acute catastrophic injuries, infectious diseases, terminal illnesses, neonatal complications and burns. Should any serious illness or injury arise, a nurse case manager will contact you and your family to discuss your medical care needs. Your personal nurse case manager will help you by facilitating all activities and communication among the professionals involved in your treatment plan, providing information about your treatment options and identifying any needed medical resources that may be available to you.

PRESCRIPTION DRUG BENEFITS

The Fund has engaged Sav-Rx as the administrator of its prescription drug benefit program. You should use your prescription drug benefit card whenever you fill a prescription, and should keep your benefit card as safely as you would a credit card. Loss of a benefit card should be reported to the Fund Office immediately. You should use the benefit card only for benefits for you, your spouse and

your dependent children. Any unauthorized use of your benefit card could result in revocation and/or the elimination of your right to have new benefit cards issued to you in the future.

Prescription drug coverage includes disposable insulin needles/syringes when prescribed and dispensed at the same time as insulin. Prescription drug coverage also includes prescription smoking deterrents.

You will pay a co-payment of $5 for a generic drug purchased at a retail pharmacy, or $0 for a generic drug purchased via mail order, or 30% of prescription cost for any other prescription.

DENTAL BENEFIT

Traditional Benefits: If a covered person is treated by any licensed dentist, oral surgeon or hygienist (with respect to prophylaxis) the Fund will pay 100% of the Reasonable and Customary amounts for dental treatment up to the following limits:

Per Covered Person - Actives, COBRAs and NBUEs	$400 (annually)
Per Covered Person - Early Retirees, Medicare-Eligible Retirees, Permanently and Totally Disabled Participants and Surviving Spouses:	$400 (annually)

Orthodontic treatment only covers Adult Subscriber, Spouse, and dependents up to age 19.

All types of dental services, surgical and non-surgical, are covered under this benefit, including periodontal work, extractions (impacted and non-impacted), radiographs, consultations, orthodontics, exams and cleanings.

No separate enrollment is needed for traditional dental coverage. Benefits are payable in accordance with the Fund's schedule of dental benefits and will be paid directly to the dentist unless you submit a paid, itemized bill for services rendered. Charges in excess of the amount allowed by the Fund's schedule of benefits are your responsibility.

Golden Dental Managed Care Program Option

Participants may elect, on an annual basis, to participate in the Golden Dental Managed Care Program instead of the traditional dental benefits described above. The Golden Dental Managed Care Program option allows up to $1,500 of dental benefits per covered person per calendar year. If you choose the Golden Dental Managed Care Program option, you must use **your** specific Golden Dental Managed Care Program provider. If you do not use **your** Golden Dental Managed Care Program provider, claims will not be paid on your behalf. If services are performed by **your** Golden Dental Managed Care Program Provider, claims will be processed as follows, up to your yearly maximum:

- 100% of Class I Diagnostic and Preventative (examinations, cleanings, x-rays, prophylaxis and fluoride treatments *every 6 months, up to age 15*)
- 75% of Class II Restorative (fillings, routine extractions & root canals)
- 75% of Class III Prosthetics (crowns, bridges and dentures, & *partials*)
- 50% of Class IV Specialty Care (oral surgery, endodontics, & periodontics)
- 50% Orthodontics Coverage: Golden Dental pays 50%; Lifetime Maximum for dependents up to age 19 - $1,500.00

  Golden Dental pays 50%; Lifetime Maximum for Adult Subscriber and Spouse - $1,200.00

VISION BENEFIT

The Plan provides coverage for expenses incurred for eye examinations, eyeglass lenses, eyeglass frames and contact lenses up to the amount stated in the Schedule of Benefits.

This benefit provides for an eye examination, frames and lenses or contact lenses (in lieu of frames and lenses) **once every calendar year** for active members, COBRA participants, NBUE participants and their eligible dependents.

This benefit also provides for an eye examination, frames and lenses or contact lenses (in lieu of frames and lenses) **once every two calendar years** for Early Retirees, Medicare-Eligible Retirees, Permanently and Totally Disabled Participants, Surviving Spouses and their eligible dependents.

Vision benefits are **not** provided for the following services:

- Sunglasses, unless they are prescribed to be worn at substantially all times.
- Glasses with tinted lenses, scratch coat, UV protection, and other specialty items.
- Routine yearly examinations required by an employer in connection with the occupation of the individual.
- Vision expense for covered services resulting from occupational bodily injury or disease.
- Vision expense for covered services in a hospital owned or operated by the Federal Government or for which the Employee is not required to pay.
- Any vision care to the extent that benefits for the service or supply is payable under any other insurance or group policy.
- A service or supply not furnished by a licensed physician, optometrist or ophthalmologist.
- Service or supplies in connection with occupationally related conditions.

The Plan pays l00% of covered expenses up to the following benefit limits once each calendar year (for active participants, COBRA participants, NBUE participants and their eligible dependents) or once every two calendar years (for Early Retirees, Medicare-Eligible Retirees, Permanently and Totally Disabled Participants, Surviving Spouses and their eligible dependents):

Examination	$50
Lenses, per pair	
Single	$75
Bifocal	$90
Trifocal	$100
Contacts, per pair (in lieu of frames and lenses)	$140
Frames	$100

To help reduce your costs, you may choose to obtain your vision services through Co-Op Optical, DOC Optical or SVS Vision. These companies have agreed to charge reduced fees to eligible Fund participants and dependents. However, as always, you are free to use any provider you wish - eligible persons are not required to go to Co-Op Optical, DOC Optical and SVS Vision. These vision providers' agreement to provide discounts to Fund participants and dependents is in no way the Fund's endorsement or recommendation of any of these providers, and you are encouraged to shop around for the best arrangement you can make.

Depending on your provider, you may be required to pay up front for whatever services or materials you receive, or the provider may bill the Fund directly. Payment will be in accordance with the Fund's schedule of benefits, but not more than the actual cost.

You will be responsible to pay any amounts charged which are in excess of the applicable maximum amount payable under the Fund's schedule of vision care benefits.

NON-MEDICAL PROGRAM FOR RETIREES

Instead of the regular retiree program which includes medical coverage, retirees may elect to enroll in a special non-medical program, and receive the following coverages only, for a special reduced monthly self-payment established by the Board of Trustees. That rate may change from time to time at the discretion of the Board of Trustees.

Dental: Either $400 each calendar year for Traditional Benefits or $1,500 each calendar year if Golden Dental Managed Care Program dental benefits are elected,

Vision: Every two years coverage for up to $50 per exam, $100 for frames, $75 for single vision lenses, $90 for bi-focal lenses, $100 for tri-focal lenses or $140 for contacts in lieu of frames and lenses.

Death Benefit: $1,000 for the Retiree only

The Fund does not provide any prescription drug benefits to Retirees, except for the $100 per year reimbursement program.

WEEKLY DISABILITY BENEFITS (Active Participants and S-2 and S-3 (NBUEs) only)

If you are covered by the Fund, and are unable to work because of an accident occurring **off** the job or any illness **not** connected with employment or an auto accident, or because of illness, you will be entitled to $200 in Weekly Disability Benefits for a period of 26 continuous weeks or the period of your disability, whichever is shorter, after you file an application with the Fund Office. However, you will not be eligible for Weekly Disability Benefits for any weeks in which you are collecting State unemployment benefits. Payment for any one payable day of disability benefits is 1/7th of the weekly benefit amount.

If you are eligible for Weekly Disability Benefits, you are also eligible for Loss-of-Time Credit (see page 12 of this Summary for an explanation of that Credit).

If your disability is due to an accident, the accident must have occurred when you were actively employed and eligible for benefits under the Plan based on your active employment. You must also be under the care of a physician or surgeon. However, an Employee who is eligible by reason of self-payment shall not be eligible for Weekly Disability Benefits if his disability is incurred after the first four consecutive months of self-payments and while the Employee is still making self-payments.

Benefits begin on the first day of disability due to an accident, and on the eighth day of disability due to an illness (which include pregnancy and substance abuse). If you are pregnant, your period of disability due to that pregnancy is normally considered to be for the period six weeks prior to the delivery date through the six to eight weeks following the delivery date. You must provide medical documentation deemed sufficient by the Board of Trustees to receive Weekly Disability Benefits for a longer period, not to exceed the twenty-six (26) continuous week maximum.

Note: You must apply for Weekly Disability Benefits within **60 days** from the onset of your disability on a form provided by the Fund Office.

You will not be eligible for a new period of Weekly Disability Benefits until you have been re-employed in Covered Employment on a full-time basis for a minimum of one (1) day (eight hours of work). Under no circumstances will you be eligible for more than three (3) disability periods as a result of disability due to the same cause.

Non-working Owners and other S-1 NBUEs (see page 23 of this Booklet) are not entitled to Weekly Disability Benefits (or continuation of coverage during short-term disability).

DEATH BENEFIT

1. Amounts Payable

The amount of Death Benefits payable from the Fund upon your death varies based on whether you are an Active Participant or a Retired Participant on the date of your death. Death Benefits are payable based on the death of your dependents only while you are an Active Participant, and they are otherwise eligible for coverage.

- Active Participants (Including those whose coverage is continuing through the hour bank, self-payments or during short term disability and NBUEs) — $10,000
- Dependents of Active Participants (Including Spouse and Dependent Child) — $1,000
- Retired Participant (Early Retiree or Medicare-Eligible Retiree) — $1,000
- Permanently and Totally Disabled Participant — $1,000
- Surviving Spouse — $500

Dependent coverage: Benefits are payable upon the death of your dependent only if you are an Active Participant on the date of your dependent's death. The Death Benefit for dependents ends when the dependent loses dependent status (e.g. because the dependent spouse is no longer married to the participant, the dependent spouse or child became eligible for insurance under the Fund as a participant, the dependent child attains age 26).

However, if your coverage terminates due to your death, and your dependents are otherwise eligible for coverage, they will continue to have Death Benefit coverage until your hour bank falls below 120 hours.

2. Application

Upon receipt of acceptable proof of death (usually a death certificate), a Death Benefit is payable as stated in the Schedule of Benefits. Written notice of the death must be given to the Fund Office within one year of the date of death; if later, no Death Benefit will be paid.

An application on a form prescribed and furnished by the Plan must be completed by anyone wishing to be considered for a Death Benefit, accompanied by such documentation, identification and proofs as the Board of Trustees may require.

3. Beneficiaries

Active Participants, Medicare-Eligible Retirees, Early Retirees, Permanently and Totally Disabled Participants and Surviving Spouses: An Active Participant, a Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse may designate the beneficiary to whom a Death Benefit payable on their behalf shall be paid; if more than one (1) beneficiary is designated, the beneficiaries will share equally.

The designation of a spouse as a beneficiary is automatically canceled upon entry of a judgment or decree of divorce between the participant and that spouse. The Active Participant, Medicare-Eligible Retiree, Early Retiree, Permanently and Totally Disabled Participant or Surviving Spouse may

designate a former spouse as his or her beneficiary, but must make this designation on a beneficiary designation card **after** his/her divorce to do so. If you die, and your ex-spouse remains designated as your beneficiary, on a card you filled out before you were divorced, any Death Benefit payable on your behalf will be paid as though you had no valid designation on file with the Fund, because that designation automatically terminated upon your divorce.

If, upon the death of the Active Participant, Retired Participant (Medicare-Eligible Retiree or Early Retiree), Permanently and Totally Disabled Participant or Surviving Spouse, no beneficiary has been designated, or the designated beneficiary has predeceased the covered person, or the designated beneficiary is the ex-spouse of the deceased on a card completed prior to their divorce, any Death Benefit payable will be paid to the first of the following:

(1) wife or husband, but if none are living,

(2) all children then living in equal shares, but if none living,

(3) parents in equal shares, but if none are living,

(4) all brothers and sisters then living in equal shares, but if none are living,

(5) any individual(s) that is a beneficiary of the deceased's estate, in equal shares, but if there is no estate,

(6) the individual(s) identified as entitled to a share of the deceased's property in a sworn Affidavit of Decedent's Successor for Delivery of Certain Assets Owned by Decedent with respect to the Participant, in accordance with MCL §§700.3983-700.3984, in proportion to the shares identified on the form.

If there are none of the foregoing, then no Death Benefit is payable on behalf of the covered person.

Beneficiaries for Dependents: You are the beneficiary of the Death Benefit provided for your dependents under the Plan, if you are living. If you are not living, then the beneficiary is your spouse. If your spouse is not living, the dependent's siblings are the beneficiaries in equal shares. If there are no siblings, your dependent's estate is the beneficiary.

Change of Beneficiary: Each active participant shall have the right to change his/her beneficiary at any time by written notice, submitted directly to the Fund Office, and the change will become effective on the date of receipt by the Plan.

Burial Expenses: The Plan may pay a benefit to any individual who submits an application accompanied by proof that the individual incurred the expenses in connection with the covered person's burial, which are unreimbursed from any other source. The amount to be paid hereunder shall be equal to the lesser of $500 or the unreimbursed amount, and will be subtracted from the full Death Benefit payable.

Any payment that the Fund makes according to the Plan's provisions regarding the designation of beneficiaries will be made in good faith and will fully release the Plan of any further responsibility for such payment.

4. Time for Filing

Written notice of your death must be received by the Fund Office within one year of the date of your death. If it is not received by then, no Death Benefit will be paid.

5. Termination of Eligibility for Death Benefit

No Death Benefit will be issued on behalf of an Active Employee after the earliest of the following dates:

- The date the Employee stops being eligible under the Plan;
- The date the Employee enters the military or other uniformed services of any country or at any time during the period of his service;
- The date the Employee becomes covered under COBRA; or
- The date this Plan no longer provides this benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Eligible Participants only)

Accidental Death and Dismemberment Benefits are payable on behalf of an Active Participant (including a NBUE) who is eligible through working or drawing on his hour bank.

1. Amounts Payable

ACCIDENTAL DEATH	$10,000

This Accidental Death Benefit is in addition to the Death Benefit described on page 41 of this Summary.

DISMEMBERMENT BENEFITS

Loss of Both Hands or Both Feet	$2,000
Entire Sight of Both Eyes	$2,000
One Hand and One Foot	$2,000
One Hand or One Foot and Entire Sight of One Eye	$2,000
One Hand or One Foot	$1,000
Entire Sight of One Eye	$1,000

If you suffer an accidental bodily injury or illness which results in one of the losses described above while you are an Active Participant, the Fund will pay benefits up to the maximum amount set out above.

With respect to a hand or foot, “loss” means complete severance through or above the wrist or ankle joint. With respect to an eye, “loss” means the irrevocable loss of the entire sight thereof. Accidental Death and Dismemberment Benefits will not be paid for more than one of the losses sustained by the Covered Employee as the result of any one accident.

Benefits under these provisions will be paid directly to you if you are still living. If you are not living, benefits will be paid to your designated beneficiary or beneficiaries. You may designate any person(s) of your choice as your beneficiary (or beneficiaries), and you may change your beneficiary at any time by completing forms that are available at the Fund Office. If you have not named a beneficiary or if your beneficiary predeceases you and you do not name a replacement, your Accidental Death and Dismemberment Benefits will be paid as follows: to your widow or widower; or, if none, to your surviving children in equal shares; or, if none, to your estate.

2. Termination of Eligibility for Accidental Death and Dismemberment Benefit

No dismemberment benefits will be issued after the earliest of the following dates:

- The date the Employee stops being eligible under the Plan;

- The date the Employee enters the military, naval or air force of any country or at any time during the period of his service;
- The date this Plan no longer provides this benefit; or
- The date the Employee becomes eligible for COBRA benefits or the date the Employee elects and becomes entitled to Medicare Part B.

3. Time for Filing

Written notice of your death or dismemberment must be received by the Fund Office within **one year** of the date of death or dismemberment. If it is not received by then, no benefits will be paid for accidental death or dismemberment.

4. Exclusions

Accidental Death and Dismemberment Benefits are **not** paid for losses caused by:

- War or any act of war, whether war is declared or undeclared;
- Disease or infection, except pyogenic or septic infection of visible wound that resulted because of an accident; or
- Loss or injury while participating in or as the result of the commission of a criminal act.

CLAIMS INFORMATION

FILING A CLAIM

All claims and supporting documentation must be submitted to the Fund Office by you. Your Sav-Rx - participating prescription provider and your Primary Network- participating health care provider will submit claims to the Fund for payment of the Fund's share of any covered benefits you receive from them. However, if for some reason a provider does not do so, contact the Fund Office for assistance in filing such claims.

To avoid delays in processing your claims, remember the following:

1. Notify the Fund Office of your claim as soon as possible after it is incurred. Be careful not to exceed the time limits set out throughout this Summary.
2. Submit a **complete and itemized bill** with "ICD-9" and "CPT" codes. Balance forward statements, cash register receipts and canceled checks are not acceptable.
3. Submit accident information as soon as possible.
4. File your claims as quickly as possible.
5. If the Fund Office requests additional information from you, please respond promptly.
6. If you have already paid your physician for services, indicate on your claim that payment has been made and send the Fund Office a copy of a complete and itemized bill with "ICD-9" and "CPT" codes and evidence that the bill has been paid.
7. Notify the Fund Office of any change of address.

TIME LIMITS FOR CLAIMS

The Fund requires that all claims for Medical, Hospital and Surgical Benefits; Prescription Drugs; Vision Care; and Dental Benefits be submitted for reimbursement within **90 days** of the date of service. All claims for Death Benefits must be filed within **one year** from the date of death. All claims for Accidental Death and Dismemberment Benefits must be filed within **one year** from the date of the death or accidental dismemberment. All claims for Weekly Disability Benefits must be filed within **60 days** from the onset of disability. Applications for Loss-of-Time Credit must be filed within **60 days** of the accident or onset of the sickness. After these time limits have passed, the Fund is no longer obligated to pay or reimburse the amount of the claim.

If you fail to provide the Fund Office with notice or proof of claim by the applicable deadline, the claim may still be paid if your failure was because of reasons beyond your control, or if you provided such notice or proof as soon as reasonably possible and no later than one (l) year from the time notice or proof was otherwise required (except if you were legally incapacitated). The Fund Office will process all claims for benefits made by Covered Persons.

DENIAL OF CLAIMS

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

1. The person receiving the benefit was not eligible for benefits on the day the expense was incurred. This includes a former spouse or any person no longer eligible as a dependent when an expense was incurred.
2. The claim was not received by the Fund within the applicable time limit, unless the delay was due to circumstances beyond the participant's control.
3. The expense was for services not covered by the Fund or the expense was not actually incurred.
4. The person for whom the claim was filed already received the annual maximum benefit for the type of benefit.
5. The person for whom the claim was filed (or his or her representative) failed to sign the Fund's subrogation agreement, failed to cooperate with the Fund's right of reimbursement or failed to remit the Fund's reimbursable amount from a recovery, including a partial recovery (in which case, future claims will be denied up to the amount of the Fund's reimbursable amount).
6. Another entity was primarily responsible for paying benefits (see the Fund's rules on coordination of benefits, page 45).
7. The Fund was terminated.

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

If your claim is denied, you will normally be notified with the specific reason for denial within 90 days. In unusual circumstances, additional time will be required to process your claim. You will be notified when additional time is needed.

If your claim is denied by Sav-Rx, you will be informed of the reason for the denial by the pharmacy. If the denial is due to missing information or a missing signature, you should supply the information directly to the service provider. If the denial is due to any other reason and you believe that the claim should have been covered, you should follow the procedure set out below for appealing a denial of your benefit claim.

APPEALING A DENIAL OF YOUR BENEFIT CLAIM

You, your spouse or your dependent ("claimant") may appeal a denial of any **eligibility** request or any claim for medical, prescription drug, dental and vision benefits within **180** days of the notice of denial to the Board of Trustees, Detroit & Vicinity Trowel Trades Health and Welfare Fund, P.O. Box 99490, Troy, Michigan 48099-9490. The appeal should be in writing, but an appeal of the denial of a pre-service claim for urgent care may be requested by telephone. No special form is required. Just be sure that the appeal explains the claimant's position as clearly as possible. The claimant has the right to appoint someone else (such as a lawyer) to prepare and submit the appeal to the Fund. Make sure your name, Subscriber ID number, trade and name of the claimant (such as your spouse) are included to avoid delays in processing your appeal.

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

The claimant, or his representative, may submit issues, comments, additional legal arguments and new information in writing to the Board of Trustees for its consideration in the appeal. The review of the appeal will take into account all materials and information received before the review and decision on the appeal, whether or not that information was previously submitted or considered by the Fund Office in the initial determination on the claim. The Board of Trustees reviews the claim on appeal de novo (anew) and they will review the additional materials and information submitted, if any.

The Board of Trustees will respond to appeals of denials of eligibility request or any claim for medical, dental and vision care and for claims for prescription drug benefits administered by Sav-Rx no later than 72 hours after receiving an appeal of a denial of a pre-service urgent care claim, no later than 30 days after receiving an appeal of a pre-service non-urgent care claim, and no later than 5 days after the Board of Trustees' first regularly scheduled meeting after receiving an appeal of a claim for post-service care, unless the appeal is filed less than 30 days prior to such meeting, in which case it will be reviewed at the subsequent Board of Trustees' meeting.

If, due to special circumstances, the Board of Trustees requires additional time to review the appeal of a claim for post-service care, the claimant will be notified in writing of the special circumstances and when a determination will be made. The Board of Trustees will communicate their decision and the reasons for it in writing within 5 days after they make their decision on the appeal.

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

No action at law or equity may be brought to recover under the Fund's Plan or this Summary until these appeal rights have been fully exercised and benefits requested in such appeal have been denied in writing, in whole or in part, by the Board of Trustees. You should seek legal advice with respect to this requirement.

FACILITY OF PAYMENT

In the event of your death or mental incompetence at a time when benefits remain unpaid, such benefits will be paid to the person or institution who incurred the Covered Charges if the charges have not otherwise been paid.

ADDITIONAL ADMINISTRATIVE MATTERS

EXAMINATIONS

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

TRUSTEE INTERPRETATION AND AUTHORITY

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

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

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

The right to change or eliminate any and all aspects of benefits provided for retirees and their dependents is a right specifically reserved to the Board of Trustees, since coverage for retirees and their dependents, like all of the benefits from the Fund, is not an accrued or vested benefit. The Board of Trustees has the authority to amend or terminate such benefits and to modify or increase the self-payment amount for coverage at any time. Any such change shall be effective even though an employee has already become a retiree, or has met the eligibility requirements to retire now or in the future.

WORKERS' COMPENSATION NOT AFFECTED

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

PLAN DISCONTINUATION OR TERMINATION

The Fund and its Plan may be discontinued or terminated under certain circumstances - for example, if future collective bargaining agreements and participation agreements do not require contributions to the Plan. In such event, benefits for covered expenses incurred by the termination date will be paid on behalf of eligible participants and their dependents as long as the Fund's assets are more than its liabilities. Full benefits may not be paid if the Fund's liabilities are more than its assets, and benefit payments will be limited to the funds available. The Board of Trustees will not be liable for the adequacy or inadequacy of such funds. If there are any assets remaining after payment of Fund liabilities, those assets will be used for purposes determined by the Board of Trustees according to the Trust Agreement.

RIGHT OF OFFSET

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

LEGAL ACTIONS – TIME LIMITS FOR FILING

You may not file legal action against the Fund or its Trustees until you have followed all of the proper claim and claim appeal procedures. In addition, no action may be brought more than three years after the time written proof of loss or claim is to be furnished to the Fund Office. You should seek legal advice if you have questions on this matter.

ALTERED OR FORGED CLAIMS

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

NOTICE OF HOURS WORKED

Each month the Fund Office will mail you a statement listing a summary of hours worked during the previous contribution month so that you may compare the Fund's records to your pay stubs and information about the balance in your hour bank.

You must report any discrepancy to the Fund Office or BAC Local #1 immediately. The Fund, through its collections committees, and/or BAC Local #1 will investigate the issue and pursue collection of unpaid contributions on the Fund's behalf.

If your Employer fails to remit contributions based on your work, the Fund will pursue collection, but you are responsible for maintaining your coverage by self-payment. If the Fund recovers some or all of the unpaid contributions, your self-payment amounts will be refunded to you based on the extent of the recovery.

RIGHT TO OBTAIN, REQUIRE AND RELY ON INFORMATION

The Board of Trustees shall have the right to require, as a condition precedent to the payment of any benefit under the Plan, all information which they reasonably deem necessary, including records of employment, proof of dates of birth and death, marital status, independent medical examinations of any person for whom benefits are being claimed, any and all medical records relating to a claim, etc., and no benefit dependent in any way upon such information shall be payable unless and until such information so required is furnished. Such evidence shall be furnished by the Unions, the Associations, Employers, Employees, Participants, Dependents, beneficiaries, alternate recipients or the representative of any of them.

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

MEDICARE

Eligibility for Medicare

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

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

Contact your Social Security Administration office three (3) months prior to your 65th birthday, or, if you are otherwise eligible, to find out the enrollment requirements.

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

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

When you are eligible for Medicare, you and your spouse must enroll for Part B Medicare in order to enroll in the Fund's Supplemental Program.

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

Medicare also has prescription drug insurance available to you and your covered dependents through Medicare Part D programs. **Medicare-eligible participants and retirees receive IMPORTANT additional information regarding Medicare Part D annually. Please contact the Fund Office if you have not received that information or if you would like another copy.**

Relationship Between Medicare and HAP Coverage for Retirees

Medicare is generally primary if:

- You or any of your covered dependents is over age 65 and not actively working;
- You or any of your covered dependents is under age 65 and have received Social Security Disability benefits for 24 months or longer;
- You or any of your covered dependents is under age 65 and qualifies for Medicare because he needs hemodialysis treatment or a kidney transplant because of chronic kidney disease.

When Medicare is primary, you must file any medical claims with Medicare first. The HAP supplemental policy available to Medicare-eligible Retirees under this Fund will adjust its benefit payment taking into account the amount approved and paid by Medicare.

The Detroit & Vicinity Trowel Trades Health and Welfare Fund is considered primary if:

- You are over age 65 and still actively working;
- You are under age 65 and
    - have received Social Security Disability Benefits for less than 24 months;

- need hemodialysis treatment or a kidney transplant because of chronic kidney disease, but you have not met Medicare's eligibility requirements;
- have been an end stage renal disease (ESRD) patient for less than 30 months during a period in which he has retained coverage under the Fund as an active Employee.

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

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

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

You should contact the Fund Office if you have any questions concerning the effect Medicare will have on your coverage.

Dependents on Medicare: If you are eligible by way of hours worked in covered employment, the Fund will be the primary payer of benefits to your dependent who is on Medicare because of age or disability. In addition, special rules apply to a person with end-stage renal disease under Medicare. Check with the Fund Office or your local Social Security office for additional information on this.

MEDICAID

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

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

COORDINATION OF BENEFITS/NON-DUPLICATION OF BENEFITS

Benefits from the Plan are subject to, and limited to, amounts payable in accordance with these COORDINATION OF BENEFITS (COB) Rules. The purpose of these Rules is to avoid duplicate or overlapping payments of benefits resulting in unjust overpayments. The COB Rules apply generally to all benefits payable from the Plan other than Death, and Accidental Death and Dismemberment. COB Rules come into play whenever any individual has coverage under the Plan and any other group insurance program, health and welfare fund, HAP, Medicare, or health care plan.

This Plan **excludes** coverage and will pay **no** benefits for treatment of injuries resulting from an automobile or motor vehicle accident. Therefore, coordination of benefits is unnecessary with respect to no-fault automobile insurance coverage because there are no benefits for motor vehicle related injuries provided from this Fund. You should carefully review this with your automobile or other motor vehicle insurance carrier to make certain that your own insurance is adequate in this regard.

Generally speaking, the following rules are applied to determine whether the Detroit & Vicinity Trowel Trades Health and Welfare Fund or the other health care plan, fund, policy, contract, program, or statutory payer pays first in accordance with its Schedule of Benefits.

A. If the Employee terminates his employment and becomes employed by another employer that provides a health insurance program other than the Detroit & Vicinity Trowel Trades Health and Welfare Fund, then that Employer's health insurance program is primary for the coverage. **The Detroit & Vicinity Trowel Trades Health and Welfare Fund will be secondary only.**

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

C. If both have coordination of benefits provisions, then

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

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

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

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

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

(c) if the child's biological parents are divorced, or legally separated, the plan covering the biological parent who has the earlier birthdate anniversary in the calendar year shall be primary. If both biological parents have the same birthdate, the plan that covered the child for longer period of time shall be primary. If the biological parent with the earlier birthday anniversary in the calendar year is remarried, the plan covering his or her spouse is primary over that which covers the other biological parent, irrespective of the birthday anniversary in the calendar year of the spouse of the biological parent who has the earlier birthday anniversary in the calendar year;

(iv) where the claim is for an individual who is both a dependent child under this Plan and a dependent spouse under the plan of his or her spouse, the following order of priority shall be followed in determining which health and welfare plan, fund, policy, contract or program shall pay as primary:

(a) the plan covering the covered parent or the covered spouse who has the earlier birthdate anniversary in the calendar year shall be primary;

(b) if both the covered parent and the covered spouse have the same birthdate, the plan that covered the child/spouse for the longer period of time shall be primary.

SUBROGATION AND REIMBURSEMENT

In the event of any payments of services to or on behalf of any person under this Plan, the Fund shall, to the extent of such payments, be subrogated to all rights of recovery of that person (or his representative(s)) arising out of any claim or cause of action which may accrue against a third party, including any occupationally related claim or cause of action covered by the Michigan Workers' Disability Compensation Act or Occupational Disease Act or similar federal or state statutes. That

person (or his representative(s)), by acceptance of benefits provided by this Fund, hereby agrees to reimburse the Fund for any benefits so paid hereunder out of monies recovered, fully or partially, from such third party as the result of judgment, settlement or otherwise, irrespective of how differentiated, without any offset for expenses, including legal fees, that person (or his representative(s)) may owe, and before that person (or his representative(s)) pays any other individual, organization or entity out of that full or partial recovery. That person (or his representative(s)) may take no action which would prejudice the Fund and/or any of the Fund's designees' rights, and that person (or his representative(s)) hereby agrees to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Trustees may require to facilitate the enforcement of the Fund's rights. The Fund and/or any of the Fund's designees will not be responsible for attorney's fees or costs incurred and/or paid by or on behalf of that person (or his representative(s)) unless the Fund and/or any of the Fund's designees has agreed in writing to pay such fees or costs or some portion thereof.

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

RESTITUTION WHERE BENEFITS IMPROPERLY RECEIVED

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

EXCLUSIONS AND LIMITATIONS
(Applicable to All Benefits)

EXCLUSION OF COVERAGE FOR AUTO-VEHICULAR ACCIDENTS

The Fund ***excludes*** coverage for any claim arising out of an auto or other vehicular accident (see the Exclusion Section below). "Vehicle" includes all usual forms of transportation designed primarily for use on public highways, including autos, motorcycles, vans, pick-up trucks, etc. Consequently, all Eligible Persons are expected to cover themselves for auto and other vehicular-related accident claims under their individual insurance policies.

It is important that eligible persons check with their respective insurance agent and/or their insurance carrier to make certain they are completely covered under their policy for any claims arising out of a vehicular accident. They should make it perfectly clear to their agent or carrier that the Fund completely excludes coverage for vehicular-related accidents. Therefore, no one covered by this Plan should buy a coordinated automobile policy.

However, Death Benefits and Accidental Death and Dismemberment Benefits continue to be payable for any loss resulting from automobile or vehicular accidents.

OTHER EXCLUSIONS

Except as may be provided for under the terms of the Plan, the Plan shall not provide benefits for the following:

1. The Fund will **NOT** provide for loss or expense from sickness, or disease that entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law, or as a result of any accidental bodily injury, which arises out of or in the course of employment for pay or profit.
2. The Fund will **NOT** provide for care and services available at no cost in veteran's, marine or other hospital, facility, or institution owned or operated by or on behalf of any national government, its agencies or a political subdivision thereof, unless a charge is imposed and an itemized bill for services is submitted, or for care obtainable without cost from governmental agencies.
3. The Fund will **NOT** provide for treatment of a condition caused by military action or war or determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.
4. The Fund will **NOT** provide for care and services payable by government-sponsored health care programs such as Medicare or TRICARE.
5. The Fund will **NOT** provide for payment to the extent that such payment is prohibited by any law of the jurisdiction where the covered person resides at the time the expenses are incurred.
6. The Fund will **NOT** provide for services that the covered person is not legally required to pay, that would not be charged if no coverage existed, for which a charge is not customarily made, for services available without cost, or for any nonresident tax levied by a community hospital.
7. The Fund will **NOT** provide for any procedure, care or treatment for which the medical necessity cannot be proven to the satisfaction of the Plan, except allergy treatments and reconstruction after mastectomy.
8. The Fund will **NOT** provide for services outside the scope of the license of the institution or practitioner rendering the services.
9. The Fund will **NOT** provide for custodial care, rest therapy, education, training, or bed and board while confined to an institution that is primarily a school or other institution for training, a place of rest, or a place for the aged.
10. The Fund will **NOT** provide for services for treatment of an illness or injury due to declared or undeclared war or any act thereof, active participation in a riot, the commission of or attempted commission of an assault or felony, engagement in an any unlawful act, or as the result of a fight when you are the aggressor or it is determined that you are not the victim. However, the Fund does provide for services for injuries resulting from domestic violence.
11. The Fund will **NOT** provide for occupational therapy, except if such therapy is necessary following hospital confinement for an accident (except accidents that are work-related or auto/vehicular related), surgery, stroke, cancer or heart-related problems.
12. The Fund will **NOT** provide for services and supplies that are not medically necessary according to accepted standards of medical practice, including cosmetic surgery solely for improving appearance, except that coverage will be provided for 1) reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast for symmetrical appearance and prostheses and physical complications in all stages of mastectomy; 2) to correct a condition resulting from a congenital anomaly; or 3) to correct a condition resulting from an accident (excluding auto/vehicular accidents).
13. The Fund will **NOT** provide for drugs, devices, medical treatments or procedures that are experimental or investigative, including organ transplants. Experimental or investigative means medical practices, procedures, treatment, services, drugs, or supplies that are considered experimental or investigational by or not approved by the American Medical

Association, the Food and Drug Administration, the Department of Health and Human Services or the appropriate medical society.

14. The Fund will **NOT** provide for expense incurred for in-vitro fertilization or artificial insemination.
15. The Fund will **NOT** provide for reversing sterilization.
16. The Fund will **NOT** provide for pre-employment, pre-marital, school or sports examination provided by non-network providers.
17. The Fund will **NOT** provide for routine treatment or services primarily for weight loss or control, unless necessitated as the direct result of a specifically identifiable and diagnosed condition or disease etiology, except bariatric surgery, which is covered as set forth on page 50.
18. The Fund will **NOT** provide for acupuncture, hypnotism or any goal-oriented behavior modification type therapy.
19. The Fund will **NOT** provide for air conditioners, purifiers, humidifiers, dehumidifiers, whirlpool, heating pads, hot water bottles, waterbeds, bandages and support garments, rubber gloves, treadmills, exercise equipment, lift chairs, and other equipment that does not constitute medically necessary durable medical equipment, even if prescribed by a physician.
20. The Fund will **NOT** provide for expenses incurred or resulting from self-inflicted injuries, unless the injuries resulted from a medical condition such as depression.
21. The Fund will **NOT** provide for travel or transportation by other than professional ground ambulance.
22. The Fund will **NOT** provide for services in connection with speech therapy, unless the speech therapy is performed during confinement as an inpatient.
23. The Fund will **NOT** provide for care or treatment rendered by a member of the covered person's family or by a person normally residing in the covered person's home.
24. The Fund will **NOT** provide for services in connection with sex transformation procedures.
25. The Fund will **NOT** provide for hospital admissions, medical services and supplies provided **prior** to the effective date of coverage or **after** the coverage termination date.
26. The Fund will **NOT** provide for treatment of temporal mandibular jaw disorders ("TMJ"), however, diagnosis of TMJ may be covered through the Dental Benefit.
27. The Fund will **NOT** provide for the use of a private room. If used, the average semi-private room rate of that hospital will be paid, except private room accommodations required by the hospital for treatment in quarantine purposes and not for the comfort of the patient.
28. The Fund will **NOT** provide for charges for hospital rooms in excess of the hospital's regular charges.
29. The Fund will **NOT** provide for services and/or supplies for personal comfort items such as, television, telephones, lotion, powder, transportation within hospital, guest trays or other non-essential personal items and services, including take-home prescription drugs and supplies, etc.
30. The Fund will **NOT** provide for services and/or supplies for recreational or educational therapy, massage therapy, or some forms of non-medical self-care or self-help training.
31. The Fund will **NOT** provide for nutritional and dietary supplements.
32. The Fund will **NOT** provide for home health care except as provided by a licensed Hospice provider.

33. The Fund will **NOT** provide for psychiatric services after determination that a condition will not respond to treatment.
34. The Fund will **NOT** provide for psychological tests for guidance or counseling for vocational purposes.
35. The Fund will **NOT** provide for drugs that require a prescription by state law, but not Federal law.
36. The Fund will **NOT** provide for administration of drugs or any drug consumed at the time and place of the prescription order.
37. The Fund will **NOT** provide for refills not authorized by a physician.
38. The Fund will **NOT** provide for more than a 34-day supply of prescription drugs (except for specified maintenance drugs that are covered for 90 days).
39. The Fund will **NOT** provide for refills dispensed after one year from the date of the original order.
40. The Fund will **NOT** provide for drugs dispensed for cosmetic purposes.
41. The Fund will **NOT** provide for hospital confinement or other medical expenses due to a child of a dependent child, unless that grandchild is also a dependent of the participant subject to the requirements for Coverage for Dependents. The Plan will not provide for hospital confinement and other medical expenses due to a second or subsequent pregnancy of a dependent child.
42. The Fund will **NOT** provide for voluntary termination of pregnancy (abortions) for dependent children.
43. The Fund will **NOT** provide for non-prescription (over-the-counter) drugs.

Note: An item that does not appear as an exclusion is not automatically covered as a benefit.

LEGAL NOTICES

ERISA RIGHTS

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

1. Examine, without charge, at the Fund Office and at other specified locations, such as worksites and the union hall, all Plan documents including collective bargaining agreements and copies of all documents filed by the Fund with the United States Department of Labor, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Board of Trustees, the Plan Administrator. The Fund will, however, make a reasonable charge established by the Board of Trustees for furnishing the copies.
3. Receive a summary of the Plan's annual financial report. The Board of Trustees is required by law to furnish each participant with a copy of this summary annual report.
4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. See page 21 of this summary plan description on the rules governing your COBRA continuation coverage rights.
5. Reduction or elimination of the exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage for another plan. You should

be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, the union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you may be entitled or exercising your rights under ERISA.

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

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, located at 211 W. Fort Street, Suite 1310, Detroit, Michigan 48226, (313) 226-7450, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You can read the materials listed above by making an appointment at the Fund Office during normal business hours. In addition, copies of the materials will be mailed to you if you send a written request to the Fund Office. There will a per-page charge for copying some of the materials. Before requesting materials, call the Fund Office and find out the cost. If a charge is made, your check must be attached to your request for the material.

NOTICE OF PRIVACY PRACTICES

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

We are required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that health information that identifies you is kept private to the extent required by law. We are also required to give you this notice regarding (1) the uses and disclosures of health information that may be made by the Plan of the Detroit & Vicinity Trowel Trades Health and Welfare Fund, and

(2) your rights and the Plan's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA. Please be advised that the Fund's service providers may issue separate Notices regarding disclosure of health information maintained on the Plan's behalf by those entities.

How We May Use and Disclose Health Information About You

The following categories describe different ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

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

For Health Care Operations. We may use and disclose health information about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use health information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Plan administrative activities.

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

For Disclosure to the Fund's Board of Trustees. We may disclose your health information to the Fund's Board of Trustees for plan administration functions performed by the plan sponsor on behalf of the Fund including, but not limited to, reviewing appeals. We may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. We also may disclose to the plan sponsor information on whether you are participating in the Fund.

When Legally Required. We will disclose your health information when we are required to do so by any federal, state or local law.

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

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

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, we may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when we receive

satisfactory assurance from the party seeking the information that reasonable efforts have been made to notify you of the request or, if such assurance is not forthcoming, if we have made a reasonable effort to notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, in an emergency to report a crime.

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

Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or transplantation.

In the Event of a Serious Threat to Health or Safety. We may disclose your health information if necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person.

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

For Workers' Compensation. We may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

For Other Purposes. Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only if you provide a written authorization. If you provide us with written authorization to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. We are unable to take back any disclosures that we have already made with your permission.

We may use or disclose your health information for other purposes for which we are permitted to, including those not set forth in this Notice, without your written authorization or consent.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

You have the following rights:

The right to request restrictions or limitations on the health information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Fund's Privacy Officer. In your request, you must tell us (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both; and (3) to whom the limits apply.

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

The right to access documents regarding your eligibility, payment of claims, appeals or other similar documents for inspection and/or copying. Your request for access to documents containing your health information must be made in writing to the Fund's Privacy Officer. When a request for

access is accepted (in whole or in part), you will be notified of the decision and you may then inspect the health information, copy it, or both, in the form or format requested at a time and place convenient to you and us. If you would like, you may receive a summary of the requested health information instead of your entire record, for a reasonable fee. You may also receive a copy of your health information by mail if you prefer. (We charge a reasonable, cost-based fee for copying, including labor and supplies [for instance, paper, computer disks] and for postage if you request that the information be mailed. No fee is charged for retrieving or handling the health information or for processing the participant's request for access.) When a request for access is denied (in whole or in part), we will inform you why your request for access was denied, how to appeal the denial (if the denial is reviewable), and how to file complaints with us and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, we will designate a licensed health care professional, not involved in the original denial decision, to serve as a reviewing official, and will notify you in writing of the reviewing official's determination.

The right to request to amend your health information if it is inaccurate or incomplete. You may request that your health information be amended. That request must be in writing to the Fund's Privacy Officer and include a reason why your health information should be amended. If you do not include a reason, we will not act on the request. When a request for amendment is accepted (in whole or in part), we will inform you that your request for amendment has been accepted. We will request from you permission to contact other individuals or health care entities that you identify that need to be informed of the amendment(s), and will inform them and other entities with whom the Fund does business, who may rely on the disputed health information to your detriment. We will identify the record(s) that are the subject of the amendment request and will append the amendment to the record. When a request for amendment is denied, you will be notified why the request was denied (e.g., the information requested was not created by the Fund, is accurate and complete, is not part of the record, or may not legally be changed, such as information compiled in anticipation of a civil, criminal or administrative proceeding), how to file a statement of disagreement or a request that we provide the request for amendment and the denial in any future release of the disputed health information, and how to file a complaint with us or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, we may write a rebuttal statement and will provide a copy to you, and we will include the request for amendment, denial letter, statement of disagreement, and rebuttal (if any), with any future disclosures of the disputed health information. If you do not choose to write a statement of disagreement with the denial decision, we are not required to include the request for amendment and denial decision letter with future disclosures of the disputed health information unless you request we to do so.

Receipt of notification of amendment: When we receive notification from you that your health information has been amended, we will ensure that the amendment is appended to your records, and will inform entities with whom the Fund does business that may use or rely on your amended health information of the amendment and require them to make the necessary corrections.

The right to obtain an accounting of disclosures of your health information. The right to an accounting extends to disclosures, other than disclosures made (1) for the purposes of treatment, payment or health care operations, including those made to business associates, (2) to individuals about their own health information, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for national security or intelligence purposes; (8) to correctional institutions or law enforcement officials; and (9) those made prior to April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Fund's Privacy Officer. Your request must specify a time period, which may not be longer than six (6) years. You may request and receive an accounting of disclosures once during any twelve (12) month period for no charge. If you request more than one accounting within the same twelve (12) month period, a reason-

able, cost-based fee may be charged. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

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

LEGAL DUTIES OF THE DETROIT & VICINITY TROWEL TRADES HEALTH AND WELFARE FUND REGARDING YOUR HEALTH INFORMATION

The Detroit & Vicinity Trowel Trades Health and Welfare Fund is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Detroit & Vicinity Trowel Trades Health and Welfare Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Detroit & Vicinity Trowel Trades Health and Welfare Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information we have about you as well as any information we receive in the future. If the Detroit & Vicinity Trowel Trades Health and Welfare Fund changes its policies and procedures, the Detroit & Vicinity Trowel Trades Health and Welfare Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Detroit & Vicinity Trowel Trades Health and Welfare Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Detroit & Vicinity Trowel Trades Health and Welfare Fund should be made in writing to the Fund's Privacy Officer. The Detroit & Vicinity Trowel Trades Health and Welfare Fund encourages you to express any concerns you may have regarding the privacy of your information.

You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

For questions about this Notice, to exercise your privacy rights, or to file a complaint, contact the Fund's Privacy Officer, Detroit & Vicinity Trowel Trades Health and Welfare Fund, P.O. Box 99490, Troy, Michigan 48099-9490, (248) 828-6000 (local) or (800) 435-4080 (toll-free).

SOCIAL SECURITY NUMBER PRIVACY POLICY

(Effective January 1, 2006)

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

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

In order to protect your privacy and in compliance with the law, the Fund will use alternate identification numbers wherever feasible, including on benefits cards and explanations of benefits. The Fund does not print Social Security numbers on the exterior of any envelope or package sent through the mail or in a manner that can be seen from the exterior of such envelope or package. The Fund's website is secure and permits participants to access information through use of a password other than their Social Security number.

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

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

The Fund disciplines its employees who violate this Policy, up to and including termination.

TWO IMPORTANT NOTICES REGARDING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

I. NOTICE OF GRANDFATHERED STATUS

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

Detroit & Vicinity Trowel Trades Health and Welfare Fund
Office Address: 700 Tower Drive, Suite 350, Troy, Michigan 48098
Mailing Address: P.O. Box 99490, Troy, Michigan 48099-9490
Phone Number (local): (248) 828-6000; Phone Number (Toll-Free): (800) 435-4080
Fax Number: (248) 828-6001
Web Site Address: www.dvtt.org

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

II. NOTICE OF WAIVER

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage of key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.

Your health insurance coverage, offered by the Detroit & Vicinity Trowel Trades Health and Welfare Fund, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of:

- $4,000 for nuclear medicine;
- $4,000 for laboratory diagnostic benefits for Active Participants, COBRA Participants, and non-bargaining unit Participants;
- $3,000 for laboratory diagnostic benefits for Early Retirees, Permanently and Totally Disabled Participants, and Surviving Spouses;
- $500 for hearing aids for Active Participants only (one or more hearing aids every three years);
- $1,000 for physical therapy, with another $1,000 for post-surgical therapy when medically necessary;
- $3,000 for prescription drug benefits for Active Participants, COBRA Participants, and non-bargaining unit Participants;

$100 for prescription drug benefits for Early Retirees, Permanently and Totally Disabled Participants, and Surviving Spouses;

$400 for pediatric traditional dental benefits

$1,500 for pediatric Golden Dental Managed Care Program dental benefits;

$50 for pediatric eye examination;

$75 for pediatric single lenses;

$90 for pediatric bifocal lenses;

$100 for pediatric trifocal lenses;

$100 for pediatric frames;

$140 for pediatric contact lenses (in lieu of frames and lenses).

* Until the government provides additional guidance, the Fund will interpret "pediatric" to mean dependent children who have not yet reached age 16.

In order to continue to apply the limits described above, the Fund requested a waiver of the requirement that coverage for key benefits be at least $750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on the Fund's representation that providing $750,000 in coverage for these key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the Fund's Administrative Manager at:

Detroit & Vicinity Trowel Trades Health and Welfare Fund
Office Address: 700 Tower Drive, Suite 350, Troy, Michigan 48098
Mailing Address: P.O. Box 99490, Troy, Michigan 48099-9490
Phone Number: (248) 822-0100
Web Site Address: www.dvtt.org