# ROOFERS LOCAL 149 FRINGE BENEFIT FUNDS

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November, 2006

## IMPORTANT NOTICE REGARDING CHANGES IN PLAN COVERAGE AND ELIGIBILITY RULES PERTAINING TO DETROIT PARTICIPANTS AND DEPENDENTS

In order to address the continuing rise in the cost of health care, to protect the financial integrity of the Fund, the Trustees have made the following changes, applicable to all Participants and Dependents, to the rules governing the Roofers Local 149 Security Benefit Trust Fund ("Fund") for all Participants:

### 1. Coverage Changes

**Annual Deductible:** A deductible is an amount that must be paid by the Covered Person before any benefits will be paid by the Fund. Effective January 1, 2007, the Annual Deductible will be $250 per Covered Person or $750 per family per Calendar Year, and it will be applicable for all benefits, whether received in or out of network, unless otherwise stated in the benefit chart set forth below. (Prior to this change, the Annual Deductible has only applied to out of network claims.)

**Co-insurance:** Effective January 1, 2007, the co-insurance rate will change for out of network services. Currently, most benefits are covered at 90% out of network (subject to certain co-payments and deductibles). As of January 1, 2007, out of network claims will be covered at 80%, subject to an annual out of pocket maximum (in network and out of network claims combined) of $1,000 per Covered Person and $2,000 per family per Calendar Year. This limit does not include co-payments or deductibles, or any benefits not subject to the co-insurance maximum as noted in the benefit chart set forth below.

The change in co-insurance amounts are set forth in the following chart (please note that all benefits set forth below are subject to Plan exclusions and limitations, which have not changed):

| Benefit | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **INPATIENT**<br>(a person is "inpatient" when he/she has spent over 23 consecutive hours in a Hospital) | | |
| Inpatient/Hospital Room and Board<br>Limited to ward or semi-private rooms. | 100% | 80% of R&C, after $75 co-payment |

| Benefit | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| Surgery and Anesthesia (in hospital) | 100% | 80% of R&C |
| Technical Surgical Assistant<br>Provided only where the complexity of the surgery warrants a surgical assistant | 20% of the surgical procedure allowance at 100% | 20% of the R&C surgical procedure allowance at 100% |
| Special care units (e.g. burn, cardiac, intensive care) | 100% | 80% of R&C |
| Physician Visits in Hospital | 100% | 80% of R&C |
| Physical Therapy | 100% | 80% of R&C |
| Diagnostic Lab, testing, and X-ray | 100% | 80% of R&C |
| Organ Transplants | 100% | 80% of R&C |
| Hemodialysis | 100% | 80% of R&C |
| **MATERNITY** | | |
| **Eligibility:** Maternity benefits are only available as follows:<br>1. For Spouses of Active Employees<br>2. For Dependents of Active Employees and Pensioners, first pregnancy only (note: no coverage for newborn of Dependent will be provided)<br>3. For Surviving Spouses of Active Employees for 9 months following death of such Active Employee | | |
| **Office Visits**<br>Includes pre-natal office visits, post-natal office visits, related laboratory/diagnostic testing, etc. in conjunction with a maternity course | 100%, after $10 co-payment on first visit only | 80% of R&C |
| **In-Patient Hospital**<br><br>See Special Notice following this chart | 100% | 80% of R&C, with $75 co-payment upon admission<br><br>If the mother has a cesarean section and her son has a circumcision during the same in-patient stay, then only one $50 co-payment will be charged |
| **In-Patient Birthing Center**<br>See Special Notice following this chart | 100% | 80% of R&C, with $75 co-payment upon admission<br><br>If the mother has a cesarean section and her son has a circumcision during the same in-patient stay, then only one $50 deductible will be charged |

| Benefit | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **Nurse-Midwifery**<br>Limited to care from a nurse-midwife who is a licensed registered nurse, has successfully completed formal advanced specialty training as a nurse-midwife in a program accredited by the American College of Nurse-Midwives; and is certified by the American College of Nurse-Midwives. The nurse-midwifery benefit will be paid for normal care surrounding the birth of a child. Services also include a week of visits with the mother. The American College of Nurse-Midwives must confirm that an individual is certified by that organization. | 100% | 80% of R&C |
| **Routine In-Patient Well Newborn Care**<br>Limited to well newborn care services rendered during the first 7 days after birth while the newborn is Hospital confined. | 100% | 80% of R&C (if mother admitted, no additional deductible charged for newborn)<br><br>Initial examination of newborn performed by Physician other than delivering Physician limited to $120 |
| **OUTPATIENT** | | |
| Physician Visits<br>(Office visit) | $10 co-payment, then 100%. Not subject to deductible. | 80% of R & C, after $10 copayment |
| Physical Exam for Active Employees, Pensioners, Spouses, and Surviving Spouses | 100%, limited to maximum benefit of $300 per year. Not subject to deductible. | 80% of R & C after $10 copayment, only if participant does not reside in Michigan, up to $300 per year. No benefit for Michigan residents. |
| Well Baby Care for Children up to age 2 | 100%, less $10 co-payment. Not subject to deductible. | No benefit; in-network benefit only |
| Urgent Care Facility | 100%, after $25 co-payment | 80% of R & C, after $25 co-payment |
| Emergency Room Visits | 90%, after $75 co-payment<br><br>All co-payment and co-insurance requirements are waived if (1) the Covered Person is admitted as a bed patient, or (2) the purpose of the emergency room visit is to treat an Injury resulting from an Accident that occurred no more than 24 hours prior to the emergency room visit. | 80% of R&C, after $75 co-payment<br><br>All co-payment and co-insurance requirements are waived if (1) the Covered Person is admitted as a bed patient, or (2) the purpose of the emergency room visit is to treat an Injury resulting from an Accident that occurred no more than 24 hours prior to the emergency room visit. |

| Benefit | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| Immunizations for Children up to age 19 | 100%, Not subject to deductible | No benefit – In-network benefit only |
| Diagnostic X-ray, Lab & Supplies in Doctor's Office or Outside Facility | 100%, after $10 co-payment per billing statement, Not subject to deductible | 80% of R&C |
| Surgery/Anesthesia: Physician's Office or surgical facility | 100%, after $10 co-payment per billing statement, Not subject to deductible | 80% of R&C |
| Assistant Surgeon | 20% of the surgical procedure allowance at 100% | 20% of the R&C surgical procedure allowance at 100% |
| Second Surgical Opinion | 100% | 80% of R&C |
| Speech Therapy | 100%, after $10 co-payment, Not subject to deductible | 80% R&C |
| Physical Therapy | 100%, after $10 co-payment, Not subject to deductible | 80% R&C |
| Hemodialysis<br>Must be approved program of hemodialysis in an approved outpatient facility or home. Reasonable and necessary expenses for installation, maintenance and repair of equipment and supplies used in the home are covered. Includes related physician services when covered person is receiving treatment in approved facility. | 100%, limited to 120 days per Calendar Year – Fund will pay pursuant to Medicare Secondary Payer Rules | 80% R&C, limited to 120 days per Calendar Year– Fund will pay pursuant to Medicare Secondary Payer Rules |
| **OTHER PROVISIONS** | | |
| Psychiatric And Substance Abuse Treatment | 80% coverage, limited to 30 outpatient visits and 15 in-patient days. Maximum co-insurance limitation does not apply. | 80% coverage of R&C, limited to 30 outpatient visits and 15 in-patient days. Maximum co-insurance limitation does not apply. |
| Allergy Injections | 100%, after $10 co-payment, Not subject to deductible | 80% R&C |
| Diabetic Teaching Class | Cost of class covered at 100%, limited to maximum benefit of $400.00. Covers one class only per Participant or Dependent per lifetime. Not subject to deductible. | Cost of class covered at 100%, limited to maximum benefit of $400.00. Covers one class only per Participant or Dependent per lifetime. Not subject to deductible. |
| Radiation and Chemotherapy | 100% | 80% R&C |
| Durable Medical Equipment (equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury, and (d) is appropriate for use in the home) | 90% | 80% of R & C |

| Benefit | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| Home Health Care | 100% | 80% |
| Hospice Care | 100%, up to $90 per day, 90 day combined in-patient and out-patient limit | 80%, up to $80 per day, 80 day combined in-patient and out-patient limit |
| Family Counseling | 80%, after $50 co-payment and $500 maximum benefit. Maximum co-insurance limitation does not apply. | 80%, after $50 co-payment and $500 maximum benefit. Maximum co-insurance limitation does not apply. |
| Family Bereavement Counseling | 80%, after $50 co-payment, with maximum benefit of $250 for maximum of 90 days. Maximum co-insurance limitation does not apply. | 80%, after $50 co-payment, with maximum benefit of $250 for maximum of 80 days. Maximum co-insurance limitation does not apply. |
| Skilled Nursing Facility | 100% | 80% |
| Chiropratic Services and Alternate Therapies - chiropractic, acupuncture, acupressure, therapeutic massage, biofeedback and homeopathy therapy provided by a practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license | 100%, after $10 co-payment, limited to $1,000 per year (including x-rays and related physical therapy) | 80%, limited to $1,000 per year (including x-rays and related physical therapy) |
| TMJ/Jaw Joint | 90% | 80% R&C |
| Hearing Aids<br><br>Replacement limited to once every 2 years. | 80%, up to $1000. | 80% R&C, up to $1000. |
| Mammograms<br>Limit 1 every 6 months | 100%, Not subject to deductible | 80% R&C |
| Lasik | 100%, limited to one procedure per eye per lifetime | 80%, limited to one procedure per eye per lifetime |
| Sterilization (no reversal) | 100%, up to $300.00 maximum benefit (one-time only). Deductible does not apply. | 100% R&C, up to $300.00 maximum benefit (one-time only). Deductible does not apply. |
| Dental Surgery<br>Surgery for multiple extractions or removal of unerupted teeth under general anesthesia where a concurrent hazardous medical condition exists, or surgery necessitated by an accident that occurred while eligible for coverage. | 100% | 80% of R & C |

**Example:** The following is an example of amounts to be paid by a Participant for hypothetical charges incurred by himself and his dependents in 2007, based on the coverage set forth in the chart above and deductibles and co-insurance amounts effective January 1, 2007:

| Date | Service/Charge | Amount Paid by Participant | Amount Paid by Fund |
|---|---|---|---|
| 1/6/07 | Participant in network office visit: $250 | $10 co-payment (no deductible applied to office visit) | $240 |
| 1/10/07 | Participant in network outpatient surgical procedure: $1,500 | $10 co-payment (no deductible applied to outpatient surgical procedure) | $1,490 |
| 3/15/07 | Spouse in patient in network hospital claim: $4,000 | $250 deductible | $3,750 – 100% less deductible |
| 7/1/07 | Dependent in patient out of network hospital claim: $22,000 | $250 deductible<br>$75 co-payment<br>$1,000 co-insurance*<br><br>*Although out of network claims have 20% co-payment, which in this case would equal $4,335, this is limited by out of pocket annual individual maximum $1,000 co-insurance amount. | $20,675 |
| 9/1/07 | Dependent well baby visit: $120 | $10 - co-payment (again, no deductible applied to well baby visit) | $110 |
| 11/10/07 | Participant in-network Lasik surgery: $1800 | $250 deductible (family deductible of $750 per year has now been met) | $1,550 |
| | **Totals** | **$1855**** | **$27,815** |

In this example, had the family used an in-network hospital for the 7/1/07 hospital admission, they would not have incurred the $75 co-payment or $1,000 co-insurance, which would have meant their total out of pocket for all the incurred medical expenses would have been **$780**.** (Note that this example assumes the in network charges are acceptable, the out of network charge is reasonable and customary, and there are no applicable plan exclusions or limitations.)

4. **The following is a statement of the revised appeal process, which gives a claimant two opportunities to appeal a benefit denial:**

An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Claimants are entitled to two appeals. The first appeal ("Level 1 Appeal") is to be submitted to the Plan Manager at P.O. Box 396, Troy, Michigan 48099-0396. The second and final appeal ("Level 2 Appeal"), is to be submitted to the Board of Trustees at the same address.

The reviews on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. In deciding the second appeal, the Trustees will not provide deference to the decision of the Plan Manager on the first appeal.

Level 1 Appeals must be submitted in the time frames set forth below:

For Urgent Health Claims – 180 days after receiving denial.
For Pre-Service Health Claims - 180 days after receiving denial.
For Post-Service Health Claims – 180 days after receiving denial.
For Concurrent Claims – Claimant must be given enough time to appeal decision before termination effective.
For Disability Claims – 180 days after receiving denial.

Level 2 Appeals must be submitted within 60 days of a denial of the Level 1 Appeal.

**ALL APPEALS MUST BE TIMELY SUBMITTED. A CLAIMANT WHO DOES NOT TIMELY SUBMIT AN APPEAL WAIVES HIS/HER RIGHT TO HAVE THE BENEFIT CLAIM SUBSEQUENTLY REVIEWED BY THE PLAN OR IN A COURT OF LAW.**

**Notice of Decision on Appeal**

The notice of a decision on appeal will include the specific reasons for the denial; the specific Plan provision or provisions on which the decision was based; a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits; a statement of the Claimant's right to bring a civil action under ERISA; the internal rule or similar guideline relied upon in denying the claim; and, if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same.

**The deadline for deciding Level 1 Appeals is:**

For Urgent Health Claims – 72 hours after receiving appeal.
For Pre-Service Health Claims – 15 days after receiving the appeal.
For Concurrent Claims – Prior to termination of previously approved course of treatment.
For Post-Service Health Claims – 30 days after receiving the appeal.
For Disability Claims – 30 days after receiving the appeal.

**The deadline for deciding Level 2 Appeals is:**

For Urgent Health Claims – 72 hours after receiving appeal.
For Pre-Service Health Claims – 15 days after receiving the appeal.
For Concurrent Claims – Prior to termination of previously approved course of treatment.
For Post-Service Health Claims – The Trustees shall decide the appeal at a Board Meeting.*
For Disability Claims – The Trustees shall decide the appeal at a Board Meeting.*

* Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third board meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees decision on appeal no later than 5 days after the decision is made.

**5. Life Insurance**

Effective August 1, 2006, life insurance is provided pursuant to an insurance contract issued by The Union Labor Life Insurance Company ("ULLICO"), 1625 Eye Street, Washington, D.C. 20006. The amount of coverage has not changed. You will receive a certificate of insurance from ULLICO. Please review this carefully, as it contains terms and conditions of coverage.

**6. Prescription Drug Coverage**

Injectible Immunomodulators will be covered only under the Envision RX Options Specialty Pharmacy Program, with a $100.00 co-payment for each 34-day supply.

If you have any questions regarding this notice, please contact the Fund Office.

Respectfully submitted,

**BOARD OF TRUSTEES**
**ROOFERS LOCAL 149 SECURITY**
**BENEFIT TRUST FUND**