OUTSTATE TROWEL TRADES
FRINGE BENEFIT FUNDS

Michigan Trowel Trades Health And Welfare Fund
Outstate Michigan Trowel Trades Pension Fund
Michigan Operative Plasterers' & Cement Masons' International Association Apprenticeship and Training Fund

Managed for the Trustees by:
TIC INTERNATIONAL CORPORATION

Si Quires Copias De Estas Formas y Reportes Annuales Por Favor Llamen Al Administrator Del Plan a Este Numero (877) 876-9357 or (517) 321-7502 y Prequntar Que Quiere Hablar Que Quiere Hablar Con Algien Que Habla Espaňol.

November 2016

To: **ALL PLAN PARTICIPANTS OF THE MICHIGAN TROWEL TRADES HEALTH AND WELFARE FUND**

Dear Plan Participants:

We have attached the following Important Notices and Annual Report for your review. These Notices and Report are required to be mailed to each Plan Participant annually as provided by the Employee Retirement Income Security Act of 1974 (ERISA):

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 8-9 for more details.

If you have any questions, please contact your Local Union office, or the Medical Claims Department at the Fund Office.

Sincerely,

BOARD OF TRUSTEES

6525 Centurion Drive • Lansing, MI 48917-9275
(517) 321-7502 • FAX (517) 321-7508
Toll Free (877) 876-9357
(877) tro-wels
www.outstatetroweltrades.org

IMPORTANT NOTICE OF BENEFIT IMPROVEMENTS

The Board of Trustees of the Michigan Trowel Trades Health and Welfare Fund is pleased to announce the following benefit improvement:

Effective January 1, 2016, office visit co-payment and chiropractic office visit co-payment, when using an in-network provider, will be reduced from $40.00 to $20.00. As previously, office visit co-payments do not apply for preventive care visits.

For additional information regarding the Fund's benefits, please see the Summary of Benefits and Coverages enclosed with this notice.

As always, the Board of Trustees continues to carefully and routinely review the Fund's finances, benefits provided, and the impact of increases in the cost of providing health care and it is committed to protect your Fund.

If you have questions regarding this benefit change, please contact the Fund Office at the address or telephone number listed below.

SUMMARY OF MATERIAL MODIFICATIONS

This Notice, known as a Summary of Material Modifications ("SMM"), provides a brief description of the changes adopted by the Board of Trustees since the most recent Summary Plan Description ("SPD") was distributed. It is an amendment to the SPD and should be kept with the SPD for future reference.

Effective January 1, 2016, the Office Visit Co-Payment and Chiropractic Office Visit Co-Payment will be decreased from forty dollars ($40.00) to twenty dollars ($20.00) per visit.

Effective January 1, 2015, implemented coverage through Blue Care Network for Pre-Medicare Retirees at the full cost of coverage.

Effective June 1, 2014, coverage for early retirees was discontinued.

Effective July 1, 2013, the **in-network** annual deductible of five hundred dollars ($500.00) per person and one thousand dollars ($1,000.00) per family for in-network services increased to one thousand dollars ($1,000.00) per person, and two thousand dollars ($2,000.00) per family. The **out-of-network** annual deductible of one thousand hundred dollars ($1,000.00) per person and two thousand dollars ($2,000.00) per family for out-of-network services increased to two thousand dollars ($2,000.00) per person and four thousand ($4,000.00) per family.

Effective July 1, 2013, a new **in-network** coinsurance of twenty percent (20%) will apply to the Blue Cross Blue Shield of Michigan (BCBSM) approved amount for covered services; previously there was no coinsurance for in-network services. The coinsurance maximum will be one thousand dollars ($1,000.00) per person and two thousand dollars ($2,000.00) per family for **in-network** services.

Effective July 1, 2013, the **out-of-network** coinsurance of thirty percent (30%) increased to forty percent (40%) of the BCBSM approved amount for covered services. The coinsurance maximum did not change; it is three thousand dollars ($3,000.00) per person and six thousand dollars ($6,000.00) per family for **out-of-network** services.

Effective July 1, 2013, the emergency room copay of one hundred dollars ($100.00) per visit increased to one hundred and fifty dollars ($150.00) per visit.

Effective July 1, 2013, the requirements for initial and continuing eligibility increased from three hundred and thirty (330) hours during three consecutive calendar months to three hundred and forty-five (345) hours during three consecutive calendar months. This is the minimum number of hours which must be met for initial eligibility and to continue eligibility and coverage with the Fund. The requirement for the alternative 12 month continuing eligibility period increased from one thousand three hundred twenty (1,320) hours to one thousand three hundred eighty (1,380) hours.

Effective July 1, 2013, the self-payment rates for all members increased by eight percent (8%). This amount is equal to last year's increase in benefits paid by the Fund.

Effective June 1, 2012, the **in-network** annual deductible of two hundred fifty dollars ($250.00) per person and five hundred dollars ($500.00) per family for in-network services increased to five hundred dollars ($500.00) per person, and one thousand dollars ($1,000.00) per family. The **out-of-network** annual deductible of five hundred

dollars ($500.00) per person and one thousand dollars ($1,000.00) per family for out-of-network services increased to one thousand dollars ($1,000.00) per person and two thousand ($2,000.00) per family.

Effective June 1, 2012, the prescription drug co-payments were changed as follows: co-payments were raised from ten dollars ($10.00) to fifteen dollars ($15.00) for generic drugs, decreased from forty dollars ($40.00) to thirty dollars ($30.00) for a preferred brand-name drug and increased from forty dollars ($40.00) to sixty dollars ($60.00) for other, non-preferred brand-name drugs. The table below defines the three new tiers:

Tier	Definition	Co-Payment Level
Generic (Formulary Preferred)	Drugs made with the same active ingredients, that are available in the same strength and dosage form, and administered in the same way as equivalent brand-name drugs.	Members pay the lowest co-payment **($15.00)**
Preferred Brand	Includes brand name medication found in the BCBSM Custom Formulary	Members pay a higher co-payment **($30.00)**
Non-Preferred Brand	Includes brand-name medications not include in the BCBSM Custom Formulary	Members pay the highest co-payment **($60.00)**

Effective June 1, 2012, the self-payment rates increased for Totally and Permanently Disabled, Early Retiree, Retiree Spouse and Widows effective June 1, 2012. The rates for those categories are as follows:

Single:	$450.00
Two person:	$500.00
Family:	$700.00

Effective January 1, 2011, dependent coverage was extended for eligible participant's adult children up to age 26; the $5,000,000 overall lifetime limit per person was eliminated so that there is no longer any lifetime limit on the dollar value of all covered services per member; the Fund is required to provide external review for adverse benefit determinations involving medical judgment; the $1,000,000 lifetime limit per person per human organ transplant was eliminated so that there is no longer a lifetime limit on the dollar value of human organ transplants per person (transplants must still be coordinated through the Blue Cross Blue Shield of Michigan Human Organ Transplant Program); the $500 annual maximum limit per person for preventive health benefits and services was eliminated and preventive health benefits and services are now covered with no cost-sharing, such as co-payments and deductibles, when performed by an in-network physician (these preventive health benefits and services are generally not covered when performed by an out-of-network physician); and, covered preventive health benefits and services has been expanded to include: (i) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force with respect to the individual involved (except that recommendations of the Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current), (ii) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention), (iii) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health

Resources and Services Administration, and (iv) with respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Effective June 1, 2010, the annual deductible was increased to two hundred fifty dollars ($250.00) per person, and five hundred dollars ($500.00) per family; the Office Visit Co-Payment and Chiropractic Office Visit Co-Payment was increased from thirty dollars ($30.00) to forty dollars ($40.00) per visit; and Dental Benefits were reduced to provide coverage for preventive services only up to an annual maximum of five hundred dollars ($500) per individual.

Effective July 1, 2009, an annual deductible of one hundred dollars ($100.00) per person and two hundred dollars ($200.00) per family was implemented. This means that **before** Blue Cross Blue Shield of Michigan (BCBSM) will pay for services received after July 1, 2009, you will be required to pay the first one hundred dollars ($100.00) per person or the first two hundred dollars ($200.00) per family. (The annual deductible does not apply to the annual preventive health benefits. These benefits will continue to be paid at 100% up to the annual maximum of $750.00 per person, per year.)

Effective July 1, 2009, the Office Visit Co-Payment was increased from twenty dollars ($20.00) to thirty dollars ($30.00) per visit starting July 1, 2009 for any office visits on or after July 1, 2009. If any other services are performed, such as laboratory, x-rays, etc., these services are applied toward the annual deductible, so the member is responsible for paying the first one hundred dollars ($100.00) per person or the first two hundred dollars ($200.00) per family.

Effective July 1, 2009, a Chiropractic Office Visit Co-Payment of thirty dollars ($30.00) took effect with any chiropractic office visit on or after July 1, 2009.

Effective with charges incurred on or after June 1, 2008, the Fund included coverage for adult immunizations within the Preventive Health Benefits for adults nineteen (19) years of age and older. All adult immunizations listed by the Department of Health and Human Services Centers for Disease Control and Prevention (CDC) will be covered. Listed below are the current immunizations recommended by the CDC. *This listing is subject to change by Blue Cross Blue Shield of Michigan or the CDC.*

- **Tetanus, Diphtheria, Pertussis –** Recommended for adults between the ages of 19 to 64 who received their last vaccine more than 10 years ago.
- **Human Papillomavirus (HPV) –** Recommended for girls and women between the ages of 13 and 26.
- **Measles, Mumps, Rubella –** Recommended for anyone recently exposed to measles, health care workers, travelers, college students and anyone vaccinated from 1963 to 1967.
- **Varicella –** Recommended for anyone who has never had chickenpox or has a weakened immune system.
- **Influenza –** Recommended for anyone age 50 or older or for individuals with chronic illness.
- **Pneumococcal –** Recommended for anyone 65 or older or for individuals with chronic illness.
- **Hepatitis A –** Recommended for those with a clotting factor discord or chronic liver disease, health care workers and those who travel in countries with a high incidence of hepatitis.

- **Hepatitis B –** Recommended for hemodialysis patients, health care or public safety workers, for those who inject illegal drugs, have more than one sex partner in six months or have sex with a person infected with hepatitis B.
- **Menigococcal –**Recommended for college students or for individuals who travel in areas with a high incidence of meningitis.
- **Zoster (shingles)** – Recommended for anyone age 60 and over.

Benefits are paid at one hundred percent (100%) if charges are billed as part of a routine physical examination. If charges are not billed as a routine and have a diagnostic code included, the office visit co-payment of twenty dollars ($20) will apply.

Effective with charges incurred on or after March 1, 2008, the maximum payable each calendar year for Preventative or Routine Wellness Benefits and immunizations for each eligible dependent age 18 or younger has increased from five hundred dollars ($500.00) to seven hundred fifty dollars ($750.00). Wellness benefits remain subject to current age and frequency restrictions.

Effective March 1, 2008, the Fund no longer covers any prescriptions obtained at Wal-Mart or Sam's Club. We believe that in order to provide the best service and benefits for Union workers, we must promote and work directly with our Union partners. Neither Wal-Mart nor Sam's Club stores promote union practices, so the Fund will no longer reimburse the costs of prescriptions purchased there. **If you or your dependents purchase a prescription at Wal-Mart or Sam's Club on or after March 1, 2008, you will not receive any benefit or reimbursement from the Fund, and you will be required to pay a one hundred percent (100%) co-payment even if Wal-Mart and Sam's Club are still affiliated with the Blue Cross Blue Shield of Michigan pharmacy network.**

Effective with hours worked on and after May 1, 2008, the Fund will use the same pro rating for all contributions and hours. So, if you work for an employer that pays contributions at an hourly rate lower than the standard rate, even an employer that contributes to the Michigan Fund, the hours to be credited to you will be calculated by dividing the contributions actually received by the hourly contribution rate ($5.20 currently). This may affect your eligibility. You must be credited with three hundred thirty hours (330) hours within a quarter to remain eligible for coverage. If your hours are reduced because of lower contributions, you may not meet that eligibility requirement.

Effective with the eligibility month of July 2007, the Plan was modified to allow participants to remit "short hour self-payments" for a maximum of ten (10) hours each month at the current hourly contribution rate. If, for example, three hundred and twenty-five (325) hours of contributions are paid on your behalf within a quarter, you may make a self-payment at the currently hourly contribution rate (5 x $5.20 = $26) for the five (5) hours you are short of the 330 hours required to continue your eligibility for coverage. You will then remain eligible for the quarter.

Effective August 1, 2007, the self-payment rate for all categories was increased to three hundred and seventy dollars ($370) per month.

The Board of Trustees as of the date of this Notice is as follows:

Union Trustees:

Michael Stanfield, Chairman
Cement Masons Local 514
1154 E. Lincoln Avenue
Madison Heights, MI 48071

Sherman Smith
Cement Masons Local 514
1154 E. Lincoln Avenue
Madison Heights, MI 48071

Jack McCool
Cement Masons Local 514
1154 E. Lincoln Avenue
Madison Heights, MI 48071

Henry Williams
Cement Masons Local 514
1154 E. Lincoln Avenue
Madison Heights, MI 48071

Martin Jimenez
Cement Masons Local 514
1154 E. Lincoln Avenue
Madison Heights, MI 48071

Management Trustees:

Glenn Bukoski, Secretary
Michigan Infrastructure &
Transportation Association
PO Box 1640
Okemos, MI 48805

Scott Fisher
AGC of Michigan
2323 N. Larch, PO Box 27005
Lansing, MI 48906

James E. Like
AGC of Michigan
2323 N. Larch, PO Box 27005
Lansing, MI 48906

Rachelle VanDeventer
Michigan Infrastructure &
Transportation Association
PO Box 1640
Okemos, MI 48805

Lawrence V. Walraven, Jr.
AGC of Michigan
2323 N. Larch, PO Box 27005
Lansing, MI 48906

Administered for the Trustees by:
TIC International Corporation

Legal Counsel
Derek Watkins
Sachs Waldman, Professional Corporation
1423 East Twelve Mile Road
Madison Heights, Michigan 48071

If you have any questions regarding the Plan Modifications described above, please contact the Medical Claims Department at the Fund Office.

Important Notice
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug under the Michigan Trowel Trades Health and Welfare Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Michigan Trowel Trades Health and Welfare Fund has determined that the prescription drug coverage provided under the Plan is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare Part D drug plan, you can also keep your current prescription drug coverage through the Michigan Trowel Trades Health and Welfare Fund.

If you decide to join a Medicare drug plan, and drop your current Michigan Trowel Trades Health and Welfare Fund prescription drug coverage, be aware that you and your dependents may not be able to get back into the prescription drug plan offered by the Fund until you are again eligible to participate in the Plan and complete the Enrollment and Coordination of Benefits Forms.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage under the Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the department listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage under the Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778)..

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 2015
Name of Entity/Sender:	Michigan Trowel Trades Health and Welfare Fund
Contact:	Fund Office
Address:	6525 Centurion Drive, Lansing, MI 48917
Phone Number:	517-321-7502

SUMMARY ANNUAL REPORT

This is a summary of the Annual Report of the Michigan Trowel Trades Health and Welfare Fund, Employer Identification Number 38-6238055, Plan No. 501, for the period of January 1, 2015 through December 31, 2015. The Annual Report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees has committed itself to pay certain medical, surgical and other health care claims incurred under the terms of the Plan.

INSURANCE INFORMATION

The Plan has contracts with Blue Cross Blue Shield of Michigan and Unum Life Insurance of America to pay Stop Loss, Basic Life Insurance and Accidental Death & Dismemberment claims incurred under the terms of the Plan. The total premiums paid for the Plan Year ending December 31, 2015 were $$274,144,$8,768 and $32,976, respectively.

BASIC FINANCIAL STATEMENT

The value of Plan Assets, after subtracting Liabilities of the Plan, was $2,318,961 as of December 31, 2015, compared to $2,067.945 as of January 1, 2015. During the Plan Year, the Plan experienced an increase in its Net Assets of $251,016. This increase includes unrealized appreciation or depreciation in the value of the Plan Assets; that is, the difference between the value of the Plan Assets at the end of the year and the value of the Assets at the beginning of the year or the cost of the Assets acquired during the year. During the Plan Year, the Plan had Total Income of $5,621,803, including Employer Contributions of $5,489,732, Employee Contributions of $107,429, earnings from Investments of $408 and Other Income of $24,234.

Plan Expenses were $5,370,787. These Expenses included $563,571 in Administrative Expenses (See Schedule A) and $4,807,216 in benefits paid to Participants and Beneficiaries.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have a right to receive a copy of the full Annual Report, or any part thereof, on request. The items listed below are included in that report:

1. An Accountant's report;
2. Financial information and information on payments to service providers;
3. Assets held for investment;
4. Transactions in excess of 5% of the Plan Assets; and
5. Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full Annual Report, or any part thereof, write or call the office of the Board of Trustees, Michigan Trowel Trades Health and Welfare Fund, 6525 Centurion Drive, Lansing, MI 48917-9275, toll free (877) 876 9357 or (517) 321-7502. The charge to cover copying costs will be $6.75 for the full Annual Report or twenty-five cents per page for any part thereof.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the Assets and Liabilities of the Plan and accompanying notes, or a statement of Income and Expenses of the Plan and accompanying notes, or both. If you request a copy of the full Annual Report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the Report, because these portions are furnished without charge.

You also have the legally protected right to examine the Annual Report at the main office of the Plan (Board of Trustees, Michigan Trowel Trades Health and Welfare Fund, 6525 Centurion Drive, Lansing, MI 48917-9725), at any other location where the report is available for examination and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Schedule A: Administrative Expenses

Claim administration fee	$348,467	Lockbox and bank service charges	$ 5,823
Administrative manager's fee*	103,250	Meeting expenses	4,759
Collection coordinator expenses	25,778	Member communications	4,317
Payroll audit fees	17,228	Trustee and fiduciary liability	
Legal fees - collection	13,526	insurance and bonding	2,125
Legal fees	13,525	Website expense	1,800
Audit fee	13,500	Forms 5500 and 990 preparation fee	1,400
Printing and miscellaneous	6,823	Consulting fee	1,250
		Total	$563,571

*includes rent, equipment, staffing, postage, computer services, etc.

TO: ALL HEALTH FUND PARTICIPANTS

RE: **NOTICE OF HIPAA PRIVACY POLICY**

This Notice is intended to confirm that the Fund complies with the Privacy Regulations issued under the Health Insurance Portability and Accountability Act (HIPAA). The law restricts the use and disclosure of the non-public "protected health information" of the Participant and the Participant's covered dependents, if any, with regard to benefits provided under the Fund's group health plan. That protected health information can generally be disclosed only by the Fund, its vendors and the Participant's/dependent's health care provider(s) only if necessary for the payment of claims, treatment of illness or other health care operations, including the administration of health care benefits, as permitted by law and the HIPAA Privacy Regulations.

Blue Cross Blue Shield of Michigan and Blue Care Network may issue separate Notices of Privacy Policies and Practices.

For a complete copy of the Fund's Notice of Privacy Policy, write or call the Fund Office at the address and telephone number and listed below:

Michigan Trowel Trades Health and Welfare Fund
6525 Centurion Drive
Lansing, MI 48917-9275

Telephone (517)321-7502
Toll Free (877)876-9357
Fax 517-321-7508

WOMEN'S HEALTH AND CANCER RIGHTS/NEWBORNS' AND MOTHERS' HEALTH PROTECTION NOTICE

The **Women's Health and Cancer Rights Act of 1998** requires that all health care plans that provide medical and surgical benefits for mastectomies provide participants and beneficiaries receiving mastectomy benefits and who elect mastectomy related breast reconstruction with benefits coverage for the following:

- **Reconstruction of the breast on which the mastectomy has been performed;**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance; and**
- **Prostheses and physical complications of all stages of mastectomy, including lymph edemas, in a manner determined in consultation with the attending physician and the patient**.

Such coverage may be subject to annual deductibles and coinsurance provisions **as may be deemed appropriate and as are** consistent with those established for other benefits under the plan or coverage.

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

Also, the **Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)** generally prohibits group health plans from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean section deliveries for a mother and her newborn child, except with consent of the mother and approval of her physician, or from requiring that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above.

Please keep this notice with your Summary Plan Description. If you have any questions regarding these federal requirements, please contact the Medical Claims Department at the Fund Office.

SOCIAL SECURITY NUMBER PRIVACY POLICY

(Effective January 1, 2006)

The Michigan 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 retirement 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's third-party administrator, TIC International Corporation ("TIC"), and the Blue Cross Blue Shield of Michigan ("BCBSM") will use alternate identification numbers wherever feasible, including on monthly notices of contributions. TIC and BCBSM do 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 TIC's employees and agents and employees and agents of other Fund service providers such as BCBSM may access the Social Security numbers of Fund participants and family members and only as necessary to provide services to the Fund. TIC uses practical means to limit access to written and electronic records in its possession that contain Social Security numbers to those employees and agents 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. TIC 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. TIC's employees and agents 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.