MICHIGAN TROWEL TRADES
HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

July 2017

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HEALTH AND WELFARE FUND

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IMPORTANT NOTICE

This Summary Plan Description booklet describes the formal documents governing the terms of the Fund's coverage and eligibility rules for the Michigan Trowel Trades Health and Welfare Fund as they are in effect on July 1, 2017. If you have questions about the Fund or your rights under the formal documents governing the terms of the Fund's coverage and eligibility rules, contact the Fund Office. However, any response cannot modify or contradict the written terms of the formal documents.

A word of caution: No one has the authority to speak for the Board of Trustees, the legal Administrator of the Fund, in interpreting the eligibility rules or benefits of the Fund except the full Board of Trustees.

Aviso

Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo el Michigan Trowel Trades Health and Welfare Fund.

Si usted tuviera dificultad para entender cualquier parte de este folleto, o dificultad para entender cualquier información que usted reciba de Michigan Trowel Trades Health and Welfare Fund , usted puede recibir ayuda en español contactando a la Oficina del Fondo entre las horas de 7:30 a.m. y 5:30 p.m., de lunes a viernes. La Oficina del Fondo está ubicada en 6525 Centurion Drive, Lansing, Michigan 48917, y puede contactarse por teléfono en el (517) 321-7502 y gratis en el (877) 876-9357.

Si usted tuviera dificultad para entender cualquier información que usted reciba de Blue Cross Blue Shield de Michigan (ABCBSM@), usted puede recibir ayuda en español llamando a cualquiera de los números de Servicios al Cliente enumerados en este folleto.

Por favor preste atención a toda carta y aviso que reciba del Fondo de Salud y Bienestar y BCBSM sobre su cobertura de atención médica y responda inmediatamente a cualquier pedido de información y/o de pago. Una respuesta y un pago oportunos, cuando se requiera, es esencial para continuar su cobertura de atención médica sin interrupción.

Por favor llame a la Oficina del Fondo y/o BCBSM si usted tuviera dificultad para entender cualquier información que usted reciba de ellos.

IMPORTANT ADDRESSES AND PHONE NUMBERS

BOARD OF TRUSTEES

Employer Trustees

Glenn Bukoski (Secretary)
Michigan Infrastructure and
Transportation Association
2937 Atrium Drive, Suite 100
Okemos, MI 48864

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

James E. Like
Christman Constructors
324 East South Street
Lansing, MI 48910

James Malenich
Fessler & Bowman
4099 Eagle's Nest Ct.
Flushing, MI 48433

Rachelle VanDeventer
Michigan Infrastructure and
Transportation Association
2937 Atrium Drive, Suite 100
Okemos, MI 48864

Union Trustees

Michael Stanfield (Chairman)
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

Jesse Parelta
Cement Masons Local 514
1154 E. Lincoln Avenue
Madison Heights, MI 48071

Keino Walker
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

FUND OFFICE / ADMINISTRATIVE MANAGER / BOARD OF TRUSTEES

Street Address
6525 Centurion Drive
Lansing, Michigan 48917-9275

Telephone
(517) 321-7502
Toll Free (800) 876-9357

Office Hours
Monday – Friday, 7:30 a.m. to 5:30 p.m.

Fax
(517) 321-7508

AGENT DESIGNATED FOR SERVICE OF LEGAL PROCESS

Derek Watkins
Sachs Waldman, Professional Corporation
1423 East Twelve Mile Road, Madison Heights, Michigan 48071
Telephone (248) 658-0797 / Fax (248) 658-0801

Legal process may also be served on any Trustee or on the Administrative Manager.

Contacting BCBSM.

When you call BCBSM Customer Service, please be ready to provide your contract number (as listed on your BCBSM ID card). If you are inquiring about a claim, you will need to provide the following information:

- Patient's name
- Provider's name (hospital, doctor, laboratory, other)
- Date of service and type of service (surgery, office call visit, X-ray, other)
- Provider's charge for each service

Please remember, BCBSM follows strict privacy policies in accordance with state and federal law. For example, BCBSM will never release your health information to anyone, unless you have authorized BCBSM in writing to do so. You can find the necessary release documents and forms at bcbsm.com.

To call BCBSM, please use the phone number on the back of your ID card. You can also find this number on your Explanation of Benefit Payments statement, or Explanation of Benefits ("EOB"). Customer service hours are Monday through Friday from 8:30 to 5 p.m.

Hearing- or speech-impaired participants, please call:
Area codes 248, 313, 586, 734, 810 and 947: 313-225-6903
Area codes 231, 269 and 616: 1-800-867-8980

You can also visit one of BCBSM's walk-in customer service centers for personal, face-to-face service. Customer service representatives are available weekdays to assist you. For a list of walk-in customer service centers and hours of operation, go to bcbsm.com or call BCBSM Customer Service.

To write BCBSM, please use the address in the upper right-hand corner of your EOB. If you do not have an EOB, call BCBSM Customer Service for assistance.

Helpful Tip: When calling any provider customer service, please remember to document the date, time, name and department of the representative you speak with. This could help locate your call should there be any discrepancies or questions in the future.

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INTRODUCTION

We are pleased to provide you with this Summary Description of the formal documents governing the terms of the Fund's coverage and eligibility rules for the Michigan Trowel Trades Health and Welfare Fund. As you read this 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 this 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 Trust Agreement, Collective Bargaining Agreements, Participation Agreements, Certificates and Riders that form the basis of coverage with BCBSM and BCN, and other contracts entered into by the Fund) (together, the "Plan"), the provisions of those documents will govern. This Summary Plan Description supersedes and replaces any Summary Plan Description previously issued by the Fund.

The Board of Trustees of the Michigan 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 Michigan Trowel Trades Health and Welfare Fund.

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

Each year, you will receive a Summary of Material Modifications, which includes a statement of significant changes in the Plan after July 1, 2017 if any material changes are made to the Plan. Like this Summary, it is intended as a general statement of the changes and is not a substitute for other formal documents governing the terms of the Fund's coverage and eligibility rules. This Summary Plan Description and other notices are also posted on the Fund's website:

http://www.outstatetroweltrades.org

That website contains useful information such as the amount of contributions received by the Fund on your behalf and information on any changes to the Plan that may be made after this Summary Plan Description and Plan are printed. You may receive, free of charge, a paper copy of the information on that website, or any of the formal documents identified above, by contacting the Fund Office.

If you have any question about any provision of the Plan or the Summary or your rights under the Plan, do not hesitate to contact the Fund Office, preferably in writing, to have your question answered. However, any response cannot modify or contradict the written terms of the Plan.

PLAN INFORMATION

MICHIGAN TROWEL TRADES
HEALTH AND WELFARE FUND
Address: 6525 Centurion Drive, Lansing, Michigan 48917
Phone Number (local): (517) 321-7502; Phone Number (toll-free): (877) 876-9357
Fax Number: (517) 321-7508
Web Site Address: www.outstatetroweltrades.org

INTERNAL REVENUE SERVICE EMPLOYER AND PLAN IDENTIFICATION NUMBERS

The employer identification number (EIN) issued to the Fund is 38-6238055. The Plan number is 501.

THE FUND IS TAX EXEMPT

The Fund is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the employer's contributions to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefits paid on your behalf are not tax deductible and are not part of your personal income.

Obviously, such tax exemption works to the benefit of both employer and employee. In effect, it means that money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses.

The Board of Trustees are well aware of these advantages and will take whatever steps are necessary to keep your Plan tax exempt under Internal Revenue Service rules.

TYPE OF ADMINISTRATION

The Board of Trustees of the Michigan Trowel Trades Health and Welfare Fund is the Plan Administrator and Plan Sponsor and is responsible for overall Plan administration. There are five Union Trustees appointed by the Michigan State Council of the Operative Plasterers and Cement Masons International Association of the United States and Canada and five Employer Trustees, with three appointed by the AGC of Michigan and two appointed by the Michigan Infrastructure and Transportation Association. The Board of Trustees has retained TIC International, the Administrative Manager, to fulfill the day-to-day responsibilities for contract administration. The Board of Trustees has retained Blue Cross and Blue Shield of Michigan ("BCBSM"), as a third party administrator, to provide the Fund with provider network access and claims processing for the self-funded plan for active participants. The Board of Trustees has purchased insurance through Blue Care Network of Michigan ("BCN") for early retiree (pre-Medicare) coverage.

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 Michigan Trowel Trades Health and Welfare Fund. With respect to claims processing for active participants and beneficiaries, the Board of Trustees has delegated responsibility to BCBSM. BCBSM's fiduciary claims administrator responsibilities extend only to the full and fair review of claims and administrative appeals as set forth in ERISA §503 and applicable regulations. Any determination or interpretation made by BCBSM pursuant to its claim determination authority is binding on the Enrollee, Fund, and BCBSM unless it is demonstrated that the determination or interpretation was arbitrary and capricious.

PLAN NAME

Plan of the Michigan Trowel Trades Health and Welfare Fund.

TYPE OF PLAN

The Plan is a Group Health Plan. It is an employee welfare benefit plan providing hospitalization, surgery, medical, prescription drug, dental, vision, life insurance, 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 Michigan 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 or amend 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, co-payment or co-insurance required for any benefit.

Although the Board of Trustees does not foresee that the Plan will be terminated, the Trust Agreement provides that termination may occur when:

1. Effective action is taken by the Union and the Associations which results in its termination.
2. Effective action is taken by the Trustees to merge or consolidate the Fund with or into, or transfer the Fund's assets to, another Fund.
3. No funds are left for administration in the Trust.
4. No individuals remain alive who can qualify for benefits hereunder.

The Board of Trustees are obligated to use the Trust assets for payment of expenses incurred up to the date of termination and expenses related to the termination as their first priority. Remaining assets, if any, must be used in such manner as will, in the Board of Trustees' best judgment, best effectuate the purposes of the Trust.

Upon written request, you may examine the Trust Agreement at the Fund Office or other specified locations. Or you may request a copy of the Trust Agreement which may be provided for a reasonable charge.

COLLECTIVE BARGAINING AGREEMENTS

The Plan is established and maintained under the terms of collective bargaining agreements. The parties to the collective bargaining agreements are the Michigan State Council of the Operative Plasterers and Cement Masons International Association of the United States and Canada (1154 E. Lincoln Avenue, Madison Heights, Michigan 48071), the Cement Masons Union Local 514, Detroit, Michigan, Operative Plasterers' and Cement Masons' International Association (1154 E. Lincoln Avenue, Madison Heights, Michigan 48071), the AGC of Michigan (2323 N. Larch, Lansing, Michigan 48906) and the Michigan Infrastructure and Transportation Association (2937 Atrium Drive Suite 100, Okemos, Michigan 48864). A copy of such agreement(s) may be obtained upon written request to the Fund Office or any of the bargaining parties, which may make a reasonable charge for copying. Copies are also available for examination by participants and beneficiaries at the Fund Office.

SOURCES OF CONTRIBUTIONS AND FUND INCOME

The Plan is funded through employer contributions, participant self-payments and investment earnings. All income is held in trust by the Board of Trustees pending the payment of benefits and administrative expenses. The collective bargaining agreements between the Associations and the Union and participation agreements with the Fund specify the amount of contributions, due date of employer contributions, type of work for which contributions are payable and the geographic area covered. Contributions are generally required to be made on an hourly basis pursuant to the terms of these agreements. Participants, retirees, spouses and other dependents may make direct 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.

METHOD OF FUNDING BENEFITS

Life Insurance and Accidental Death and Dismemberment benefits payable under this Plan are provided through an insurance contract. The provider may change from year to year.

Hospital, surgical, medical, dental, vision care, and prescription drug benefits for Early Retiree (pre-Medicare) coverage is provided through an insurance contract with Blue Care Network.

Hospital, surgical, medical, dental, vision care, and prescription drug benefits payable under this Plan for active participants and beneficiaries are self-funded (i.e., not covered through an insurance policy). Although Blue Cross and Blue Shield of Michigan provides access to networks of health care providers and provides administration services for benefits provided

through those networks, it does not insure coverage for those that are not Retirees. The Fund is responsible for the payment of these claims, changes in Plan benefits and enrollment.

Stop loss insurance related to hospital, surgical, medical, and prescription drug benefits payable under this Plan for active participants and beneficiaries is provided through Blue Cross and Blue Shield of Michigan.

A portion of Fund assets is also allocated for reserves to meet future liabilities to carry out the objectives of the Plan.

Benefits payable are limited to Fund assets available for such purposes.

PLAN YEAR/FISCAL YEAR

The Plan Year, for purposes of maintaining the Plan's fiscal records, begins on the first day of January and ends on the last day of December 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 a vested right to any benefit provided by the Fund, now or at any time in the future.**

TRUSTEE AUTHORITY
PLAN ADMINISTRATION AND DISCRETION

The Board of Trustees has full authority and sole and exclusive discretion 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 Plan terms, including those relating to coverage and benefits, are legally enforceable while they are in effect. 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, or its delegate, 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, or its delegate (such as BCBSM), 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.

With respect to claims processing, the Board of Trustees has delegated responsibility to BCBSM. BCBSM's fiduciary claims administrator responsibilities extend only to the full and fair review of claims and administrative appeals as set forth in ERISA §503 and applicable regulations. Any determination or interpretation made by BCBSM pursuant to its claim determination authority is binding on the Enrollee, Fund, and BCBSM unless it is demonstrated that the determination or interpretation was arbitrary and capricious.

Coverage for early (pre-Medicare) retirees is provided pursuant through an insurance contract with Blue Care Network.

If you have questions about your eligibility or a claim, contact the Fund Office. However, any response cannot modify or contradict the written terms of the Plan.

DOING YOUR PART

You have certain responsibilities in order to protect your rights and eligibility for benefits from the Fund.

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.

Complete an Enrollment Form immediately and return it to the Fund Office if you are a new participant.

Keep the Fund Office informed about you. Failure to make certain that the Fund Office always has current and accurate information about you and your dependents can result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that you or your dependents might otherwise reasonably expect the Plan to provide on the basis of the description of benefits in this Summary. It may further result in missed notices from the Fund Office and your being legally liable for expenses the Fund paid which the Fund should not have paid.

Keep your records up to date. 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:

- Change of address
- Changes in your family, such as your marriage, your child attains the age of 26, birth, adoption, any death or divorce or a child losing dependent status
- Change in your beneficiary designation for purposes of the Fund's Death Benefit. Remember to designate a new beneficiary if your beneficiary dies, or if your beneficiary is your spouse, and you divorce.
- Disability due to accident or illness, including pregnancy and childbirth
- Termination of disability
- Termination of your employment with a contributing Employer
- Application for family or medical leave from a contributing Employer
- A court or the friend of the court issuing a qualified medical child support order directing that health care coverage be provided for your child(ren) through the Fund
- Eligibility for or receipt of benefits under any other health care plan, insurance contract, program, or statute by you and/or your dependents

- Eligibility for Social Security benefits and/or Medicare coverage by you and/or your dependents (Note: You *must* sign up for Medicare Part A and B and send a copy of the Social Security Award letter and/or the Medicare Card to the Fund Office immediately)

- Working outside the Local 514 area (Note: If your employer is making health care contributions on your behalf, you may be able to have those contributions related to that work transferred to this Fund)

- You or your dependent joining the armed forces of any country

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. You will be held liable for claims paid by the Fund or BCN illegally.**

Keep documents that you receive from the Fund, such as:

- **Bills and Explanations of Benefits ("EOBs").** 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.

- **Notices.** After the publication of this book, you will receive notices of benefit changes as they occur. You should keep those together with this book in order for you to have a complete record of the Plan's communications to you on your benefits. You will also receive annual notices relating to the Fund and your rights.

Keep track of the Employer contributions submitted to the Fund on your behalf. Your eligibility depends on it. The Fund has set up an employer audit and collection program to make sure that your employers pay the contributions owed to the Fund for your work. But, it is your responsibility to keep records of your employment, including the names of your employers, your pay stubs, and other information that proves you worked and for how many hours, so that if one of your employers fails to pay the required contributions or keep records of your work, the Fund will have the information necessary to grant you the credit and benefits to which you are entitled. In addition, the Fund Office will send monthly contribution notices, which provides you with information concerning contributions received on your behalf based on information available to the Fund. If you believe that information is incorrect or incomplete, you must notify the Fund in writing immediately.

Follow the proper procedures for receiving benefits, filing claims, and submitting appeals. Review the information in this book for information on claims processing. 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 benefits card. Be certain to carry this benefits card and show it whenever you receive medical services or get a prescription filled.

About your ID card.
Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage. Unless you request a replacement card, you will receive new ID cards only when there is a change in your benefit plan. Make sure you carry the latest card. Using outdated cards delays payment of your claims. Call the Fund Office if your card is lost or stolen. Your provider can call BCBSM or BCN to verify your coverage until you receive your new card. If you need additional ID cards, you can request new cards at no cost. Go to bcbsm.com and log in to Member Secured Services or call the Fund Office or the BCBSM or BCN Customer Service phone number on the back of your ID card.

Preventing fraud.
If your provider asks for another form of identification, do not worry. Checking a cardholder's identification is one way providers help protect you against unauthorized use of your ID card. You can help prevent fraud by reporting a lost or stolen ID card and by checking your EOB. All fraud reports are confidential, and you remain anonymous. If you see a discrepancy on your EOB, contact your provider first to see if it is an error. If it is not and you believe it is a fraudulent billing or use of your card, then let BCBSM or BCN know. There are four ways you can report suspected fraud:

1. Visit the BCBSM Web site at bcbsm.com

2. Write or fax BCBSM. You can download the form on the BCBSM Web site, fill it out online, print it and mail or fax it to BCBSM. The address and fax number are printed on the form.

3. Call the BCBSM Anti-fraud Hotline at 1-800-482-3787. The hotline is open Monday through Friday from 8:30 a.m. to 4:30 p.m.

4. Call the Fund Office.

Identify yourself. When you write to the Fund Office, always include your name, the contract number on your BCBSM or BCN ID Card and your trade in your letter. If you call, be sure to have the contract number on your BCBSM or BCN ID Card 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.

Helpful Tip: When calling any provider customer service, please remember to document the date, time and name of the department of the representative you speak with. This could help locate your call should there be any discrepancies or questions in the future.

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, BCBSM and BCN.

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

- Day-to-day details of running the Fund, including financial and record-keeping functions
- All matters pertaining to eligibility
- Self-payments, including actives, early retirees (pre-Medicare), surviving spouse, and COBRA
- Forwarding claims for Life Insurance and Accidental Death and Dismemberment Benefits to the commercial insurance carrier
- Reviewing and presenting eligibility appeals to the Board of Trustees.

Blue Cross and Blue Shield of Michigan: The Fund has an administrative services contract (self-funded) with BCBSM to provides access to networks of health care providers and administer and pay all medical, surgical, hospital, dental, vision care, and prescription drug claims.

Blue Care Network of Michigan: The Fund has an insurance contract with Blue Care Network ("BCN") to administer and pay all medical, surgical, and hospital claims for early retirees (pre-Medicare). BCN is a Health Maintenance Organization (HMO) licensed by the state of Michigan and affiliated with BCBSM.

CHOICE OF PROVIDER

With the exception of the early retiree (pre-Medicare) coverage through BCN, 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 network used by the Fund.

Early retirees (pre-Medicare) with coverage provided through BCN are required to select a Primary Care Physician. You have the right to designate any Primary Care Physician who is a Participating Physician and who is able to accept you. If you do not select a Primary Care Physician upon enrollment, one will be selected for you. Information on how to select a Primary Care Physician and a list of Participating Primary Care Physicians is available at bcbsm.com or by calling Customer Service at the number provided on the back of your BCN ID card.

DISCHARGE OF LIABILITY

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

YOUR EXPLANATION OF BENEFITS (EOB)

Each month BCBSM or BCN processes medical claims under your contract number, you will receive an Explanation of Benefit Payments statement, or EOB. This statement is not a bill. At the top of the EOB, you will find BCBSM Customer Service phone numbers and an address to use for inquiries.

An EOB is a record of paid or rejected claims. It also lists any amounts applied to deductibles, co-pays and/or co-insurance. All health insurance carriers will accept the EOB statement to process any available benefits for coordination of benefits. They can also be used to keep track of medical expenses for tax purposes.

Note: It is very important for your provider and the Fund Office to have your correct mailing address. In most cases, your EOB will be mailed to the address that is in the BCBSM system. However, if a payment is being sent directly to you, the address that is on the claim form will be used for mailing purposes.

Online EOB statements. You can sign up to receive your EOB statements online. With online EOBs, you can access your EOB statements safely and securely from any personal computer at any time to track the following:

- Health care services
- Benefit payment histories
- Status of deductibles and copays

Go to bcbsm.com and log in to Member Secured Services to register for online EOBs.

About your EOB. Briefly the EOB tells you:

- The family member who received services
- The date services were provided ("claims processed from...to...")
- "Summary of Balances" includes the provider(s) of the services, details about charges and payments, including the amount saved by using PPO network providers
- "Summary of Deductibles and Copayments" provides your deductible and copay requirements as well as a total of all deductibles and copays paid to date
- "Helpful Information" includes messages and reminders

- "Detail on Services" summarizes the BCBSM payment and shows your balance

If you see an error, contact your provider first. If your provider cannot correct the error, call the customer service number on 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 if the Fund is provided with all necessary documentation. 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

All employees working for a contributing employer(s) within the jurisdiction of a collective bargaining agreement that requires contributions to the Fund are eligible to receive benefits after meeting the applicable eligibility requirements.

The Fund will grant proportional hours credit for employer contributions per hour which are below the level set by the Fund. If you work for an employer with an hourly contribution rate lower than the standard contribution rate set by the Fund, the Fund will credit your hours of work by dividing the employer contributions actually received by the standard hourly employer contribution rate determined by the Board ($6.68 as of June 2016). **This rule may affect your eligibility.** If the hours with which you are credited are reduced because you work for an employer with a lower hourly employer contribution rate, you may not meet the eligibility requirements.

Benefits under this Plan cannot be paid unless you complete the "Enrollment/Change of Status" form and the "Coordination of Benefits Information" form that you will receive from the Fund Office. If the Fund Office does not have this information, you cannot be properly reported to Blue Cross Blue Shield of Michigan as eligible for benefits, even if you work the required number of hours.

> ***Return the forms to the Fund Office in the pre-addressed envelope given to you with the forms. Do not return the forms directly to Blue Cross Blue Shield.***

Enrollment forms will generally be given to you as soon as you meet the initial eligibility criteria. If they are provided sooner, completing these forms does not make you eligible for benefits. You must work the required number of hours at the standard contribution rate for a contributing employer to become and to stay eligible. The complete Initial Eligibility and Continuation of Eligibility rules are provided in this section.

A Note of Explanation

The Eligibility Rules represent the requirements which must be satisfied for you and your

dependents to become, and to remain eligible for benefits from this Plan. In the event the requirements are not satisfied, eligibility is lost and benefits are not payable. The Board of Trustees reserves the right to deny benefits to any claimant who is, in its sole and exclusive determination, attempting to subvert the purpose of the Plan or who do not present a bona fide claim. This includes the right to retroactively terminate any claimant as a result of fraud or an intentional misrepresentation of a material fact.

Remember: Changes in employment may have an effect on employer contributions paid in your behalf. For example, employer contributions cease in the event you:

a) Change job classifications from covered to non-covered employment, **even if that employment is with the same employer**; or
b) Change employment from a participating to a non-participating employer.

You and your dependents may obtain, upon written request to the Fund Office, information as to the address of a particular employer and whether that employer is required to pay contributions to this Plan.

If you have any questions about the Eligibility Rules, call the Fund Office. However, any response cannot modify or contradict the written terms of the Plan.

INITIAL ELIGIBILITY REQUIREMENTS

You will become initially eligible if you have been employed by one or more contributing employers, and employer contributions have been received by the Fund at the standard contribution rate on your behalf for at least 345 hours of work within a period of three, or fewer, consecutive calendar months. Your initial eligibility is effective on the first day of the second calendar month immediately following the month in which you complete the 345 hour requirement (and for which all employer contributions have been received on your behalf).

Remember, if you work for an employer with an employer contribution rate which is lower than the Fund's standard contribution rate at the time the work was performed, the hours with which you will be credited will be reduced in proportion to the relative rates.

Example 1: If you begin working in January and complete the 345 hour requirement during March (for which all employer contributions have been received at the standard contribution rate), you would become initially eligible on the first day of May.

Example 2: If you begin working in January and complete the 345 hour requirement during February (for which all employer contributions have been received at the standard contribution rate), you would become initially eligible on the first day of April.

Example 3: If you begin working in January and do not complete the 345 hour requirement during March (the end of the three-month period), you do not become initially eligible and the hours worked in January are lost. Your new three-month test period would be February through April; the earliest you could become initially eligible would be the first day of June, provided

you complete the 345 hour requirement in April (for which all employer contributions have been received at the standard contribution rate).

Example 4: If you begin working in January and complete 345 hours of work, but do not meet the 345 hour requirement during March (the end of the three-month period) because the contributions remitted on your behalf were below the standard contribution rate, you do not become initially eligible and the hours worked in January are lost. Your new three-month test period would be February through April; the earliest you could become initially eligible would be the first day of June, provided you complete the 345 hour requirement in April (for which all employer contributions have been received at the standard contribution rate or an equivalent number of hours based on a lower rate).

Once you meet the initial eligibility requirement, you will be provided three consecutive calendar months of coverage.

Initial Eligibility and Hospital Confinement

Unless otherwise stated in this booklet, neither BCBSM nor the Fund will pay for any services, treatment, care or supplies you or your dependents receive before coverage becomes effective or after coverage ends.

If your coverage begins or ends while you (or one of your covered dependents) are an inpatient at a facility, BCBSM's payment will be based on the facility's contract with BCBSM. The payment may cover:

- The services, treatment, care or supplies received during the entire admission, or
- The services, treatment, care or supplies received while your coverage is in effect.

In addition, if you or your covered dependent has other coverage when you or they are admitted to or discharged from a facility, the other carrier may be responsible for paying for the care received before the effective date of your coverage from this Fund, or after it ends.

CONTINUING ELIGIBILITY REQUIREMENTS FOR ACTIVE PARTICIPANTS

Continuing Eligibility By Employer Contributions

After you become initially eligible, you continue to be eligible for additional periods of three consecutive calendar months as long as you are working for a contributing employer(s), and those employers remit employer contributions to the Fund at the standard contribution rate on your behalf for at least 345 hours during the 3 calendar months ending one month prior to the next 3 month coverage period **or** 1,380 hours during the 12 calendar months ending one month prior to the next 3 month coverage period. Remember, if you work for an employer with an employer contribution rate which is lower than the Fund's standard contribution rate at the time the work was performed, the hours with which you will be credited will be reduced in proportion to the relative rates.

> ***Example:*** If you completed the 345 hour initial eligibility requirement in September (for which all employer contributions have been received at the standard contribution rate) you became initially eligible November 1 and you would remain eligible for the months of November, December and January based on that initial eligibility. Your eligibility for February, March and April would continue based on working at least 345 hours during the 3 calendar months of October, November and December (for which all employer contributions at the standard rate are received) **or** 1,380 hours during the 12 calendar months of January through December (for which all employer contributions at the standard rate are received).

Continuing Eligibility by Self-Payment

After you have met the requirements for initial eligibility, there are two options for continuing eligibility through self-payments. Which one is available to you depends on how many hours you are short of the requirements for continuing eligibility.

The first option permits you to self-pay for the number of hours by which you are short of the requirements for continuing eligibility at the standard contribution rate, but *only up to 10 hours per month*. (345 hours in three months **or** 1,380 hours during the 12 calendar months ending one month prior to the next 3 month coverage period).

> ***Example*****:** If you worked 340 hours for which employer contributions at the full rate were remitted on your behalf in three calendar months, you would be short by five hours in meeting the requirements for continuing eligibility. Therefore, the Fund will accept a self-payment from you in the amount of $33.40 (5 hours x $6.68 per hour at the current contribution rate = $33.40) to continue your eligibility for coverage. You will then remain eligible for three months, credited in the usual manner.

Under the second option, if you are short of the requirements for continuing eligibility by more than 10 hours per month, you must remit a full self-payment.

The self-payment amount is established by the Board of Trustees from time to time, and it can be changed by the Board at any time. The full self-payment amount is not reduced or offset by any hours you work or any contributions received during the three-month or the 12-month eligibility test periods.

These options are only available if you have not met the requirements for continuing eligibility because you are unemployed or underemployed, but you are available for work at covered employment in the industry with an employer who participates in this Fund. The Fund will determine whether you are available for work by verifying that you are on your Local Union's out-of-work list throughout the relevant period. **If you are retired, you will not be considered available for work.**

Self-payments must be received at the Fund Office by the due date specified on the Self-Payment/Termination Notice which will be sent to you. All notices are sent to the last known address on file at the Fund Office so **it is important that you keep the Fund Office notified of any change in your address. This is your responsibility!**

Eligibility by means of the full self-payment method described above can be continued for a **maximum** of four consecutive 3-month periods (a total of 12 consecutive months). However, if the Board of Trustees determines that the industry is suffering from an extended period of widespread unemployment, the Board may temporarily allow self-payment of contributions for more than four consecutive 3-month periods.

Each month of continuing eligibility by self-payments will reduce by one month the 18 month period available for COBRA continuation coverage, as explained later in this Section, because continuing eligibility by self-payment is an alternative offered by the Fund to COBRA.

Work Outside the Fund's Jurisdiction (Reciprocity)

The Board of Trustees of the Fund has entered into contracts known as Reciprocity Agreements that may allow employer contributions remitted on your behalf for work outside the jurisdiction of the Fund to be transferred to this Fund so that you can earn eligibility credit for coverage under this Fund. **Transfer of work hours under Reciprocity Agreements is not automatic; you must provide the other Fund with a written request and authorization to make transfers to this Fund on your behalf.** If you plan to work in the trade outside the jurisdiction of this Fund, you should contact your local union office or this Fund's Administrative Office and ask whether there is a Reciprocity Agreement that will allow transfer of employer contributions from the other Fund to this Fund for that work. You also need to request the forms you must sign to make that transfer possible.

If the hourly contribution rate paid to the other fund is less than this Fund's standard contribution rate, the hours with which you are credited will be in proportion to the contribution rate of that Fund compared to the Michigan Fund.

> ***Example***: You work out of state for one hundred and fifty (150) hours for an employer that pays contributions to a fund at three dollars ($3.00) per hour (150 x $3.00 = $450). If the out of state fund has a reciprocal agreement with the Michigan Fund and you have completed the required forms to make a transfer possible, the Michigan Fund will receive $450 on your behalf.
>
> However, $450 is what the Michigan Fund would receive if you worked 67.4 hours here ($450 ÷ $6.68 = 67.4 hours). Therefore, upon receipt of the $450 on your behalf, you will be credited with 67.4 hours of work with the Michigan Fund, instead of the 150 hours you worked out of state.

This rule may affect your eligibility. If the hours with which you are credited are reduced because you work for an out of jurisdiction employer with a lower hourly employer contribution rate, you may not meet the eligibility requirements.

Continuing Eligibility During Short Term Disability

If you become temporarily disabled and unable to work while you are eligible in this Plan, you will be allowed to continue coverage by making self-payments. You may be required to prove your continued disability by the Board from time to time, and if you do not prove your continued disability, the regular self-payment rules will immediately apply (that is, you must be registered on your Local Union's out of work list).

The self-payment amount is established by the Board of Trustees from time to time, and it can be changed by the Board at any time. The full self-payment amount is not reduced or offset by any hours you work or any contributions received during the three-month or the 12-month eligibility test periods.

Self-payments must be received at the Fund Office by the due date specified on the Self-Payment/Termination Notice which will be sent to you. All notices are sent to the last known address on file at the Fund Office so **it is important that you keep the Fund Office notified of any change in your address. This is your responsibility!**

Eligibility by means of short term disability self-payments described above can be continued for a **maximum** of four consecutive 3-month periods (a total of 12 consecutive months) or a shorter period if the Board of Trustees decides to discontinue this self-payment option.

Your eligibility under this provision shall terminate upon the first of the following to occur:

1. The end of the last coverage period for which you make a timely self-payment in the required amount;
2. The date 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 disability;
3. You refuse or fail to submit proof of continuing disability;
4. The date you are no longer disabled;
5. The date you become eligible for Medicare; or
6. The Fund no longer provides Short Term Disability coverage.

Months of coverage during short-term disability do **not** reduce the time for which COBRA is available.

Continuing Eligibility During Total and Permanent Disability

If you become totally and permanently disabled while you are eligible in this Plan and you are not eligible for Medicare, you will be allowed to continue coverage by remitting self-payments.

To be eligible to continue your coverage by self-payment based on total and permanent disability, you must be eligible for and receiving disability benefits from the Cement Masons

Pension Trust Fund – Detroit and Vicinity or the Outstate Michigan Trowel Trades Pension Fund or received a disability benefit from the Plasterers Local 67 Pension Trust Fund. You may be required to prove your continued disability by the Board from time to time. Your eligibility under this provision shall terminate upon the first of the following to occur:

1. The end of the last coverage period for which you make a timely self-payment in the required amount;
2. The date you engage in 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;
3. 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 disability;
4. The date you are no longer totally and permanently disabled;
5. The date you become eligible for Medicare; or
6. The Fund no longer provides Total and Permanent Disability coverage.

The self-payment amount is established by the Board of Trustees from time to time, and it can be changed by the Board at any time. The full self-payment amount is not reduced or offset by any hours you work or any contributions received during the three-month or the 12-month eligibility test periods.

Self-payments must be received at the Fund Office by the due date specified on the Self-Payment/Termination Notice which will be sent to you. All notices are sent to the last known address on file at the Fund Office so **it is important that you keep the Fund Office notified of any change in your address. This is your responsibility!**

These months of coverage do **not** reduce the time for which COBRA is available.

ELIGIBILITY FOR NON-BARGAINING UNIT EMPLOYEES

Individuals employed by a contributing employer(s) outside the bargaining unit ("non-bargaining unit employees" or "NBUEs") may participate in the Fund subject to the provisions of the Fund's Trust and the following rules:

- The contributing Employer must be an active employer 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 (proof of which must be provided promptly when requested by the Fund); and

3. at the Employer's option, NBUEs who only perform work in non-discriminatory classifications for the Employer.

! All NBUEs to be covered by the Fund's Plan must identified to the Fund Office at the time the Participation Agreement is signed, and the Employer must notify the Fund Office of any change in NBUEs upon whom the Employer is contributing.

Eligibility When Entering Military or Uniformed Service

If you leave covered employment to serve in the military or other uniformed services, you may elect to continue eligibility for yourself and your dependents up to 24 months by making monthly self-payments. However, your right to continue by self-payments ends if you do not begin working for a covered employer within the time set by law:

1. If you served fewer than 31 days, on the first business day after your discharge under honorable conditions;
2. If you served between 31 and 180 days, within fourteen days after your discharge under honorable conditions;
3. If you served more than 180 days, within 90 days after your discharge under honorable conditions;
4. If you are delayed due to an illness or injury caused or aggravated by your service, within 24 months after your discharge under honorable conditions.

If you serve fewer than 31 days, you and your dependents will continue eligibility without charge to you during that period. If you serve for 31 or more days, you must pay the Fund a monthly self-payment at a rate of no more than 102% of the Fund's actual cost of coverage to maintain eligibility for yourself and your dependents. Any hours you had accumulated on the date you entered military or other uniformed service will be applied to meet the Fund's eligibility requirements when you return to work.

Remember that in order for you and your dependents to be eligible for coverage while you are in the military or other uniformed service, you are **required** to notify the Fund **immediately** when you enter that service and **immediately** when you are discharged.

Eligibility for Medicare

Whether or not you or your dependent (spouse or child) is eligible for coverage under Medicare will affect both your eligibility for coverage, and the manner in which claims will be paid.

Wherever the phrase "eligible for Medicare" is used, it will apply to both:

1. Persons who are actually enrolled and participating in Medicare, and

2. Persons who are eligible to enroll and participate in Medicare.

ELIGIBILITY OF DEPENDENTS

Who is Covered: Definition of Eligible Dependent

This Plan provides medical, dental, vision and prescription drug coverage for you and your dependents when you are eligible according to the rules described in this section for active participants and you have properly completed the enrollment procedures. The Early Retiree Program provides pre-medicare coverage under the BCN policy for you and your dependents when you are eligible according to the rules described in this section for pre-medicare retirees and you have properly completed the enrollment procedures.

Your "eligible dependents" are:

- Your legal spouse.

- Your children until the end of the calendar year in which they reach age 26, as follows:

    - Your children by birth.
    - Your children by legal adoption.
    - Your children by legal guardianship, while they are in your custody and financially dependent on you.
    - Your spouse's children.

    A child may remain covered to any age if *totally or permanently disabled by either a physical or mental condition prior to reaching age 26.*

To Add a Dependent to Your Contract

When you become a participant in the Fund, your eligible dependent family members may be added to your coverage if they are identified on your initial Enrollment Form.

To add a dependent after you become a participant, you must notify the Fund Office and fill out an **Enrollment/Change of Status form.** You must notify the Fund Office within 30 days of the date any change occurs *(the date of event listed in the chart below)*, so that the Fund and BCBSM can adjust their records to include your change. **The chart below shows the coverage effective date <u>when BCBSM is notified within 30 days of the event listed</u>.** *If BCBSM is notified **more** than 30 days after the date of the event, the change you are requesting (like an addition of a dependent) could be delayed.*

When Adding...	The Dependent's Coverage Will be Effective...
Your Spouse	On the date of marriage.
Your Newborn	On the date of birth.
Your Adopted Child	Date of placement. (Placement occurs when the participant becomes legally obligated for the total or partial support of the child in anticipation of adoption.) A sworn statement with the date of placement or a court order verifying placement is required.
Legal Guardianship	Date legal guardianship is granted or when the date of petition for legal guardianship and residency is established.

To Remove a Dependent From Your Contract

When you (the participant) need to remove a dependent from your contract, notify the Fund Office and fill out an **Enrollment/Change of Status form.**

Be sure to include your group and contract numbers, the dependent's Social Security number, the date you would like the dependent removed, and the reason for removing the dependent.

See the chart below for information about removing dependents. **Remember, if a dependent child is no longer eligible, you must notify the Fund Office promptly.**

When Removing...	Because Of...	The Dependent Will Be Removed Effective...
Your Spouse	Divorce or legal separation.	On date of the divorce or legal separation.
Your Child	Reaches age 26 and is no longer eligible for coverage.	The end of the calendar year in which the child turns 26.
Your Stepchild	Divorce or legal separation from the child's parent.	On date of the divorce or legal separation.
Any Dependent	Death	First day following the date of death.

*If the Fund Office is notified **more** than 30 days after the date of the event, the change to your contract will be delayed which may cause errors when your claims are processed. Please remember to report any dependent changes to the Fund Office so these changes can be reflected*

on your records. ***Important: 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 or stepchildren, 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.* ***Also, if the Fund receives notification later than 60 days after your divorce, this may result in loss of COBRA rights.***

Qualified Medical Child Support Order

Under Federal law, the Fund must recognize qualified medical child support orders (QMCSO) mandating continuation of health care coverage for certain dependent children. A QMCSO is a court order that recognizes the right of an alternate recipient (the child) to receive benefits under the Plan. A QMCSO may not require the Plan to provide a type or form of benefit not otherwise provided to children of eligible participants. A QMCSO is usually issued in a divorce or a paternity case in which the eligible participant is ordered by the court to continue to provide medical support for their child or children, but it may also be in the form of a National Medical Support Notice (NMSN) issued by the Friend of the Court.

Legal counsel for the Fund will determine whether a document is a QMCSO. If the document is determined to be a QMCSO, the Fund will notify the participant and the custodial parent or issuing agency, as appropriate. If the document is determined not to be a QMCSO, the Fund will send a letter describing the reason for that determination. Any payment of benefits made by the Plan pursuant to a QMCSO, and notices and explanations of benefits relating to the alternate recipient will be sent to the parent(s) with physical custody.

Continuation of Eligibility for Dependents in the Event of a Participant's Death

The Fund offers coverage for dependents after your death that is an alternative to COBRA coverage. If you die while you are eligible based on work and employer contributions under this Plan, your eligible dependents may continue to be eligible as follows:

Eligibility During the Period in Progress at the Time of your Death

Eligibility for your surviving dependents will continue automatically, without any requirement for self-payment, so long as they continue to meet the definition of dependent, until the end of the last eligibility period based on your work and employer contributions received.

Continuing Eligibility by Self-Payment

After the end of the eligibility period in progress at the time of your death, your surviving dependents may elect to continue their eligibility by making self-payments until the first of the following to occur:

1. The end of the last coverage period for which your dependent(s) make a timely self-payment in the required amount;
2. The end of 12 months' coverage due to self-payments;
3. For your dependent spouse, the date the spouse remarries;
4. For your child, the date the child no longer meets the definition of dependent;
5. The date your dependent (spouse or child) becomes eligible for Medicare.

The self-payment amount is established by the Board of Trustees from time to time, and it can be changed by the Board at any time. The full self-payment amount is not reduced or offset by any hours you work or any contributions received during the three-month or the 12-month eligibility test periods.

Eligibility for surviving dependents under this self-payment provision must begin **immediately** after the end of the eligibility period due to your work and employer contributions and must be continuous. 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.** ***Coverage under this section will not be reinstated if it lapses, either initially or later, for any reason.***

REINSTATEMENT OF ELIGIBILITY

Employees

If you were once eligible under this Plan and lose that eligibility at a later date, you may be reinstated by meeting the requirements under the "Continuing Eligibility" section of these rules, provided you were ineligible for no more than 12 consecutive months. If you become ineligible for more than 12 consecutive months, then you must meet the full requirements under the "Initial Eligibility" section of these rules to become covered again.

Dependents

A dependent child who loses eligibility for reasons other than age may have eligibility reinstated on the first day of the month after the date on which the child again meets all the requirements of the dependent definition.

Hospital Confinement and Reinstatement

The effective date of any reinstated coverage as an participant or a dependent will be as determined under the rules; except that if you (or your dependent) are confined in a hospital on the date coverage would become effective, the effective date of reinstated coverage for hospital benefits will be as described under the "Initial Eligibility" section of these rules.

FAMILY AND MEDICAL LEAVE

You may be eligible for a limited number of weeks of unpaid, job protected leave for certain

family and medical reasons under the Family and Medical Leave Act of 1993. You are eligible under the Act if:

1. You are employed by an employer with at least 50 employees for at least 20 work weeks in the current or preceding year
2. You have worked for that employer for at least 12 months;
3. You have worked at least 1,250 hours during the 12 months prior to the start of the FMLA leave; and
4. You work at a location where at least 50 employees are employed at the location or within 75 miles of the location.

Leave is available for the following purposes and following time periods under the Act:

- for the birth and care of the newborn child of the employee (up to 12 weeks);
- for placement with the employee of a son or daughter for adoption or foster care (up to 12 weeks);
- to care for an immediate family member (spouse, child, or parent) with a serious health condition (up to 12 weeks);
- to take medical leave when the employee is unable to work because of a serious health condition (up to 12 weeks); or
- to permit a spouse, son, daughter, parent, or next of kin to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness (up to 26 weeks).

Your employer determines whether you are eligible for family or medical leave under the Act, not the Fund Office or the Board of Trustees.

Both you and your employer are required to notify the Fund Office if you take a family or medical leave and to provide certain other information as required by the Board. Your coverage in the Plan will continue during the period of your family or medical leave, provided your employer makes contributions to the Plan at the same rate and in the same amount as if you were continuously employed during the period of your leave and fully complies with all requirements established by the Board.

ELIGIBILITY OF PRE-MEDICARE RETIREES (RETIREE PROGRAM)

Early (pre-Medicare) retiree coverage is provided in accordance with the BCN policy.

When you retire from employment covered by this Fund, you may, if you are not yet eligible for Medicare, continue coverage for yourself and your dependents through this Plan under the Retiree Program provided you meet all of the following requirements:

1. You must be eligible in this Plan immediately before the date of your retirement; and

2. You must be eligible for, and must be receiving retirement benefits from the Outstate Michigan Trowel Trades Pension Fund, the Cement Masons Pension Trust Fund – Detroit and Vicinity or, if you were not a participant in either of those Plans, received a retirement benefit from the Plasterers Local 67 Pension Trust Fund.

If you are eligible to participate in the Retiree Program, you must declare your intent to participate immediately upon retirement. If you do not declare your intention to participate in the Retiree Program immediately upon retirement, you will not be allowed to begin participation at a later date. This is true even if you continue to be eligible under the rules applicable to active participants.

IMPORTANT: Once you or your dependents are entitled to Medicare coverage, you or your dependent are no longer eligible to participate in the Plan.

Retiree benefits do **not** include Accidental Death and Dismemberment Benefits or self-payment rights under the provisions for Continuation of Eligibility during Short-Term or Total and Permanent Disability.

Special Retiree Delayed Enrollment Due to Other Coverage

If you decline enrollment in the Retiree Program for yourself or your dependents (including your spouse) because you or they have other health coverage, you may enroll yourself and your dependents in this Plan in the future if the other coverage is lost, provided that you request enrollment within 30 days after your other coverage terminates; however, the termination of the other coverage can only be due to legal separation, death, divorce, termination of employment, or reduction of hours. You/your dependents cannot enroll if the other coverage is terminated due to failure to pay premiums or termination of coverage for cause, such as making a fraudulent claim. If you decline enrollment in the Retiree Program because you had COBRA continuation coverage under another plan, you must exhaust your COBRA coverage before you may enroll in this plan because of a loss of eligibility.

You may also enroll yourself and your dependents (including your spouse) in the Retiree Program if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided that you request enrollment within 30 days after marriage, birth, adoption, or placement for adoption.

Self-Payment of Contribution

When you become eligible for Early Retiree (Pre-Medicare) coverage, your continuing eligibility based on contributions for hours worked will first be exhausted and your coverage will continue as though you were an active participant. Once you are required to continue eligibility through self-payments, your coverage will be provided under the Retiree Program and you will be required to make monthly self-payments. The self-payment amounts required for eligibility in the Retiree Program are established by the Board of Trustees from time to time, and can be changed by the Board at any time at its sole and exclusive discretion. Self-payments must be received at the Fund Office by the due date specified on the Self-Payment/Termination Notice

sent to you. All Notices are sent to the last known address on file at the Fund Office so it is important that any address changes are reported immediately. **Keeping the Fund Office advised of your current address is your responsibility!** Reinstatement of coverage will not be permitted if you fail to pay a notice because you moved and did not advise the Fund Office.

Self-payments are due on a monthly basis and may be made in advance if so elected by the Retiree. You can also elect to have the Pension Fund deduct your self-payment from your monthly benefit check – please contact the Pension Fund to arrange this.

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

If after retiring, you return to covered employment, your coverage will continue be provided under the BCN policy. However, you may earn continuing eligibility toward that coverage under the same rules that apply to active participants, although the self-payment rates will be those that apply to the Retiree Program.

Termination of Early Retiree (Pre-Medicare) Coverage

Coverage is terminated under the Retiree Program when the first of the following occurs:

1. For your dependent child, the date on which your child no longer meets the definition of dependent;

2. For you, the date you become eligible for Medicare. The dependents of a retiree may continue coverage after the retiree becomes eligible for Medicare, provided the dependent is not also eligible for Medicare;

3. For your dependent (spouse or child), the date s/he becomes eligible for Medicare;

4. When a self-payment for coverage is not received in full or on time; or

5. When the Fund no longer provides Early Retiree (pre-Medicare) coverage.

Coverage under this section will not be reinstated if it lapses.

COBRA CONTINUATION COVERAGE

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 includes only medical, dental, vision and prescription drug coverage for you and your dependents when it is elected.

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 other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- 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 parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events.

You must notify the Plan Administrator within 60 days after the following qualifying events: divorce or legal separation of the participant and spouse or a dependent child's losing eligibility for coverage as a dependent child. The Plan may require that you provide evidence that a qualifying event has occurred, such as a complete copy of the Judgment of Divorce or a birth certificate. You must provide this notice to: Board of Trustees, Michigan Trowel Trades Health and Welfare Fund, 6525 Centurion Dr., Lansing, Michigan 48917.

How is COBRA continuation coverage provided?

Once the Plan Administrator 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. However, covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to purchase a maximum of 36 months of coverage.

However, as noted above in the section on Continuing Eligibility by Self-Payment, each month of coverage for which you made self-payments to continue your eligibility reduces the 18-month period by one month.

> Example: If you continued your coverage by self-payment for 12 months, your COBRA coverage eligibility period is reduced to 6 months.

When the qualifying event is the death of the employee, the employee's becoming eligible for Medicare Part A or B (or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage is available 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 becomes entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee is available for up to 36 months after the date of Medicare entitlement.

> Example: If you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your 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).

There are two ways in which the 18-month period of COBRA continuation coverage can be extended, which are described below.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to purchase up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability must 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 COBRA 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.**

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

For more information about extending the length of COBRA continuation coverage visit http://www.dol.gov/ebsa/publications/cobraemployee.html.

How much does COBRA Continuation Coverage Cost?

You do not have to show 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.

If elected, you must pay, and continue to pay, a monthly self-payment based on the type of coverage elected, Individual, Couple, or Family. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the Election Form is received by the Fund Office.

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.

Under What Circumstances Would COBRA Continuation Coverage Terminate?

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.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov. IN addition, the Fund offers a COBRA alternative, subsidized continuation of coverage at a monthly self-payment rate established by the Board of Trustees as discussed above.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a

new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage or the Plan's COBRA alternative coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage or the Plan's COBRA alternative coverage?

If you sign up for COBRA continuation coverage or the Plan's COBRA alternative coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage or the Plan's COBRA alternative coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though – if you terminate your COBRA continuation coverage or the Plan's COBRA alternative coverage early

without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have continued coverage under the Plan's COBRA alternative for 12 months, you may elect to continue coverage under the regular COBRA continuation coverage option at the unsubsidized rates applicable to that coverage for the remainder of the regular COBRA continuation coverage period (that is, 6 more months for a total of 18 months unless extended as explained above).

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage or the Plan's COBRA alternative coverage, you cannot, under any circumstances, switch to COBRA continuation coverage (unless you are still within the original 60-day election period) or the Plan's COBRA alternative coverage.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Fund contact information

Michigan Trowel Trades Health and Welfare Fund
6525 Centurion Dr.
Lansing, MI 48917
(517) 321-7502
(877) 876-9357 Toll Free

ELIGIBILITY APPEALS

You may appeal a denial of a claim related to an eligibility determination by writing out the

reasons for your disagreement and the facts on which you rely for your claim to benefits and mailing your appeal within 180 days of the notice of denial to the Michigan Trowel Trades Health and Welfare Fund, ATT: Appeals Committee, 6525 Centurion Drive, Lansing, MI 48917. No special form is required. Just be sure that what you have written explains your position as clearly as you can state it. You have the right to appoint someone else (such as a lawyer) to prepare and submit your appeal to the Fund. Make sure your name, the last four digits of your social security number, trade and name of the claimant (such as your spouse) are included to avoid delays in processing your appeal.

The claimant or the claimant's authorized representative on the claimant's behalf, will have the opportunity to review pertinent documents and other information relevant to the claim free of charge if you submit 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).

When a claimant's appeal is received, it will be reviewed by the Board of Trustees "de novo" (meaning "anew" and without deferring to the initial denial of your claim) and additional materials and information you submit with the appeal, if any, will also be reviewed.

The claimant, or the claimant's representative, may submit issues, comments, additional legal arguments and new information in writing consideration in the appeal. The review of the appeal will take into account all materials and information received from before the review and decision on your appeal, whether or not that information was previously submitted or considered in the initial determination on the claim.

The Board of Trustees will respond to appeals of denials of claims regarding eligibility in the following timeframes: 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 five days after the Board of Trustees' first regularly scheduled meeting following receipt of your appeal of a post-service care claim, unless your 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. (Denials of claims for benefits are addressed later in this booklet under **Your Right to Request a Review of Adverse Benefit Determination**.)

If, due to special circumstances, the Board of Trustees requires additional time to review an 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 its decision and the reasons for the decision in writing within five days after it makes its decision on your 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 of Trustees' decision was based.

The Board of Trustees has the sole and exclusive authority and discretion to interpret and to apply the rules of the Plan, the Trust and other rules and regulations of the Fund.

Under the law, this authority means that the Board of Trustees' decision shall be upheld unless the Court finds that it was arbitrary and capricious.

Please note that under the Plan, no lawsuit may be brought for benefits until all appeal rights have been fully exhausted. Any lawsuit brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of these under or relating to the Plan is barred unless the complaint is filed within three years after the right of action accrues, unless a shorter time period is established by applicable statute, regulation or case law. You should seek legal advice with respect to these requirements. Also, any action in law or equity brought by a participant or beneficiary against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to this Plan must be brought in the United States District Court where the Plan is administered.

Change of Rules

The Board of Trustees has full authority and sole and exclusive discretion to increase, reduce, or eliminate benefits, increase any self-payment amount, and change the eligibility rules and all other provisions of the Plan at any time. However, the Board of Trustees intends that the Plan terms, including those relating to coverage and benefits, are legally enforceable while they are in effect. 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.

BENEFITS

MEDICAL BENEFITS

Medical benefits under the Plan are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. Active Participants receive coverage under the Plan through the self-funded arrangement with BCBSM. Pre-Medicare retirees receive coverage under the BCN policy. Upon retirement and the exhaustion of the then earned continuing eligibility as a result of employer contributions, participants are no longer eligible for coverage under the self-funded arrangement with BCBSM.

Summaries of Active and Pre-Medicare Retiree coverage are attached as Exhibit A and B, respectively.

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, and
    - by self-payments with the exception of self-payments for COBRA continuation coverage or under the Retiree Program.
- 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.

UNDERSTANDING ACTIVE PARTICIPANT COVERAGE

This section provides information to help you understand and use your BCBSM coverage. You will find information about the following:

- What is a network provider
- What is a non-network provider
- BlueCard PPO program
- Care out of the country

Community Blue PPO is designed to provide you with the highest level of benefits and the lowest out-of-pocket costs when you choose Community Blue PPO providers. You also have the freedom to receive care from a non-network provider, but with higher out-of-pocket costs.

Network Providers

Community Blue PPO uses a network of physicians, hospitals, and other health care specialists who have signed agreements to accept BCBSM's approved amount as payment in full for covered services. When you use PPO network providers, your out-of-pocket costs for covered services are limited to your **deductible, co-insurance and co-payments**.

Here is what you need to do when you need medical care:

- Choose a provider from the Community Blue/Blue Preferred PPO Provider Directory (You can access the BCBSM Provider directory through bcbsm.com)
- Make your appointment directly with that provider

With Community Blue PPO, you do not have to choose just one provider for your care and you do not have to notify BCBSM if you decide to change physicians. Just remember to select your provider from the directory and you will stay in-network. If you would like to verify if a provider is in-network, please call the number on the back of your BCBSM ID Card.

To receive medical benefits at the in-network level, your care must be received from a Community Blue PPO provider. You do not need to use a Community Blue PPO provider for

services where there is no network available. You must, however, follow any coverage requirements outlined in this Summary or the attached Exhibit.

***Special Note for Parents of Students*:** If you have dependents attending school in Michigan, but living away from home, you should help them choose a Community Blue Preferred PPO physician near their school. If you need a statewide provider directory, please call the number on the back of your BCBSM ID Card.

Change in Network Status

Your physician is your partner in managing your health care. However, physicians retire, move, or otherwise cease to be affiliated with the PPO network. Should this happen, your physician will notify you that he or she is no longer in the PPO network. If you have difficulty choosing another physician, please contact the Customer Service office for assistance. If you wish to continue care with your current physician, a Customer Service representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

Non-Network Providers

When you receive care from a provider who is not part of the Community Blue PPO network, without a referral from a PPO provider, your care is considered out-of-network. Before choosing a non-network provider, you should verify if the service would be covered. Some services, such as your preventive care services, **are not covered out-of-network.**

If you choose to receive services from a non-network provider, you can still limit your out-of-pocket costs if the provider participates in BCBSM's Traditional plans.

If you use BCBSM participating providers outside the PPO network:

- The provider will bill Blue Cross Blue Shield directly for your services.
- You will not be billed for any differences between Blue Cross Blue Shield's approved amount and their charges.

Nonparticipating Providers

Nonparticipating providers have **not** signed agreements with BCBSM. If you receive services from a nonparticipating provider, you are usually required to pay providers directly and may be required to submit a claim to BCBSM for payment.

When you use a provider **who does not participate** with BCBSM:

- You will receive payment directly from BCBSM
- The amount you receive from BCBSM may be significantly less than the amount a nonparticipating provider charges you
- You are responsible for paying the provider
- You are responsible for any difference between BCBSM's payment and the provider's

charges.

Nonparticipating Hospitals, Facilities and Alternative to Hospital Care Providers

BCBSM coverage at nonparticipating **hospitals is limited to emergency services. Even then, you may be billed, even if referred, for the difference between the approved amount and the provider's charge.** There is no coverage for non-emergency hospital services performed by a nonparticipating hospital or for services received at nonparticipating mental health or substance abuse treatment facilities, ambulatory surgery facilities, end stage renal dialysis facilities, home infusion therapy providers, hospices, outpatient physical therapy facilities, skilled nursing facilities or home health care agencies.

In Michigan

Payment for emergency services received from a Michigan nonparticipating hospital are limited to:

- $70 per day for inpatient services in accredited general acute care facilities
- $15 per day in accredited specialty hospitals
- $25 per condition for outpatient emergency services

Outside of Michigan

BCBSM will pay its approved amount for emergency services provided by an accredited nonparticipating hospital outside of Michigan if the hospital participates with another Blue Cross Blue Shield Plan or is located in an area not served by another Blue Cross Blue Shield Plan.

BlueCard PPO Program

When you need medical care **outside of Michigan**, you can receive in-network benefits by using the BlueCard PPO program. Simply call 1-800-810-BLUE (2583) and you'll be directed to the nearest BlueCard PPO provider. BlueCard PPO providers bill their local Blue Plan for any covered services you receive. The local Blue Plan does not reduce its payments to the BlueCard PPO providers by the out-of-network deductible and/or copayments. You are responsible only for the in-network deductible and copayments (if applicable) listed in Section 4 and for services not covered by your Plan.

To take advantage of your BlueCard program, just follow these three steps:

1. Call **1-800-810-BLUE (2583)** any day of the week. You will be given the name of the nearest **PPO** physician or hospital.

2. Show your BCBSM ID card and remind the provider you are covered under the BlueCard program and to include the XYP alpha prefix on all claims.

3. Pay applicable deductibles and copayments required by your Plan.

Note: If you need emergency medical care, please seek care immediately from the nearest hospital or physician.

You will not be expected to pay out-of-network deductibles or copayments if:

- You are referred to a non-network provider by a BlueCard participating PPO provider, or
- You receive treatment for an accidental injury or a medical emergency.

Note: If you are referred to a nonparticipating provider and you are charged out-of-network deductibles and/or copayments, please call the number on the back of your BCBSM ID Card.

Important: You may need to submit itemized receipts directly to BCBSM if you receive services from a non-network provider. **The BlueCard program does not include prescription drugs, dental, vision or hearing services.**

Care Out of the Country

Your coverage applies no matter where you are only if:

- The hospital is accredited
- The physician is licensed

Most hospitals and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. When you submit your claim, tell BCBSM if the charges are in U.S. or foreign currency. Be sure to indicate whether payment should go to you or the provider. BCBSM will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, minus any deductibles or copayments that may apply.

Payment of Benefits

Your coverage consists of services and supplies for which BCBSM agrees to pay under the terms of your certificate and riders. Payable services and supplies are called "benefits," and are listed in the BCBSM certificates and riders which are available upon request, without charge.

The payment amount for these benefits is called the **approved amount**. This is the BCBSM maximum payment level allowed for the covered service. Copayments and sanctions are deducted from the approved amount. **All reference to approved amount in this book will refer to the approved amount as determined by BCBSM.**

UNDERSTANDING PRE-MEDICARE RETIREE PROGRAM COVERAGE

BCN generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, BCN designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCN Customer Service at the number provided on the back of your BCN ID card. Information on how to select a Primary Care Physician and a list of Participating Primary Care Physicians is also available at bcbsm.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BCN or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BCN Customer Service at the number provided on the back of your BCN ID card.

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits under the Plan are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. Active Participants receive coverage under the Plan through the self-funded arrangement with BCBSM. Pre-Medicare retirees receive coverage under the BCN policy. Upon retirement and the exhaustion of the then earned continuing eligibility as a result of employer contributions, participants are no longer eligible for coverage under the self-funded arrangement with BCBSM.

Summaries of Active and Pre-Medicare Retiree coverage are attached as Exhibit A and B, respectively.

You can have your prescriptions filled at a network or non-network pharmacy. The choice is always yours. Remember that when your prescriptions are filled through a non-network pharmacy, you have higher out-of-pocket costs. Also, remember that the Fund does not cover any prescriptions obtained at Wal-Mart or Sam's Club. If you or your dependents purchase a prescription at Wal-Mart or Sam's Club, you will not receive any benefit or reimbursement from the Fund, and you will be required to pay a one hundred percent (100%) of the cost, even if Wal-Mart and Sam's Club are part of the Blue Cross Blue Shield of Michigan pharmacy network.

The following participants receive prescription drug benefits as described in this Summary:

- Active Participants, including those whose eligibility is continuing as follows:
    - by working, and
    - by self-payments with the exception of self-payments for COBRA

continuation coverage or under the Retiree Program.

- 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.

DENTAL BENEFIT

Dental benefits under the Plan are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. Active Participants receive coverage under the Plan through the self-funded arrangement with BCBSM. Pre-Medicare retirees do not receive dental coverage under the BCN policy. Upon retirement and the exhaustion of the then earned continuing eligibility as a result of employer contributions, participants are no longer eligible for coverage under the self-funded arrangement with BCBSM.

Ask your dentist if he or she participates. Participation under the Dental Care Program is on a case-by-case basis. This means your dentist agrees on a "per claim" basis whether or not to accept payment directly from BCBSM for covered services. By indicating "Payment to Dentist" on the claim form, your dentist is agreeing to participate with BCBSM and accept BCBSM's payment as payment in full. You do not have to pay any additional charges. You are responsible only for your copayment and any non-covered services.

If your dentist does not choose to participate with BCBSM, the claim will be submitted indicating "Payment to Subscriber." This means that your dentist may not choose to accept the BCBSM payment in full. This means you are responsible for the difference between your dentist's charge and the BCBSM payment, including any copayments.

Summaries of Active and Pre-Medicare Retiree coverage are attached as Exhibit A and B, respectively.

The following participants receive dental benefits as described in this Summary:

- Active Participants, including those whose eligibility is continuing as follows:
    - by working, and
    - by self-payments with the exception of self-payments for COBRA continuation coverage or under the Retiree Program.
- Those whose eligibility is continuing through COBRA continuation coverage.
- 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.

VISION BENEFIT

Vision benefits under the Plan are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. Active Participants receive coverage under the Plan through the self-funded arrangement with BCBSM. Pre-Medicare retirees do not receive vision coverage under the BCN policy. Upon retirement and the exhaustion of the then earned continuing eligibility as a result of employer contributions, participants are no longer eligible for coverage under the self-funded arrangement with BCBSM.

Summaries of Active and Pre-Medicare Retiree coverage are attached as Exhibit A and B, respectively.

The following participants receive vision benefits as described in this Summary:

- Active Participants, including those whose eligibility is continuing as follows:
    - by working, and
    - by self-payments with the exception of self-payments for COBRA continuation coverage or under the Retiree Program.
- Those whose eligibility is continuing through COBRA continuation coverage.
- 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 COVERAGE

Medicare is a Federal health care program designed to provide health care benefits to persons who are 65 or older, to persons who have End Stage Renal Disease (ESRD) and to certain disabled persons. The Social Security Administration is the sole authority for determining your Medicare eligibility. If you are enrolled in this coverage, you are called a "beneficiary."

Working Persons Aged 65 or Older

When you reach age 65 and become eligible for Medicare, but are still eligible for coverage

through working, you have two options for health care coverage. You may:

1. Continue your regular current coverage as your primary health care plan, or
2. Select Medicare as your primary health care plan.

The following explains these options:

Option 1

You may continue your regular, current coverage as your primary health care plan. This is automatic unless you indicate in writing that you do not want to continue this coverage to be primary.

Important: If you continue to be covered by your Fund's plan as your primary plan, you should still apply for Medicare benefits, especially Part A.

- Part A of Medicare, the hospital insurance, is offered at no cost to you. It may provide **additional** benefits to your group coverage.

- Part B of Medicare, the medical insurance, is available for a monthly premium. If you are working at age 65, you may be able to delay enrollment in Medicare Part B, without a penalty, until you stop working. If you delay enrolling for Medicare Part B coverage when you reach age 65, you may enroll during the special enrollment period that begins on the first day of the first month in which you are no longer covered by your Fund's plan and ends two months later.

- Part D of Medicare, the prescription insurance, is available for a monthly premium. If you are working at age 65, you may be able to delay enrollment in Medicare Part D, without a penalty, until you stop working. If you delay enrolling for Medicare Part D coverage when you reach age 65, you may enroll during the special enrollment period that begins on the first day of the first month in which you are no longer covered by your Fund's plan and ends two months later.

Option 2

You may select Medicare as your primary health care plan. However, if you select this option, Federal regulations prohibit the Fund from providing you with Supplemental coverage. You must file a written notice with the Fund, with Medicare and with BCBSM if you choose this option. However, please note that contributions remitted on your behalf will continue to be retained by the Fund.

Reminder: If you have a spouse who is 65 or older and is covered under the Fund, the Fund must provide the same coverage you select to your spouse until you retire or leave employment.

Coverage for Medicare-Eligible Retirees

If you are retired and eligible for Medicare, there is no coverage offered by the Fund.

Coverage for Pre-Medicare-Eligible Retirees

If you are retired, but not yet eligible for Medicare, there is coverage offered through an insured Blue Care Network policy. The full monthly premium for that coverage is charged to the retiree who elects the coverage.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Life Insurance Benefits (Active Participants Only)

Life insurance benefits in the amount of $7,500 are payable to the beneficiary upon the death of an Active Employee (an employee who is eligible by either employer contributions or active self-payments). The Life Insurance benefit is insured with a policy issued by a commercial insurance company and is subject to all exclusions of that policy. Benefits are payable based on the policy of the commercial insurance company with which the Fund contracts. ***Where any term in this SPD conflicts with the policy issued by the commercial insurance company, the terms of the policy shall control!*** A copy of the current policy is available upon request.

Conversion Policy: A person whose eligibility for this Life Insurance Benefits has terminated may apply for a Conversion Policy. The Conversion Policy is issued by the same commercial insurance company that issues the Fund's policy, and you must apply within 31 days of the date of termination or reduction. The premium that such person will owe will be based on the standard premium rate according to the amount of insurance, class of risk, gender and age of the person. You should contact the commercial insurance company for information on this.

Benefit Termination: Your Life Insurance Benefit coverage terminates immediately when your coverage under this Plan terminates. Also, your Life Insurance Benefit coverage terminates immediately upon your coverage under COBRA or the Retiree Program.

Claims

Proof of death must be provided to the Fund Office within ninety (90) days of the date of death of the Active Employee, but in no event, other than legal incapacity, later than one year after the loss.

Accidental Death and Dismemberment Benefits (Active Participants Only)

Accidental death and dismemberment benefits in the principal sum of $7,500 are payable to the beneficiary upon the death of an Active Employee (an employee who is eligible by either

employer contributions or active self-payments). The Accidental Death and Dismemberment benefit is insured with a policy issued by a commercial insurance company and is subject to all exclusions of that policy. Benefits are payable based on the policy of the commercial insurance company with which the Fund contracts. ***Where any term in this SPD conflicts with the policy issued by the commercial insurance company, the terms of the policy shall control!***

The Fund pays the percentage of the principal sum shown below if you are injured and that injury results in any of the losses listed below. The loss must occur within 365 days of the accident that caused the injury. If you suffer more than one loss as a result of any one accident, only one amount, the largest, will be paid.

For Loss of:	Percentage of Principal Sum:
Life ……	100%
Both hands or both feet	100%
Sight of both eyes.....	100%
One hand and one foot	100%
One hand or one foot and sight of one eye	100%
Speech and hearing in both ears	100%
One hand or one foot	50%
Sight of one eye	50%
Speech or hearing in both ears	50%
Hearing in one ear	25%
Thumb and index finger of same hand	25%

Claims

Proof of loss must be provided to the Fund Office within 90 days of the loss or as soon as reasonably possible, but no later than one year after the loss except in cases of legal incapacity.

Beneficiary

As used in this Section, "Beneficiary" means the person or persons designated to receive any life insurance benefits under this Plan or any accidental death and dismemberment benefits not payable to the Active Employee under this Plan. The designation of a Beneficiary shall be initially made by the Employee when he completes an Enrollment Form or Participant Data Card with the Fund Office.

Any participant may designate a Beneficiary or change his designated Beneficiary at any time, without consent or knowledge of the Beneficiary, by filing with the Fund Office a new, completed Participant Data Card. A change of Beneficiary will be effective upon receipt in the

Fund Office of the newly completed Participant Data Card.

Participants who once were but now are no longer married should be certain to change their Participant Data Card. Otherwise, their benefit could be paid to an unintended person, such as a former spouse.

If no Beneficiary has been designated, any benefits payable upon the death of a participant will be paid to his surviving legal spouse. If there is no surviving legal spouse, benefits are paid to his surviving children. If there are no surviving children, benefits are paid to his surviving parents. If there are no surviving parents, benefits are paid to his surviving brothers and sisters. If there are no surviving brothers and sisters, benefits are paid to the estate of the deceased participant or, if there is no estate to be probated, to the person who delivers to the Fund a sworn Affidavit of Decedent's Successor for Delivery of Certain Assets Owned by Decedent with respect to the latter of the two to die in accordance with MCL §§700.3983-700.3984.

If the benefits are payable to the participant's estate, or if any payee is a minor or otherwise not competent to give a valid release for the payment, up to $5,000 may be paid to any relative of the payee who is deemed to be entitled to payment.

If claims related to Life Insurance and Accidental Death and Dismemberment Benefits are denied, the commercial insurance carrier will notify you of the denial and their appeal process.

CLAIMS APPLICATIONS, LIMITS AND APPEALS

APPLYING FOR BENEFITS

When you use your benefits, a claim must be filed before payment can be made. Most providers will submit claims to the Fund for payment for 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.

Filing a claim

To file your own claim, follow these steps:

1. Ask the provider for an itemized statement or receipt with the following information:

    - Patient's full name (no nicknames)
    - Participant's name and contract number (from your ID card)
    - Provider's name, address, phone number and federal tax ID number

- Provider's charge for each service
- Date and description of services
- Diagnosis (nature of illness or injury)
- Admission and discharge dates for hospitalization

  Note: If you receive care out of the country, try to get all receipts itemized in English. Cash register receipts, canceled checks or money order stubs may accompany your itemized receipts, but may not substitute for an itemized statement.

2. Make a copy of all items for your files, and send the originals to BCBSM if you are active or BCN if you are a Retiree. It is important that you file your claims promptly because most services have claims filing limitations.

All non-medical claims should be submitted to the Fund Office with all relevant information. Contact the Fund Office if you have questions.

TIME LIMIT FOR CLAIMS FILING AND LITIGATION

If you submit claims directly to BCBSM or BCN, they require that claims be submitted within 12 months. The Fund requires that all claims for Life Insurance and Accidental Death and Dismemberment Benefits be submitted within **90 days** of the date of the death or loss. After these time limits have passed, the Fund is no longer obligated to pay or reimburse the amount of the claim.

Any action in law or equity brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing is barred unless the complaint is filed within the earlier of three years from the date the incorrect information was first reported or the date the claim was first submitted; however, you must first go through the Fund's claim and appeal process before you can bring a suit in Court.

DENIAL OF CLAIMS

If your claim is denied by the Fund Office, you will be notified with the specific reason for denial within 30 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 BCBSM or another Fund service provider, you will be informed of the reason for the denial on the "Explanation of Benefits" you receive. 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 and in the EOB for appealing a denial of your benefit claim.

If claims related to Life Insurance and Accidental Death and Dismemberment Benefits are denied, the commercial insurance carrier will notify you of the denial and its appeal process.

The Fund will notify you when additional time is needed to process claims (other than claims administered by BCBSM, a commercial insurance carrier providing Life Insurance or Accidental Death and Dismemberment Benefits, or another Fund service provider). If the Fund's denial or delay in processing your claim is due to missing information or a missing signature, you should supply the information directly to the service provider for rebilling. 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

Every effort is made to process your claims promptly and correctly. If your claim for benefits or eligibility is denied in whole or in part, BCBSM, the Fund Office, or the commercial insurance carrier will notify you of the denial in writing. To appeal the denial or payment, you must follow those steps.

A. Appeals Regarding Prescription Drug, Medical, Hospital and Surgical Benefits

Most questions or concerns about decisions BCBSM makes on claims or requests for benefits can be resolved through a phone call to one of BCBSM's Customer Service Representatives. You can locate the phone number on your Explanation of Benefits statement, in the letter BCBSM sends to notify you that BCBSM has not approved a request for benefits or on the back of your ID card.

In addition, the Employee Retirement Income Security Act of 1974, as amended (ERISA) claims procedure regulations protect you by providing you the opportunity to request review of an adverse benefit determination.

An adverse benefit determination is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on your eligibility to participate in the Michigan Trowel Trades Health and Welfare Fund. You should request review of adverse benefit determinations by BCBSM on a pre-service claim, an urgent care claim, or a post-service claim directly to BCBSM, except denials based on your eligibility to participate in the Fund, in which case you should direct your request for review to the Fund Office.

"Pre-service claim" means a claim for a benefit where your plan conditions receipt of the benefit, in completely or in part, on obtaining approval in advance of receiving medical

care.

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

A claim will be found to be one involving urgent care in one of two ways. If a physician with knowledge of your medical condition determines that the claim is one involving urgent care, BCBSM will treat it as such. Absent a determination by your physician, BCBSM will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

"Post-service claim" means all other claims that are not "pre-service claims" or "urgent care claims."

To obtain review of an adverse benefit determination, you must follow the review procedures below. These procedures vary, depending on whether you are asking for review of a decision on a pre-service, a post-service, or an urgent care claim.

With the exception of requests for review of adverse benefit determinations involving urgent care claims, which may be made orally, all requests for review must be in writing and submitted to BCBSM at 600 E. Lafayette Blvd., Mail Code CS3A, Detroit, Michigan 48226-2998 or by facsimile to 1-877-348-2210. Normally, for all three types of claims, you must exhaust BCBSM's internal review procedure before you can initiate a civil action under section 502(a) of ERISA to obtain benefits.

Review Procedure – Post-service claims

Under the review procedure for post-service claims, you are entitled to a two-step appeal process. BCBSM must provide you with a written determination within 30 calendar days of BCBSM's receipt of your written requests for review at each level.

The review procedure for post-service claims provides two levels of review:

1. To initiate level 1 review, you or your authorized representative must send BCBSM a written statement explaining why you disagree with BCBSM's determination. Please include in your request all documentation, records, or comments you believe support your position. You must request review no later than **180 calendar days after you receive BCBSM's decision on your claim for benefits**. Mail your written request for review to the address found in the top right hand corner of the first page of your Explanation of Benefits

statement, or to the address contained in the letter BCBSM sends you to notify you that BCBSM has not approved a benefit or service you are requesting. BCBSM will respond to your request for review in writing within 30 days. If you agree with BCBSM's response, it becomes BCBSM's final determination and the review ends.

2. If you disagree with BCBSM's response to your request for review at level 1, you may then proceed to level 2, which is an external review. You must request review at level 2 in writing no later than 30 calendar days after you receive BCBSM's determination at level 1.

   Mail your request to the address specified in the letter BCBSM sends you to notify you BCBSM has not approved your appeal at level 1.

   Again, please provide all documentation, records, and comments that you feel support your position. You will receive a written determination within 30 days of receipt of your request for review at level 2. The written determination at level 2 will be the final internal determination regarding your request for review.

3. If you disagree with the final determination, or if the determination at each level is not issued within the 30-day time frame or the review procedures for level 1 or level 2 are otherwise not complied with, you may be able to request an external review of your claim by an independent third party. To the extent your claim is eligible for external review, that process will be explained on the appeal denial letter you receive.

4. After you exhaust the internal review process, you also have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.

Review Procedure – Pre-service claims

1. The review procedure for pre-service claims is identical to the review procedure for post-service claims, except that BCBSM must provide you with written determinations within shorter time frames. Appeals of pre-service claims are also handled in a two-step process. A determination will be issued within 15 calendar days of receipt of your request for a level 1 review, and within 15 calendar days of your request for a level 2 review, external review. You still have 30 days after receipt of the level 1 determination to file your level 2 appeal.

2. If you disagree with the final determination, or if the determination at each level is not issued within the 15-day time frame or the review procedures for level 1 or level 2 are otherwise not complied with, you have the right to bring

a civil action under section 502(a) of ERISA to obtain your benefits.

Review Procedure – Urgent care claims

The review procedure for urgent care claims is as follows:

1. You or your physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call customer service.

2. BCBSM must provide you with BCBSM's decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review. All necessary information, including BCBSM's decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile, or other available similarly expeditious method. If BCBSM's decision is communicated orally, BCBSM must provide you or your authorized representative with written confirmation of BCBSM's decision within two business days.

3. If you disagree with BCBSM's final determination, or if BCBSM fails to issue its determination within 72 hours, or otherwise fails to comply with the review procedures, you have the option to bring a civil action under section 502(a) of ERISA to obtain your benefits.

In addition to the information found above, the following requirements apply to review of pre-service, post-service, and urgent care claims:

- You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal review procedure.

- No fees or costs may be imposed as a condition to requesting review.

- Although there are set timeframes within which you must receive BCBSM's final determination on all three types of claims, you have the right to allow BCBSM additional time if you wish.

- You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

- You may submit written comments, documents, records, and other information relating to your claim for benefits, and this information will be considered even if it was not submitted or considered in the initial benefit determination.

- The person who reviews your adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The determination on review will be a new determination; the initial determination on your claim will not be afforded deference on review.

- If your request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.

- Upon request, the medical experts whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination.

- On review, you will be advised of the specific reason for an adverse determination with reference to the specific plan provisions on which the determination is based.

- If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol, or other similar criterion free of charge upon request.

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

- If your health plan provides for any voluntary appeal procedures beyond the level 2 review, external review, you will be advised of those procedures in the level 1 response.

Appeals regarding Life Insurance and Accidental Death and Dismemberment Benefits

Appeals of denials of claims related to Life Insurance and Accidental Death and Dismemberment Benefits should be directed to the commercial insurance carrier, unless they concern eligibility for coverage as determined under the Plan, in which case such denials must be appealed to the Board of Trustees.

Appeals Regarding Eligibility Matters

You or your family member ("claimant") may appeal a denial of any claim based on eligibility within 180 days of the notice of denial to the Board of Trustees, Michigan Trowel Trades Health and Welfare Fund, 6525 Centurion Drive, Lansing, MI 48917. 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 what the claimant has written 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 Board of Trustees. Make sure your name, the last four digits of your social security number, your trade, your union and the name of the claimant if different from you (such as your spouse or child) 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 Board's review of the appeal will take into account all materials and information received before the review and the Board's 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 (which means "anew" and without deference to the original determination) and it will review the additional materials and information submitted, if any.

The claimant may request a personal appearance before the Trustees, which they may grant or deny at their sole and exclusive discretion. Such a request must be made in writing. The claimant may designate someone of his choice to represent him or her at such an appearance at his own expense.

The Board of Trustees will respond to appeals of denials of claims 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. (Denials of claims for benefits administered by BCBSM are addressed in the prior section.)

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 its decision and the reasons therefor in writing within 5 days after it makes its 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.

The Board of Trustees has the sole and exclusive discretion to interpret and to apply the rules of the Plan, the Trust, and other rules and regulations.

Please note that under the law, no action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of these under or relating to the Plan is barred unless it is brought within ***three years*** after the first date the participant receives a determination of his rights and/or benefits under the terms of the Fund's Plan, unless a shorter period is established by applicable statute, regulation or case law. Also, any action in law or equity brought by a participant or beneficiary against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to this Plan ***must be brought in the United States District Court where the Plan is administered.***

You should seek legal advice with respect to these requirements.

CIRCUMSTANCES THAT CAN RESULT IN DENIAL OF OR LOSS OF BENEFITS

The Board of Trustees or its representatives have the authority to deny payment for claims, and the reasons for denial may include, but are not limited to, one or more of the following:

- The person receiving the services or seeking the benefit was not eligible for the specific benefit sought and/or any benefit under the Plan when the expense was incurred.

- The claim was not received by the Fund within the applicable time limit.

- The expense was for services not covered by the Fund or the expense was not actually incurred.

- The person for whom the claim was filed already received the maximum benefit for the type of benefit.

- The person for whom the claim was filed had not yet satisfied all required deductibles and percent co-payment requirements imposed by the Fund.

- The person for whom the claim was filed (or another person on their behalf) 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).

- Another entity was primarily responsible for paying benefits (see the Fund's rules on coordination of benefits, below).

- Eligibility rules were changed, coverage was eliminated, or the benefit was reduced or discontinued by action of the Board of Trustees before the services were received.

- The Fund was terminated.

The above list does not list 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, and be certain to review the section above regarding Appeals to avoid loss of rights.

ADDITIONAL ADMINISTRATIVE MATTERS

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.

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, or its delegate, 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 a participant 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

Please note that under the law, no action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of these under or relating to the Plan is barred unless it is brought within ***three years*** after the first date the participant receives a determination of his rights and/or benefits under the terms of the Fund's Plan, unless a shorter period is established by applicable statute, regulation or case law. Also, any action in law or equity brought by a participant or beneficiary against the Fund, the Board of Trustees, any of the Trustees individually, or any agent of any of the foregoing under or relating to this Plan ***must be brought in the United States District Court where the Plan is administered.***

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 immediately. The Fund, through its collections committee, and/or OPCMIA Local 514 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.**

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

Coordination of Benefits, or COB, is how health care carriers coordinate benefits when you are covered by more than one group health care plan. Under COB, carriers work together to make sure you receive the maximum benefits available under all health care plans. Your health care plan requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans. COB ensures that the level of payment, when added to the benefits payable under another group plan, will cover up to 100 percent of the eligible expenses as determined between carriers. In other words, COB can reduce or eliminate health care plan out-of-pocket costs for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for your care.

<u>How COB works</u>
If you are covered by more than one group plan, COB guidelines determine which carrier pays for covered services first.

- Your primary plan is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.

- Your secondary plan is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by both carriers.

  Note: To the extent that the services covered under your health care plan are also covered and payable under another group health care plan, BCBSM will combine the BCBSM payment with that of the other plan(s) to pay the maximum amount BCBSM would routinely pay for covered services.

Guidelines to determine primary and secondary plans
The following guidelines are used to determine which carrier pays first:

Contract Holder Versus Dependent Coverage
The plan that covers the patient as the employee (participant or contract holder) is primary and pays before a plan that covers the patient as a dependent.

Contract Holder (Multiple Contracts)
If you are the contract holder of more than one health care plan, your primary plan is the one for which you are an active member (such as an employee or participant), and your secondary plan is the one for which you are an inactive member (such as a retiree).

Dependents (The "Birthday Rule")
If a child is covered under both the mother's and father's health care plan, the plan of the parent (or legal guardian) whose birthday (month and day only) is earlier in the year is primary. If the parents' birthdates are identical, the plan that has covered the dependent longest is primary.

Children of Divorced or Separated Parents
If the child's parents are divorced, separated or never married, benefits will be paid according to any court decree. If no such decree exists, benefits are determined in the following order unless a court order places financial responsibility on one parent:

1. Custodial parent (physical custody)

2. Custodial stepparent (if remarried)

5. Non-custodial parent

6. Non-custodial stepparent (if remarried)

If the primary plan cannot be determined by using the guidelines above, then the "Birthday Rule" will be used to determine primary liability.

Filing secondary COB claims

In most instances when you go to a BCBM participating provider, your provider will bill the primary and secondary carrier directly. However, if you receive services from a non-participating provider, and the provider will not file your claim, you will need to file.

Ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or your provider can then submit the claim along with the primary carrier's payment statement to BCBSM. When you submit claims to BCBSM for payment of the balance, follow these steps:

1. Obtain an EOB from the primary carrier. Make sure the EOB matches the receipts being submitted.

2. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.

3. If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.

4. Make sure the provider's name and complete address are on all receipts.

    a. If the provider's office is in Michigan, include the provider's BCBSM Provider Identification Number (PIN).

    b. If the provider's office is located outside of Michigan, include the provider's tax ID number.

7. Keep copies of all statements, receipts and forms for your personal files. Enclose the original billing statement with your claim form.

8. Mail all claims and receipts to:

    Blue Cross Blue Shield of Michigan
    COB Department
    600 East Lafayette – Mail Code 0526
    Detroit, MI 48226-2998

Important: If any required information is missing, claims processing may be delayed.

Updating COB information is your responsibility.

You can avoid claims-processing delays if you keep your COB information updated. View your current COB information online. Go to bcbsm.com and log in to Member Secured Services. If there are any changes in coverage information for you or your dependents, notify the Fund Office immediately. Blue Cross Blue Shield of Michigan may periodically ask you to update your COB information through a letter of inquiry. Please help BCBSM serve you better by responding to requests for COB information quickly.

SUBROGATION AND REIMBURSEMENT

The Fund's contract with BCBSM contains subrogation language that delegates to BCBSM the responsibility to recover the Fund's payments from responsible third parties. If you file a lawsuit or an insurance claim, or if there is a settlement, subrogation allows the Fund to hold a party that caused an injury to be responsible for payment of the medical expenses related to the injury.

> Example: A participant is injured in a store, or other commercial property, due to negligence on the part of the store or property. The Fund pays for the services to the injured person, as required by the Plan. Later, the participant sues the store. The BCBSM subrogation unit would attempt to recover the money paid for medical services related to the injury in that lawsuit.

This is the Fund's right of recovery. The Fund is entitled to its right of recovery even if you are not "made whole" for all of your damages in the money you receive. The Fund's right of recovery is not subject to reduction of attorney's fees, costs, or other state law doctrines such as common fund.

The types of cases of third party responsibility BCBSM generally pursues fall into the following categories:

- Workers' compensation
- Personal injury
- Medical malpractice

In the event that you are injured and a third party is responsible:

- Your right to recover payment from the third party is transferred to the Fund.
- You are required to do whatever is necessary to help the Fund enforce its right of recovery.
- If you receive money through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse the Fund. However, this does not apply if the

recovery you receive is from additional coverage you purchased in your name from another insurance company.

You agree to:

- Cooperate and do what is reasonably necessary to assist the BCBSM subrogation unit in the pursuit of the Fund's right of recovery.

- Not take action that may prejudice the Fund's right of recovery.

- Permit the BCBSM subrogation unit to initiate recovery on your behalf if you do not seek recovery for illness or injury.

- Contact the BCBSM subrogation unit promptly if you seek damages, file a lawsuit, file an insurance claim or demand, or initiate any other type of collection for your illness or injury.

- Provide updates both periodically and at BCBSM's request, regarding the status of any third party recovery matters.

- Upon resolution or settlement of any a lawsuit, insurance claim or demand, or any other type of collection, you or your attorney must notify the Fund no more than three business days after such resolution or settlement has been reached. Upon notification of a settlement or proposed settlement, the Fund or the BCBSM subrogation unit will provide a final subrogation lien total as soon as practicable.

- Upon receipt of a recovery from a third party, you or your attorney must hold the entire amount in a trust account so that the recovery proceeds are segregated from your and your attorney's general assets until the Fund has been reimbursed up to the amount of benefits the Fund has paid. You *may not* comingle the recovery proceeds with your general assets or spend such proceeds until any disputes regarding the amount due of the Fund's right of recovery have been resolved and final payment is disbursed to the Fund.

Please remember that if you hire an attorney to represent you in such a situation, you should always have your attorney call BCBSM at (517) 322-8177.

The Fund and/or BCBSM may pursue a claim against you (or your beneficiaries) and your attorney/representative if any of the following occur:

- Notice of settlement is not provided to the Fund within three (3) business days of resolution between the parties; or

- The proceeds of the settlement or resolution are comingled with (i.e., not segregated from) your general assets; or

- You spend any portion of the proceeds prior to reimbursing the Fund and/or BCBSM for benefits it paid that are related to the underlying cause of action.

The Fund and/or the BCBSM subrogation unit may:

- Seek first priority lien on proceeds of your claim in order to fulfill the Fund's right of recovery.

- Request you to sign a subrogation and/or reimbursement agreement.

- Delay the processing of your claims until you provide a signed copy of the subrogation and/or reimbursement agreement.

- Offset future benefits to enforce the Fund's right of recovery.

The Fund will pay the costs of any covered services you receive that are in excess of any recoveries made.

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.

LEGAL NOTICES

ERISA RIGHTS

As a participant in the Michigan 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 participants shall be entitled to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and the union hall, all documents governing the Fund, including insurance contracts and collective bargaining agreements, and copies of all documents filed by the Fund with the United States Department of Labor, such as detailed annual reports (Form 5500 Series) and Plan descriptions.

- Obtain copies of all Fund documents and other Fund 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.

- Receive a summary of the Fund's annual financial report. The Board of Trustees is required by law to furnish each participant with a copy of this summary annual report.

- 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 pages 32-38 of this summary plan description and other Plan documents on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of the exclusionary periods of coverage for preexisting conditions in a group health plan, if you have creditable coverage from 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 preexisting 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 contributing 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 or ignored, in whole or in part, you have a right to know why and to receive a written explanation of the reason for the denial, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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 that 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 in care of the Fund Office, 6525 Centurion Drive, Lansing, Michigan 48917, (517) 321-7502. 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 (EBSA), 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 (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA), (866) 444-EBSA (3272).

You can read the materials listed above by making an appointment at the Fund Office during normal business hours. Also, 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 SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). "Loss of eligibility" includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It does not include a loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim. However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at Outstate Michigan Trowel Trades Health and Welfare Fund, 6525 Centurion Drive, Lansing, MI 48917.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you 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 lymphedemas, in a manner determined in consultation with the attending provider and the patient.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, contact the Fund Office at Outstate Michigan Trowel Trades Health and Welfare Fund, 6525 Centurion Drive, Lansing, MI 48917.

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.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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.

The Michigan Trowel Trades Health and Welfare Fund ("Plan") is 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.

The Plan is also required to give you this Notice regarding:

1) the Plan's uses and disclosures of Protected Health Information ("PHI")
2) your privacy rights with respect to your PHI;
3) the Plan's duties with respect to your PHI;
4) your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and
5) the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic) and, when applicable, includes "genetic information." De-identified information, which does not identify an individual and that cannot reasonably be expected to be used to identify an individual, is not PHI.

This Notice and its contents are intended to conform to the requirements of HIPAA. Please be advised that other entities that provide services to you related to your participation in the Plan have issued or may issue separate notices regarding disclosure of PHI that is maintained on the Plan's behalf by those entities.

How the Plan May Use and Disclose PHI About You

The following categories describe different ways that the Plan uses and discloses PHI. Not every use or disclosure in each category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories. Except for the purposes described in the categories below, we will use and disclose PHI only with your written authorization. You may revoke such authorization at any time by writing to the Plan's Privacy Officer.

Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

For Payment. The Plan may use and disclose PHI about you for payment purposes such as 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, the Plan may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. The Plan may also share PHI with a utilization review or precertification service provider. Likewise, the Plan may share PHI with another entity to assist with the coordination of benefit payments.

For Health Care Operations. The Plan may use and disclose PHI about you for Plan

operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use PHI 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. The disclosure of PHI that is genetic information for underwriting purposes is prohibited and the Plan will not disclose any of your genetic information for such purposes.

To Inform You About Treatment, Treatment Alternatives or Other Health Related Benefits. The Plan may use your PHI for treatment purposes and other related benefits. The Plan may use your PHI 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, or (4) recommended alternative treatments, therapies, health care providers, or settings of care. For instance, the Plan may forward a communication to a participant who is a smoker regarding a smoking-cessation program.

For Disclosure to the Fund's Board of Trustees. The Plan may disclose your PHI to the Plan's Board of Trustees (Plan Sponsor) for plan administration functions performed by the Plan Sponsor on behalf of the Plan including, but not limited to, reviewing appeals. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or for modifying, amending or terminating the group health plan. "Summary health information" is information that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with federal regulations.

Business Associates. The Plan may disclose PHI to its business associates that perform functions on the Plan's behalf or provide the Plan with services if the information is necessary for such functions or services. For example, the Plan may use another company to perform billing services on its behalf. All of the Plan's business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in their agreement with the Plan.

Other Uses and Disclosures for Which Consent, Authorization or Opportunity to Agree or Object is Not Required

When Legally Required. The Plan will disclose your PHI when it is required to do so by any federal, state or local law.

For Public Health Activities. The Plan may disclose your PHI 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.

For Reporting Abuse, Neglect or Domestic Violence. The Plan may disclose your PHI when required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

To Conduct Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, the Plan may not disclose your PHI 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, the Plan may disclose your PHI 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 the Plan receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to you of the request or, if such assurance is not forthcoming, if the Plan has made a reasonable effort to notify you about the request or to obtain an order protecting your PHI.

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your PHI to a law enforcement official for certain law enforcement purposes, including the reporting of certain types of wounds, upon the request of a law enforcement official for locating a suspect, fugitive, material witness, missing person, or crime victim, to report a death, to report a crime on the premises and to report a crime in a medical emergency. A disclosure of information about an individual who is or is suspected to be a crime victim may be made only if a) the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances, b) the law enforcement official represents that the information is not intended to be used against the individual and the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and c) the Plan determines disclosure is in the best interest of the individual as determined by the exercise of its best judgment.

To Coroners, Medical Examiners and Funeral Directors. The Plan may release PHI 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, the Plan may release PHI to organizations that handle organ procurement or transplantation.

For Research. The Plan may disclose your PHI for research subject to certain conditions regarding the manner in which the research is conducted.

In the Event of a Serious Threat to Health or Safety. The Plan may disclose your PHI 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 when consistent with applicable law and standards of ethical conduct and the Plan in good faith believes such use or disclosure is necessary.

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

For Workers' Compensation. The Plan may release your PHI to the extent necessary to comply with laws related to workers' compensation or similar programs.

Other Uses and Disclosures

The Plan will not (1) supply confidential information to another entity for its marketing purposes in violation of the privacy regulations, or (2) sell your confidential information in violation of the privacy regulations.

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to the Plan will be made only if you provide a written authorization.

The Plan asks you to complete an authorization form if you would like someone, such as a spouse, to be able to have access to your PHI.

If you provide the Plan with written authorization to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures that the Plan has already made with your permission.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

You have the following rights:

The right to request restrictions or limitations on the PHI the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family

member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. The Plan is not, however, required to agree to your request with the exception of a request for a restriction of a disclosure of PHI pertaining solely to a health care item or service for which the health care provider involved has been paid out of pocket that is for purposes of carrying out payment or health care operations (and not for the purposes of carrying out treatment).

To request restrictions, you must make your request in writing to the Plan's Privacy Officer. In your request, you must tell the Plan (1) what information you want to limit, (2) whether you want to limit the Plan's use, disclosure or both; and (3) to whom the limits apply.

The right to request to receive confidential communication of your PHI by an alternative means or at an alternative location if a disclosure of your PHI could endanger you. The request must be made in writing to the Plan'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. The Plan does 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 in your Designated Record Set for inspection and/or copying. If the information you request is in an electronic health record, you may request that these records be transmitted electronically. Your request for access to documents with your PHI must be in writing to the Plan's Privacy Officer. When a request for access is accepted (in whole or in part), you will be notified of the decisions and you may then inspect the PHI, copy it, or both, in the form or format requested at a time and place convenient to you and the Plan. If you would like, you may receive a summary of the requested PHI instead of your entire record, for a reasonable fee. You may also receive a copy of your PHI by mail if you prefer. (The Plan charges 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 PHI or for processing the participant's request for access.)

If a request for access is denied (in whole or in part), the Plan will grant access to PHI for which there are no grounds to deny access. The Plan will also 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 the Plan and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, the Plan 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 PHI if it is inaccurate or incomplete. You may request that your PHI be amended. That request must be in writing to the Fund's Privacy Officer and include a reason why your PHI should be amended. If you do not include a reason, the Plan will

not act on the request. When a request for amendment is accepted (in whole or in part), the Plan will inform you that your request for amendment has been accepted. The Plan 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 Plan does business who may rely on the disputed PHI to your detriment. The Plan will identify the record(s) that are the subject of the amendment request and will append the amendment to the record.

If 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 Plan, 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 the Plan provide the request for amendment and the denial in any future release of the disputed PHI, and how to file a complaint with the Plan or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, the Plan may write a rebuttal statement and will provide a copy to the participant, and the Plan will include the request for amendment, denial letter, statement of disagreement, and rebuttal (if any), with any future disclosures of the disputed PHI. If you do not choose to write a statement of disagreement with the denial decision, the Plan is not required to include the request for amendment and denial decision letter with future disclosures of the disputed PHI unless you request the Plan to do so. When the Plan receives notification that your PHI has been amended, the Plan will ensure that the amendment is appended to your records, and will inform entities with whom it does business that may use or rely on your PHI of the amendment and require them to make the necessary corrections.

The right to obtain an accounting of disclosures of your PHI. 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 (vendors), (2) to an individual (or personal representative) about his or her own PHI, (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 and (8) to correctional institutions or law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to the Plan'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 reasonable, cost-based fee may be charged. The Plan 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.

You also have the right to an accounting of disclosures of electronic health records for purposes of payment, treatment and health care operations. The right to such an accounting depends on

whether the Plan maintains such electronic health records and, if so, when the electronic health records were acquired by the Plan and when the disclosure occurred.

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 Plan'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.

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- a birth certificate identifying the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

LEGAL DUTIES OF THE MICHIGAN TROWEL TRADES HEALTH AND WELFARE FUND REGARDING YOUR HEALTH INFORMATION

The Plan is required by law to maintain the privacy of your PHI as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. If your PHI is improperly accessed, acquired, used, or disclosed, the Plan will notify you, as required by law. That notification may include a description of what happened, the information involved, and the steps you can take to protect yourself.

The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI the Plan has about you as well as any information the Plan receives in the future. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

Minimum Necessary Standard

When using, disclosing or requesting PHI, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or

otherwise as necessary, to the minimum necessary information to accomplish the intended purpose. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual or pursuant to an authorization;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

YOUR RIGHT TO FILE A COMPLAINT

You have the right to express complaints to the Michigan 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 Michigan Trowel Trades Health and Welfare Fund should be made in writing to the Fund's Privacy Officer. The Michigan 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.

FOR MORE INFORMATION CONTACT THE PRIVACY OFFICER

For questions about this Notice, to exercise your privacy rights, or to file a complaint, contact the Plan's Privacy Officer, Michigan Trowel Trades Health and Welfare Fund, 6525 Centurion Drive, Lansing, Michigan 48917-9275 – (517) 321-7502.

SOCIAL SECURITY NUMBER PRIVACY POLICY

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.

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MICHIGAN TROWEL TRADES
A0SAN2
42272000
0070044980005
Community Blue PPO℠ ASC
Effective Date: On or after January 2017
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services***.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - Select specialty pharmaceuticals do not require preauthorization.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-network	Out-of-network
Deductible	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance abuse services that are equivalent to an office visit and performed in an in-network physician's office.	$2,000 for one member, $4,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $20 copay for office visits and office consultations • $20 copay for online visits • $20 copay for chiropractic and osteopathic manipulative therapy • $150 copay for emergency room visits • $20 copay for urgent care visits	• $150 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance abuse treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance abuse treatment • 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$7,150 for one member, $14,300 for the family (when two or more members are covered under your contract) each calendar year	$13,700 for one member, $27,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity	Not Covered

Benefits	In-network	Out-of-network
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not Covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not Covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not Covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not Covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$20 copay per office visit	60% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	$20 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	$20 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	$20 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$150 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible Unlimited days	60% after out-of-network deductible
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	80% after in-network deductible Limited to a maximum of 120 days per member per calendar year.	80% after in-network deductible

Benefits	In-network	Out-of-network
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	80% after in-network deductible	60% after out-of-network deductible
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health or substance abuse service is considered by BCBSM to be comparable to an office visit, we will process the claim under your office visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	

Benefits	In-network	Out-of-network
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities **only**
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse treatment - in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not Covered	Not Covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not Covered	Not Covered
Other covered services, including mental health services, for autism spectrum disorder	Not Covered	Not Covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay per visit	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible

Benefits	In-network	Out-of-network
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MICHIGAN TROWEL TRADES
A0SAN2
42272000
0070044980005
BCBSM Preferred RX Program
Effective Date: On or after January 2017
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay $15 copay	You pay $15 copay	You pay $15 copay	You pay $15 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $30 copay	No coverage	No coverage
	84 to 90-day period	You pay $30 copay	You pay $30 copay	No coverage	No coverage

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $30 copay	You pay $30 copay	You pay $30 copay	You pay $30 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $60 copay	No coverage	No coverage
	84 to 90-day period	You pay $60 copay	You pay $60 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $60 copay	You pay $60 copay	You pay $60 copay	You pay $60 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $120 copay	No coverage	No coverage
	84 to 90-day period	You pay $120 copay	You pay $120 copay	No coverage	No coverage

Note: 100% copayment on all covered prescription drugs purchased from a Sam's Club Pharmacy or a Walmart Pharmacy. * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	Not covered	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/ coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Over-the-counter drugs	Excludes benefits for certain over-the-counter drugs.
Dosage and quantity of drugs	Your prescription drug coverage has eliminated authorization requirements for select prescription drugs, and dosages and quantities of drugs.

MICHIGAN TROWEL TRADES
A0SAN2
42272000
0070044980005
Dental Coverage
Effective Date: On or after January 2017
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Network access information
With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**
[1]Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
[2]A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Class I services	None (covered at 100%)
Class II services	Not covered
Class III services	Not covered
Class IV services	Not covered
Annual maximum for Class I services	$1,000 per member
Lifetime maximum for Class IV services	Not applicable

Class I services

Benefits	Coverage
Oral exams	100% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount **Note:** Once every 60 months
Dental prophylaxis (teeth cleaning)	100% of approved amount **Note:** Twice per calendar year
Pit and fissure sealants- for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatments	100% of approved amount
Space maintainers - missing posterior (back) primary teeth - for members under age 19	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings -permanent (adult) teeth	Not covered
Fillings- primary (child) teeth	Not covered
Onlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	Not covered
Recementation of crowns, veneers, inlays, onlays and bridges	Not covered
Oral surgery including extractions	Not covered
Root canal treatment- permanent tooth	Not covered
Scaling and root planing	Not covered
Limited occlusal adjustments	Not covered
Occlusal biteguards	Not covered
General anesthesia or IV sedation	Not covered
Repairs and adjustments of a partial or complete denture	Not covered
Relining or rebasing of a partial or complete denture	Not covered
Tissue conditioning	Not covered

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	Not covered
Bridges (fixed partial dentures) -for members age 16 and older	Not covered
Endosteal implants -for members age 16 or older who are covered at the time of the actual implant placement	Not covered

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	Not covered

Benefits	Coverage
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

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MICHIGAN TROWEL TRADES
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Vision Coverage
Effective Date: On or after January 2017
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $45 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$7.50 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	

Benefits	VSP network doctor	Non-VSP provider
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $7.50 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $70 less $7.50 copay (member responsible for any difference)
	One frame in any period of 24 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$7.50 copay	Reimbursement up to $210 less $7.50 copay (member responsible for any difference)
	One pair of contact lenses in any period of 12 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	One pair of contact lenses in any period of 12 **consecutive** months	

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Deductible, Copays and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

Deductible	$2,000 individual/$4,000 family per calendar year
Fixed Dollar Copays	$5 for allergy injections
	$30 for office visits and online visits
	$50 for urgent care visits
	$150 for emergency room visits
	No fixed dollar copay for ambulance services. See below for applicable coinsurance.
	$45 for referral physician visits
Coinsurance	50% for select services as noted below
	30% for select services as noted below
Annual Coinsurance Maximum (ACM)	$1,000 per member/$2,000 per family per calendar year
	Services that DO NOT apply to the ACM: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,600 per individual/$13,200 per family

Preventive Services

Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Child Care	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Female Sterilization	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Pre-Natal care	100%

Physician Office Services

Office Visits	$30 Copay
Online Visits	$30 Copay
Consulting Specialist Care	$45 Copay

Emergency Medical Care

Hospital Emergency Room - Copay waived if admitted	$150 Copay after deductible
Urgent Care Center	$50 Copay
Ambulance Services	70% after deductible

Benefits Selected -
1KECM,CI30%,D2000,DSR30%,IMG150,VACR50,ER150,CO30,6600PM,P640CS,90D3X,45RP,UR50,WDRPOV

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Diagnostic Services

Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	70% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay after deductible
Radiation Therapy	70% after deductible

Maternity Services Provided by a Physician

Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	$30 Copay
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges) after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	70% after deductible
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	70% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	70% after deductible
	Up to 45 days per member per calendar year
Hospice Care	100% (When authorized) after deductible
Home Health Care	$45 copay after deductible

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	70% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	70% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible

Benefits Selected -
1KECM,CI30%,D2000,DSR30%,IMG150,VACR50,ER150,CO30,6600PM,P640CS,90D3X,45RP,UR50,WDRPOV

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	70% after deductible
Inpatient Substance Abuse Care	70% after deductible
Outpatient Mental Health Care	$30 Copay
Outpatient Substance Abuse	$30 Copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	$30 Copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18	$45 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and Therapy	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$45 Copay
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$45 Copay after deductible
	One period of treatment for any combination of therapies within 60 consecutive days per calendar year
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment (DME)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	70%
Prescription Drugs	Tier 1A - $6 copay, Tier 1B - $40 copay, Tier 2 - $60 copay, Tier 3 - $80 copay, Tier4 - 20% coinsurance (max $200 copay)/Tier5 - 20% Coinsurance (max $300 copay) 30 day supply
	Sexual Dysfunction - Not Covered
	Female contraceptives - Tier 1A - Covered in full, Tier 1B - $40 copay, Tier 2 - $60 copay, Tier 3 - $80 copay
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay / coinsurance; 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10
Prescription Drug Deductible	None
Hearing Aid	Not Covered

Benefits Selected -
1KECM,CI30%,D2000,DSR30%,IMG150,VACR50,ER150,CO30,6600PM,P640CS,90D3X,45RP,UR50,WDRPOV

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Benefits Selected -
1KECM,CI30%,D2000,DSR30%,IMG150,VACR50,ER150,CO30,6600PM,P640CS,90D3X,45RP,UR50,WDRPOV

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