MICHIGAN TROWEL TRADES
HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

January 2025

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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 January 1, 2025. 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 ("BCBSM"), 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

Cesar Gonzalez
Commercial Contracting Corporation
6525 Centurion Drive
Lansing, MI 48917

Bruce Hemingway
Sorenson Gross Construction Company
6525 Centurion Drive
Lansing, MI 48917

James Malenich
Fessler & Bowman
6525 Centurion Drive
Lansing, MI 48917

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

Union Trustees

Michael Stanfield (Chairman)
OPCMIA Local 514
2630 South Grand Traverse Street
Flint, MI 48503

Juan Hernandez
OPCMIA Local 514
1154 E. Lincoln Avenue
Madison Heights, MI 48071

Lance Ryan
OPCMIA Local 514
1154 E. Lincoln Avenue
Madison Heights, MI 48071

Keino Walker
OPCMIA Local 514
1154 E. Lincoln Avenue
Madison Heights, MI 48071

Henry Williams
OPCMIA 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
Watkins, Pawlick, Calati & Prifti, PC
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 or BCN.

When you call BCBSM or BCN 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 and BCN follow 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 or BCN, 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 or BCN, please use the address in the upper right-hand corner of your EOB. If you do not have an EOB, call BCBSM or BCN 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. The benefits provided by the Fund are limited to the assets of the Fund available to pay for such benefits. No participant, dependent, or retiree has any vested right to any benefit provided by the Fund now or at any time in the future.

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 January 1, 2025 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 is 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. Claims processing for early retirees is performed consistent with the insurance policy issued by BCN.

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 under the Trust Agreement.

The Board of Trustees is 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. You can obtain the Trust Agreement and many other Fund documents from the Fund's website, http://www.outstatetroweltrades.org, without any charge from the Fund.

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 who are active participants, continuing active coverage through self pays, or their beneficiaries. 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 and the Benefit Year for purposes of provision of benefits, both begin on the first day of January and end 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.

There are generally two classes of participants, active and retired. Active participants are those who have met initial eligibility and are participating in the Plan through employer contributions or self-payments and have not subsequently retired or become a retired participant. Active participants receive benefits under the Active Program. Retired participants are those who were an Active participant and upon retirement or determination of total and permanent disability elect to continue to participate in the Plan. Once a participant becomes a retired participant, they can no longer participate in the Plan as an active participant, even if they later retorn to work. Retired participants receive benefits under the Early Retiree Program even if they subsequently return to work and employer contributions provide the basis for their continued participation. A participant's eligible dependents participate in the program the participant participates in.

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 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 the Fund Office always has current and accurate information about you and your dependents can result in disqualification, ineligibility, denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits 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 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 and your dependents 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 while you were not eligible for coverage.**

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. As part of the annual notices, the Fund sends a cumulative listing of all material changes made since the date this book was published.

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 intended to make sure 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 which proves you worked and for how many hours; so, 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 card(s) 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. It is almost always to your financial advantage to use providers participating in preferred provider network.

Early retirees (pre-Medicare) with coverage provided through BCN are required to select a Primary Care Physician and use in network providers. 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 by BCN. 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)

When BCBSM or BCN processes medical claims under your contract number, you will receive an Explanation of Benefit Payments statement, or EOB, for all of the claims processed in that month. 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. If your claim is rejected, the EOB will also provide information on how to appeal that decision.

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 give valid receipt for any benefit due to them under the Plan (for example because they are a minor), the Fund may pay benefits to the custodial parent (in the case of a minor), legally appointed guardian, conservator, or person holding the power of attorney if the Fund is provided with all necessary documentation. Any such payment shall be a payment for the account of the person involved and shall be a complete discharge of any liability of the Plan or the Trustees, therefore. 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

ELIGIBILITY FOR ACTIVE PROGRAM

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 subject to the Plan's rules for continuing eligibility.

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 listed in the Collective Bargaining Agreement(s) between the Union and Associations. **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 later 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 does 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 whether an employer is required to pay contributions to this Plan and the address of a particular employer.

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 FOR ACTIVE PROGRAM

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) and lasts for three months. Eligibility is provided in three-month increments. Once you meet the initial eligibility requirement, you will be provided three consecutive calendar months of coverage.

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 and you would remain eligible for May, June, and July.

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 and you would remain eligible for April, May, and June.

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).

Example 5: If you begin working in January and complete 245 hours of work at the standard contribution rate ($7.60 as of January 1, 2024) in February and then work an additional 120 hours in March at an hourly contribution rate of $6.84 you will be credited with a total of 353 hours of work for eligibility purposes. The 120 hours of work in March would be reduced based on the lower contribution rate (120 hours x $6.84 / $7.60 = 108). Therefore, your 120 hours of work at the lower contribution rate would be recognized as 108 hours for eligibility purposes. The Fund would recognize a total of 353 hours of work during the three-month period from January through March. Accordingly, you would meet the 345 hour requirement during March, you would become initially eligible on the first day of May and you would remain eligible for May, June, and July.

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 PROGRAM

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 based on the relation of the lower rate to the Fund's standard rate.

> ***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 have been received at the standard contribution rate) **or** 1,380 hours during the 12 calendar months of January through December (for which all employer contributions have been received at the standard contribution rate).

Continuing Eligibility Based on Work Outside the Fund's Jurisdiction (Reciprocity)

The Board of Trustees of the Fund has entered into contracts known as Reciprocity Agreements which may allow employer contributions remitted on your behalf for work outside the jurisdiction of the Fund to be transferred to this Fund so 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 which 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 you will be credited will be reduced to account for the lower contribution rate.

> ***Example***: You work out of state for one hundred and fifty (150) hours for an employer that pays contributions to an out of state fund at five dollars ($5.00) per hour (150 x $5.00 = $750). If the out of state fund has a reciprocal agreement with this Fund and you have completed the required forms to make a transfer possible, the Michigan Fund will receive $750 on your behalf, and you will be credited with 98.7 hours of work for eligibility purposes ($750 ÷ $7.60 = 98.7 hours).

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 even if you worked 345 hours or more.

Continuing Eligibility by Self-Payments

After you have met the requirements for initial eligibility, but before you retire, there are two primary options for continuing eligibility through self-payments if the contributions received by the Fund are less than the amount required to maintain your coverage, but you are available for work. Both of these options are only available to continue your current coverage; so, you must take advantage of them before your coverage based on contributions ends. Which of the two options is available to you depends on how many hours you are short of the requirements for continuing eligibility. When your coverage is about to end, you will receive a Self-Payment/Termination Notice from the Fund Office and it will identify the option(s) available to you.

The first option permits you to self-pay at the standard contribution rate, for up to ten hours, if you are short of the requirements for continuing eligibility based on contributions. This is known as a short hour self-payment. A short hour self-payment makes up for the difference in the amount of contributions required to continue your eligibility and the employer contributions received in your behalf. This self-payment option provides you with continued coverage in three month increments the same as employer contributions.

A short hour self-payment is due by the first day of the three-month period for which the coverage would be provided. If the coverage period was the three months of November, December, and January, the payment would be due by November 1. Any subsequent self-payment made under this option would similarly be limited to 10 hours.

> ***Example*:** If you worked 340 hours in January, February and March (for which all employer contributions have been received at the standard contribution rate), you would be short by five hours in meeting the requirements for continuing eligibility for May, June and July. Therefore, the Fund would offer you the opportunity to make a self-payment to the Fund in the amount of $38.00 (5 hours x $7.60 per hour at the current contribution rate = $38.00) to continue your eligibility for coverage.

You would then remain eligible for three months, credited in the usual manner. That payment would be due on or before May 1.

Under the second option, if you are short of the requirements for continuing eligibility by more than 10 hours, you must remit a full self-payment by the end of the month for which you are seeking coverage in order to continue your eligibility. If your coverage based on contributions is ending in October, you would have until the end of November to make a self-payment for coverage during the month of November. This is known as a full self-payment. This self-payment option only provides you with continued coverage in one-month increments.

The full 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. For the current full self-payment rate, call the Fund Office.

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 you are on your Local Union's out-of-work list throughout the relevant period. **If you are retired or totally and permanently disabled, 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 but are generally noted above. If the Fund Office determines a short hour or monthly self-payment was late for good cause, it can provide a one-time extension of coverage for that late payment. Any future late payment would result in a termination of coverage. 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!** Reinstatement of coverage will not be permitted if you fail to pay a notice because you moved and did not advise the Fund Office.

Eligibility by means of the full self-payment method described above can be continued for a **maximum** of 12 consecutive months.

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

If you do not take advantage of either self-payment method the first month it is available to you, your coverage under the Plan will terminate and you will need to meet the requirements of initial eligibility before you can be covered again as an active participant.

Continuing Eligibility During Short Term Disability

If you become temporarily disabled and unable to work while you are eligible as an active participant in this Plan, you will be allowed to continue coverage by making a short-term disability

self-payment. A temporary disability is one which is anticipated to last no longer than 12 months. You will initially be required to prove you are disabled and may be required to prove your continued disability from time to time. If you do not prove your initial disability or continuing disability, the short-hour and full self-payment rules described above will immediately apply.

You must remit a short-term disability self-payment by the end of the month for which you are seeking coverage in order to continue your eligibility. For example, if your coverage based on contributions is ending in October, you would have until the end of November to make a short-term disability self-payment for coverage during the month of November. This self-payment option only provides you with continued coverage in one-month increments.

The short-term disability 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 short-term disability 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. For current short term disability self-payment rates, call the Fund Office.

Short term disability 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. If the Fund Office determines a monthly self-payment was late for good cause, it can provide a one-time extension of coverage for that late payment. Any future late payment would result in a termination of coverage. 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!** Reinstatement of coverage will not be permitted if you fail to pay a notice because you moved and did not advise the Fund Office.

Eligibility by means of short-term disability self-payments described above can be continued for the duration of disability up to a **maximum** 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 month 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 totally and permanently disabled;
6. The date you retire;
7. The date you become eligible for Medicare; or
8. The Fund no longer provides Short Term Disability coverage.

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

ELIGIBILITY DURING TOTAL AND PERMANENT DISABILITY

If you become totally and permanently disabled while you are eligible as an active participant in this Plan and you are not yet eligible for Medicare, you will be allowed to continue coverage under the Early Retiree Program by remitting total and permanent disability self-payments.

Under the Early Retiree Program, coverage is provided under a BCN insurance policy. ***Where any term in this booklet conflicts with the policy or certificates issued by the commercial insurance company, the terms of the policy/certificate shall control!*** A copy of the current policy and certificate(s) are available upon request.

To be eligible to for coverage by total and permanent disability self-payment, you must meet all of the following requirements:

1. You must be eligible in this Plan immediately before the date of you begin receiving a disability benefit; and;
2. You must be eligible for, and must be 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 (each a qualifying disability benefit). If you are eligible for benefits from more than one of these three Funds, the earliest benefit payment date with any of them will be used as your eligibility date. You may be required to prove your continued disability by the Board from time to time.

When you first begin receiving a qualifying disability benefit, you will become a retired participant and your and your eligible dependent's coverage under the active program will terminate. At that time, you may continue coverage for yourself and your eligible dependents under the Early Retiree Program subject to your continuing eligibility.

If you are eligible to participate in the Early Retiree Program due to a total and permanent disability, you must declare your intent to participate immediately prior to or your receipt of a qualifying disability benefit. If you do not declare your intention to participate in the Early Retiree Program immediately, you will not be allowed to begin participation at a later date. This is true even if you would otherwise continue to be eligible under the rules applicable to active participants unless you subsequently work sufficient hours to earn initial eligibility. In which case, you will again have the option to join the Early Retiree Program. However, once you are a retired participant as a result of total and permanent disability, you will never again be eligible for coverage as an active participant. The Fund will only provide coverage to you under the Early Retiree Program.

Special Delayed Enrollment Due to Other Coverage

If you decline enrollment in the Early Retiree Program due to disability for yourself or your dependents (including your spouse) because you or they have other health coverage, you may enroll yourself and your dependents in the Early Retiree Program in the future if the other coverage

is lost or terminated, provided 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 Early Retiree Program because you had COBRA continuation coverage under another plan, you must exhaust your COBRA coverage under that plan before you may enroll in the Early Retirement Program because of a loss of eligibility.

You may also enroll yourself and your dependents (including your spouse) in the Early 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.

The total and permanent disability 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 total and permanent disability 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. For current total and permanent disability self-payment rates, call the Fund Office.

Total and permanent disability 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. If the Fund Office determines a monthly self-payment was late for good cause, it can provide a one-time extension of coverage for that late payment. Any future late payment would result in a termination of coverage. 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!** Reinstatement of coverage will not be permitted if you fail to pay a notice because you moved and did not advise the Fund Office.

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

1. The end of the last month 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. The date you are no longer totally and permanently disabled;
4. 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;
5. The date your disability benefit from the Cement Masons Pension Trust Fund – Detroit and Vicinity or the Outstate Michigan Trowel Trades Pension Fund is terminated;
6. The date you retire, or begin receiving a retirement type benefit;
7. The date you become eligible for Medicare; or
8. The Fund no longer provides Total and Permanent Disability coverage.

Each month of continuing eligibility by a total and permanent disability self-payment will reduce by one month the period available for COBRA continuation coverage, as explained later in this

Section, because continuing eligibility by total and permanent disability self-payment is an alternative to COBRA offered by the Fund.

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 that

  2. is a party to a current collective bargaining agreement requiring contributions to the Fund, and

  3. 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 (proof of which must be provided promptly when requested by the Fund);

  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 as specifically identified in the written Participation Agreement with the Fund.

- All NBUEs to be covered by the Fund's Plan must be 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 required to contribute under the Participation Agreement.

NBUEs can continue participation through short hour self-payments and full self-payments in the same manner and subject to the same limitations as active participants in the Plan, including the obligation to be available for work at the trade, but self-payment rights under the provisions for Continuation of Eligibility during Short-Term or Total and Permanent Disability are not available to NBUEs.

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, 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 EARLY RETIREE PROGRAM

Under the Early Retiree Program, coverage is provided under a BCN insurance policy. ***Where any term in this booklet 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.

When you first retire from employment covered by this Fund, you become a retired participant and your and your eligible dependent's coverage under the active program is terminated. At that time, you may continue coverage for yourself and your eligible dependents under the Early 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 or the Cement Masons Pension Trust Fund – Detroit and Vicinity, or received a distribution based on retirement from the Plasterers Local 67 Pension Trust Fund. If you are eligible for benefits from more than one of these three Funds, the earliest retirement date with any of them will be used as your retirement date.

If you are eligible to participate in the Early Retiree Program, you must declare your intent to participate immediately prior to or upon retirement. If you do not declare your intention to participate in the Early Retiree Program immediately when you retire, you will not be allowed to

begin participation at a later date. This is true even if you would otherwise continue to be eligible under the rules applicable to active participants unless you subsequently work sufficient hours to earn initial eligibility. In which case, you will again have the option to join the Early Retiree Program. However, once you retire, you are considered a retired participant and you will never again be eligible for coverage as an active participant in the Active Program. The Fund will only provide coverage to you under the Early Retiree Program.

The Fund will initially automatically provide you and your eligible dependents with coverage under the Early Retiree Program if you would have remained eligible under the active program but for your decision to retire. Enrollment forms will generally be given to you as soon as you meet the initial eligibility criteria, it is important you complete and return those forms as soon as possible. Retired participants and their eligible dependents are moved to the Early Retiree (BCN) program and permitted to run out any remaining accumulated eligibility based on active status before monthly retiree self-payments are required. After that, if you have elected to continue under the Early Retiree Program, you will be permitted to make the first twelve (12) months self-payments at the lower active participant full self-payment rate. The self-payment rate for the 13th month and forward will be a one hundred percent (100%) pass through of the BCN premium. If you subsequently return to work and earn eligibility based on employer contributions consistent with the rules of the active program, you will continue in the Early Retiree Program, but will not have any retiree self-payment obligation for those months. However, you will not be provided a right to make a second 12 months of active full self-payments following subsequent eligibility periods based on employer contributions. If you use six (6) months of self-payments at the active rate, return to work, re-establish eligibility and subsequently terminate again, you will be permitted to use the remaining six (6) months of self-payments at the active rate before being charged the standard retiree self-payment.

IMPORTANT: Once you or your dependents are entitled to Medicare coverage, you or your dependent are no longer eligible to participate in the Early Retiree Program. However, if your continuing eligibility in the Early Retiree Program is based on employer contributions, you will be permitted to continue in the Early Retiree Program when you become entitled to Medicare until your eligibility based on employer contributions terminates.

Retiree benefits do **not** include Accidental Death and Dismemberment Benefits. Once you are retired and you have exhausted your initial 12 months of full self-payments, you are not eligible for any other self-payment rights under the Plan, including, but not limited to the provisions for Continuation of Eligibility during Short-Term Disability or Total and Permanent Disability (with the exception of a retired participant who initially enters the Early Retiree Program through a total and permanent disability determination, such participant may continue total and permanent disability self-payments).

Special Retiree Delayed Enrollment Due to Other Coverage

If you decline enrollment in the Early 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 the Early Retiree Program in the future if the other coverage is lost or terminated, provided 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 Early Retiree Program because you had COBRA continuation coverage under another plan, you must exhaust your COBRA coverage under that plan before you may enroll in the Early Retirement Program because of a loss of eligibility.

You may also enroll yourself and your dependents (including your spouse) in the Early 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 first become eligible for coverage under the Early Retiree Program, you will be covered under the Early Retiree Program BCN coverage immediately, however you will not be required to remit monthly self-payment until your continuing eligibility based on employer contributions is exhausted. Once your eligibility based on employer contributions is exhausted, you will be required to continue eligibility through monthly retiree self-payments. The retiree self-payment amounts 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. It is anticipated the retiree self-payment will continue to be a 100% pass through of the cost of coverage with BCN. For current self-payment rates, call the Fund Office. Self-payments must be received at the Fund Office by the due date specified on the Self-Payment/Termination Notice sent to you. If the Fund Office determines a monthly self-payment was late for good cause, it can provide a one-time extension of coverage for that late payment. Any future late payment would result in a termination of coverage. 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 you so elect. You can also elect to have the Pension Fund deduct your self-payment from your monthly pension 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 Early Retiree Program (even if you are Medicare Eligible).

Termination of Retiree 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, unless you subsequently return to work and earn eligibility based on employer contributions. In which case, coverage would terminate upon your loss of eligibility as a result of employer contributions. 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, unless you subsequently return to work and earn eligibility based on employer contributions. In which case, coverage would terminate upon your loss of eligibility as a result of employer contributions;

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

5. When the Fund no longer provides coverage under the Early Retiree Program.

Coverage under this section will not be reinstated if it lapses unless you return to covered work and meet the initial eligibility requirements. If, after your coverage is terminated, you subsequently return to covered work and meet the initial eligibility requirements under the active program based on employer contributions, you will again be provided coverage under the Early Retiree Program.

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

ELIGIBILITY OF DEPENDENTS

Who is Covered: Definition of Eligible Dependent

The Active Program provides medical, dental, vision, and prescription drug coverage on a self-funded basis (meaning the benefits are not insured, but paid out of the Fund's assets) 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 medical and prescription drug coverage under the BCN insurance policy for you and your dependents when you are eligible according to the rules described in this section for the Early Retiree Program 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 they became *totally or permanently disabled by either a physical or mental condition prior to reaching age 26.* A Totally or Permanently Disabled child is one who has been determined by the Social Security Administration, prior to the end of the year in which he attains age 26, to be entitled to receive Social Security Disability Benefits based on a physical or mental condition which has rendered him or her totally unable to engage in any regular occupation or employment for remuneration or profit and which condition is likely to be permanent and continuous during the remainder of his life.

To Add a Dependent to Your Active or Early Retiree Coverage

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 the Fund and BCBSM can adjust their records to include your change. **The chart below shows the coverage effective date when the Fund Office and BCBSM are notified within 30 days of the event listed.** *If notice is received* ***more*** *than 30 days after the date of the event, the change you are requesting would be delayed and will be effective prospectively only.*

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	The date legal guardianship, custody, and financial dependence are established.
Your Spouse's children	On the date of marriage.

To Remove a Dependent From Your Coverage

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 spouse or 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 the 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 Spouse's Child	Divorce or legal separation from the child's parent.	On the date of the divorce or legal separation.
Your Child by Legal Guardian	Termination of Legal Guardianship or when they are no longer in your custody and financially dependent on you.	On the date of the termination of Legal Guardianship or when they are no longer in your custody and financially dependent on you.
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 and will be effective prospectively only. 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 former spouse's child(ren), you and your former spouse are each 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, your former spouse's child(ren) and/or each 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 a loss of COBRA rights for your former dependent(s).***

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 recognizing 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 to those same people 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 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 which 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 last eligibility period based on your work and employer contributions received, your surviving dependents may elect to continue their eligibility by making monthly dependent self-payments until the first of the following to occur:

1. The end of the last month 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 eligible dependent;
5. The date your dependent (spouse or child) becomes eligible for Medicare.

The dependent self-payment is due by the end of the month for which it provides coverage. However, if the Fund Office determines a monthly self-payment was late for good cause, it can provide a one-time extension of coverage for that late payment. Any future late payment would result in a termination of coverage.

The dependent 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 dependent self-payment amount is not reduced or offset by any hours you worked or any contributions received during the three-month

or the 12-month eligibility test periods. For current dependent self-payment rates, call the Fund Office.

Eligibility for surviving dependents under this self-payment provision must begin **immediately** after the end of the last 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.***

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

REINSTATEMENT OF ELIGIBILITY

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. Generally, your dependents will be eligible for coverage when you are eligible for coverage as long as they meet the Fund's definition of dependents.

Active Participants

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.

Early Retirees

Coverage under this section will not be reinstated if it lapses, either initially or later, unless you meet the full requirements under the "Initial Eligibility" section of this booklet to become covered again as an active participant.

Dependents

A spouse or 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 they again meet all the requirements of the dependent definition subject to your timely provision of notice to the Fund Office.

Hospital Confinement and Reinstatement

The effective date of any reinstated coverage as a participant or a dependent will be as determined under the Plan; except 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.

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.

Your coverage in the Plan may continue during other periods of leave your employer is required to provide you under State or Federal laws, 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.

COBRA CONTINUATION COVERAGE

This section of the Summary Plan Description contains important information about your and your dependent's rights 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 booklet. 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 you provide evidence 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 a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary and 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 through various types of self-payments, 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 making full self-payments for 12 months, your COBRA coverage eligibility period is reduced to 6 months from the end of that 12 month period (a total of 18 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 loss of 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 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 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 COBRA self-payment based on the type of coverage elected, Individual, Couple, or Family. If you choose to elect continuation coverage, you do not 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 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 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 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 tax credit which 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 will not 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 meantime.

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 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 information or documents 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

CLAIMS AND APPEALS RELATED TO ELIGIBILITY FOR PARTICIPATION

Your eligibility for participation in the Fund is determined by the Fund Office based on receipt of hours/contributions, self-payments and all other relevant factors required to become eligible and continue your participation in the Plan. Your dependent eligibility is determined by the Fund Office based on information provided on forms available from the Fund Office and supporting documentation.

If your claim for eligibility to participate in the Fund is denied by the Fund Office, you will be informed of the reason for the denial in writing. If the denial is due to missing information or a missing signature, you should supply the information directly to the Fund Office. If the denial is due to any other reason and you believe you should be eligible, you should follow the procedure set out below to appeal a denial of your claim.

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 and mailing your appeal within 180 days of the notice of denial to the Michigan Trowel Trades Health and Welfare Fund, ATTN: Appeals Committee, 6525 Centurion Drive, Lansing, Michigan 48917. No special form is required. Just be sure 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", 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 for consideration in the appeal. The review of the appeal will take into account all materials and information received from you 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 the decision was arbitrary and capricious.

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.***

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 Active Program which is a self-funded arrangement with BCBSM. Retired Participants and Totally and Permanently Disabled participants receive coverage under the Early Retiree Program, which is insured under a BCN insurance policy. Upon retirement or total and permanent disability, participants are no longer considered Active Participants and are not eligible for coverage under the Active Program even if they later return to covered employment.

Summaries of Active and Early Retiree coverage are attached as Exhibits A and B, respectively.

Active Participant Program:

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

- Active Participants, including those who have not previously retired and whose eligibility is continuing as follows:
    - by working, and
    - by self-payments (including short term disability) with the exception of self-payments for COBRA continuation coverage or under the Early Retiree Program.
- Those whose eligibility is continuing through COBRA continuation coverage.
- Those who are eligible under the Non-Bargaining Unit Employee provisions (NBUEs).
- Surviving Spouses of Active Participants who have not previously retired.

Please note that, unless stated otherwise, a participant's dependent(s) will be covered under the same program as the participant.

Understanding Active Participant Coverage

This section provides information to help you understand and use your BCBSM coverage as an Active Participant or Short-Term Disabled Participant. 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.

Preapproval

Some admissions and services must be approved before they occur. If they are not preapproved, you may have to pay their entire cost. It is important to make sure your provider gest approval before you receive services or are admitted to a hospital or facility which requires preapproval.

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 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.

Non-Network, Nonparticipating Providers

Non-network, nonparticipating providers have **not** signed agreements with BCBSM and do not participate with BCBSM. If you receive services from such a provider, you are usually required to pay that provider directly and may be required to submit a claim to BCBSM for payment or reimbursement.

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; and
- You are responsible for any difference between BCBSM's payment and the provider's charges.

Non-Network, Nonparticipating Hospitals, Facilities, and Alternative to Hospital Care Providers

BCBSM coverage at non-network, nonparticipating **hospitals, facilities and alternatives to hospital care providers 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 non-network, 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 non-network, 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 non-network, 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 Exhibit A and for services not covered by your Plan.

To take advantage of your BlueCard program, just follow each of 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 non-network, 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, nonparticipating provider. **The BlueCard program does not include prescription drugs, dental, vision, or hearing services.**

Care Out of the Country

If you need medical services while traveling or living outside of the United States, contact the BCBSM service center. The service center will help you get information about participating hospitals, physicians, and medical assistance services. If you do not contact the service center, you may have to pay for all of the services you receive.

Otherwise, your coverage generally applies for emergency and urgent care services 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 listed in U.S. or foreign currency. In addition, be sure to tell BCBSM 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 booklet will refer to the approved amount as determined by BCBSM.**

Early Retiree Program:

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

- Early Retirees who are not eligible for Medicare.

- Early Retirees who are eligible for Medicare, but who returned to work and have continuing eligibility based on employer contributions.
- Totally and Permanently Disabled participants who are not eligible for Medicare.
- Surviving Spouses of Early Retirees.

Please note that, unless stated otherwise, a participant's dependent(s) will be covered under the same program as the participant.

Understanding Early Retiree Program Coverage

This section provides information to help you understand and use your BCN coverage as an Early Retiree or a Totally and Permanently Disabled participant. ***Where any term in this booklet conflicts with the policy issued by BCN, the terms of the policy shall control!***

The Fund's Early Retiree Program coverage will be provided through a group insurance contract with Blue Care Network (BCN). BCN is a Health Maintenance Organization (HMO) in Michigan that contracts with doctors, hospitals and health care professionals across the State. An eligible individual who elects to receive early retiree coverage from the Fund must have a BCN-contracted primary care physician to access benefits.

Primary Care Physician

BCN generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the BCN 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 generally need prior-authorization or a referral from your Primary Care Physician before seeing another health 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.

Preapproval

Some admissions and services must be approved before they occur. If they are not preapproved, you may have to pay their entire cost. It is important to make sure your provider gets approval before you receive services or are admitted to a hospital or facility which requires preapproval.

Network Providers

This program uses a provider network and does not provide coverage for out of network providers. You will pay less if you use a provider in BCN's network. You will pay the most if you use an out-of-network provider. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Non-Network Providers

When you receive care from a provider who is not part of the BCN network, your care is considered out-of-network and will not be covered.

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 booklet will refer to the approved amount as determined by BCBSM.**

BlueCard Program / Out-of-Area Services

If you receive Covered Services in another state, the claims will be processed through the BlueCard Program. This Addendum explains how it works. It does not expand your Coverage to include out-of-state providers. It defines the payment method used should an incidental out- of-state claim be incurred.

BCN has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you, the Member, access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BCN serves, you obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BCN remains

responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

BCN covers only limited healthcare services received outside of our Service Area. As used in this section "Out-of-Area Covered Healthcare Services" include, emergency care, urgent care, routine care and/or follow-up care obtained outside the geographic area we serve, subject to BCN coverage and authorization rules. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless Preauthorized by your Primary Care Physician ("PCP") or BCN.

The BlueCard Program is an Inter-Plan Arrangement. Under this Arrangement, when you access Out-of-Area Covered Healthcare Services outside the BCN Service Area, the Host Blue will be responsible for contracting and handling all interactions with its participating providers.

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

Care Out of the Country

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard Service Area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Healthcare Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance,
although the Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

- Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient hospital services, except for any cost sharing you may owe. In such cases, the Blue Cross Blue Shield Global Core contracting hospital will submit your claims to the service center to initiate claims processing. However, if you paid in full at the time of service, you must submit a claim to obtain reimbursement for Covered Services. **You must contact BCN to obtain Preauthorization for non-emergency inpatient services.**

- Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard Service Area will typically require you to pay in full at the time of service. You must submit a claim to

obtain reimbursement for Covered Healthcare Services.

• Submitting a Blue Cross Blue Shield Global® Core Claim

When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. The claim form is available from BCN, the service center or online at www.bcbsglobalcore.com. If you need assistance with the claim submissions, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

• Exclusions and Limitations for Care Out of the Country.

Coverage will not apply under this provision if the service are not a benefit under the BCN coverage or performed by a vendor or provider who has a contract with BCN for those services.

You are still responsible for your deductible, coinsurance, and copayment based on your BCN coverage.

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits under both the Active and Early Retiree programs are subject to deductible, co-payment, co-insurance and, in some instances, self-payment requirements. Your cost-sharing is calculated based on the amount the Fund pays BCBSM for the prescription drug. Prescription drug coverage for the Active Participant Program is provided through the self-funded arrangement with BCBSM. Prescription drug coverage for the Early Retiree Program is provided through the BCN insurance policy. Upon retirement, participants are no longer eligible for coverage under the self-funded arrangement with BCBSM even if they return to active employment.

Summaries of Active and Early Retiree coverage are attached as Exhibits A and B, respectively.

Under the Active Program, you can have your prescriptions filled at a network or non-network pharmacy. The choice is always yours. Remember, when your prescriptions are filled through a non-network pharmacy, you have higher out-of-pocket costs. Also, remember 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 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 who have not previously retired and 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 Early Retiree Program.
- Those whose eligibility is continuing through COBRA continuation coverage.
- Early Retirees who are not eligible for Medicare.
- Early Retirees who are eligible for Medicare, but who returned to work and have continuing eligibility based on employer contributions
- 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 be covered under the same program as the participant.

The Fund has a mandatory generic program. Under this program, if you are able to take a generic version of a brand name drug but instead decide to purchase the brand name drug (or your doctor prescribes the brand name drug and you follow that prescription), the Fund will only cover the cost of the generic drug (less your applicable co-pay) and you will be responsible for the remaining cost. This restriction will apply even if the doctor writes "Dispense as Written" or "DAW" unless you have obtained prior authorization for the brand name drug from BCBSM or BCN.

The Fund requires prior-authorization and step-therapy for some prescription drugs. Under this program, the use of some prescription drugs will be reviewed by BCBSM or BCN before their use is authorized. If your doctor does not seek and obtain prior authorization, when required, the cost of your prescription may not be covered by the Fund. You and your doctor will be required to try certain alternative drugs before using more expensive ones. If you and your doctor do not follow this approach, the cost of your prescribed drug may not be covered by the Plan. Therefore, you should consult with your doctor when receiving a prescription. The Fund also has prior-authorization for select specialty pharmaceutical drugs administered in BCBSM/BCN approved locations, such as a doctor's office, clinic, or home drug administration. Under this program, your physician must contact BCBSM/BCN to obtain prior-authorization. If prior-authorization is not sought and received from BCBSM/BCN, you may be responsible for the full cost of the specialty drug without regard to your deductible or co-insurance. The list of prescription drugs impacted by these rules is updated periodically by BCBSM/BCN. Your physician or pharmacist can call for the list and you can find it on the BCBSM/BCN website. The list does not include drugs needed to treat an immediate life-threatening condition.

The Fund also has the following programs: dose optimization, brand to alternate generic interchange, one-time generic co-pay waiver, and quantity limits. Under the dose optimization program, BCBSM or BCN may discuss with your doctor your use of specific prescription drugs

in once-daily dosage regimens as opposed to using lower, multiple doses of the same drug. Under the brand to alternate generic interchange, BCBSM or BCN may discuss with your doctor options to replace a single source brand name drug with an equally effective, less-costly generic alternative (this initiative would not apply if the mandatory generic, prior-authorization or step-therapy programs require the use of the generic). Under the one-time generic co-pay waiver, the Fund will provide you with a one-time co-pay waiver if you switch from a targeted high-cost brand name drug to an equally effective, less-costly generic equivalent (this initiative would not apply if the mandatory generic, prior-authorization or step-therapy programs require the use of the generic). Under the quantity limits program, BCBSM or BCN may limit the quantity of select drugs to maintain consistency with Federal Drug Administration dosing guidelines.

Finally, the Fund implemented a High-Cost Drug Discount Optimization Program where pharmacy co-pays were increased to 30% for certain high-cost drugs where a manufacturer coupon is available.

DENTAL BENEFIT

Dental benefits under the Plan are subject to deductible, co-payment, co-insurance, and, in some instances, self-payment requirements. Dental Benefits are available only under the Active Participant Program and coverage is provided through the Plan's self-funded arrangement with BCBSM. Participants covered under the Early Retiree Program are not eligible for any dental coverage. Upon retirement, participants are no longer eligible for coverage under the self-funded arrangement with BCBSM and, even if they elect early retiree coverage, no longer eligible for dental benefits.

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.

The summary of dental benefits coverage is attached as Exhibit A.

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

- Active Participants, including those who have not previously retired and whose eligibility is continuing as follows:

    - by working, and
    - by self-payments (including short term disability) with the exception of self-payments for COBRA continuation coverage or under the Early Retiree Program.
- Those whose eligibility is continuing through COBRA continuation coverage.
- Those who are eligible under the Non-Bargaining Unit Employee provisions (NBUEs).
- Surviving Spouses of Active Participants who have not previously retired.

Early Retirees (including those who return to employment and earn eligibility based on employer contributions), Permanently and Totally Disabled Participants, and Surviving Spouses of Early Retirees are not provided Dental coverage.

Please note that, unless stated otherwise, a participant's dependent(s) will be covered under the same program as the participant.

VISION BENEFIT

Vision benefits under the Plan are subject to deductible, co-payment, co-insurance, and, in some instances, self-payment requirements. Vision Benefits are available only under the Active Participants Program and coverage is provided through the self-funded arrangement with BCBSM. Participants covered under the Early Retiree Program are not eligible for any vision coverage.

The summary of vision benefit coverage is attached as Exhibits A.

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

- Active Participants, including those who have not previously retired and whose eligibility is continuing as follows:
    - by working, and
    - by self-payments (including short term disability) with the exception of self-payments for COBRA continuation coverage or under the Early Retiree Program.
- Those whose eligibility is continuing through COBRA continuation coverage.
- Those who are eligible under the Non-Bargaining Unit Employee provisions (NBUEs).
- Surviving Spouses of Active Participants who have not previously retired.

Early Retirees (including those who return to employment and earn eligibility based on employer contributions), Permanently and Totally Disabled Participants, and Surviving Spouses of Early Retirees are not provided Dental coverage.

Please note that, unless stated otherwise, a participant's dependent(s) will be covered under the same program as the participant.

EXCLUDED BENEFITS

Both programs only provide coverage consistent with the coverage documents of BCBSM or BCN, respectively. If this document or the attachments do not expressly cover a service, treatment, care, procedure, supply, or device, it likely is not covered, but you can call BCBSM or BCN to confirm. You can also request copies of the certificates and riders from BCBSM or BCN.

The following are examples of services, treatment, care, procedures, supplies, and devices not covered by the Plan's programs:

- Services not listed as being payable in the Fund's certificates and riders with BCBSM or BCN, respectively;
- Noncontractual services that are described in your case management treatment plan, if the services have not been approved by BCBSM or BCN, respectively.
- Non-emergency and non-urgent care services for members traveling outside of the United States;
- Services that are more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results;
- Treatment of work-related injuries covered by workers' compensation laws;
- Work-related services you get at an employer's medical clinic or other facility;
- Experimental or investigational items, devices, or services;
- Services which can be paid by government-sponsored health care programs, such as Medicare, for which an individual is eligible. We do not pay for these services even if you have not signed up to receive the benefits from these programs. However, we will pay for services if federal laws require the government-sponsored program to be secondary to this coverage;
- Services that are not medically necessary;
- Services you legally do not have to pay for or for which you would not have been charged if you did not have coverage under the Fund's Plan;
- Charges for missed appointments;
- Any services, treatment, care, or supplies provided before your coverage under this certificate begins or after it ends. If your coverage begins or ends while you are an inpatient in an acute care hospital, our payment will be based on our contract with the hospital;
- Services drugs or devices that are not medically necessary or may cause significant harm to the individual or are not appropriate for the individual's documented medical condition;
- Services performed by a provider who is sanctioned at the time the service is performed or who is otherwise not appropriately credentialed or privileged (as determined by BCBSM or BCN, respectively) or legally authorized or licensed to provide such services;

- Court ordered services;
- Gender reassignment services that are considered by BCBSM to be cosmetic, or treatment that is experimental or investigational;
- Self-administered, over-the-counter drugs;
- Environmental studies, evaluation or control;
- Fungal or bacterial skin tests;
- Air ambulance services when the individual's condition does not require air ambulance transport;
- Air ambulance services when a hospital or air ambulance provider is required to pay for the transport under the law
- Marital counseling;
- Items and services provided solely to satisfy data collection and analysis needs of a clinical trial that are not used in the direct clinical management of the trial participant;
- Services clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- For End Stage Renal Disease (ESRD): services provided by a nonparticipating ESRD facility, services not provided by the employees of the ESRD facility, services not related to the dialysis process;
- Private duty nursing;
- General housekeeping;
- Lamaze, parenting or other similar classes;
- Hospital admissions for services that are not acute, such as:
  − Basal metabolism tests;
  − Cobalt or ultrasound studies;
  − Convalescence or rest care;
  − Convenience items;
  − Dental treatment, including extraction of teeth (except as otherwise noted in the underlying certificate);
  − Diagnostic evaluations;
  − Electrocardiography;
  − Lab exams;
  − Observation;
  − Weight reduction;
  − X-ray, exams, or therapy;
  − Those mainly for physical therapy, speech and language pathology services or occupational therapy;
- Hospital services that we do not pay for:
  − Services that may be medically necessary but can be provided safely in an outpatient or office location;
  − Custodial care or rest therapy;
  − Psychological tests if used as part of, or in connection with, vocational guidance training or counselling;

− Outpatient inhalation therapy;
− Sports medicine, member education or home exercise programs;

- Facility services that we do not pay for:
  − Facility services you receive in a convalescent and long-term illness care facility, nursing home, rest home, or similar nonhospital institution. (However, if a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.);
- Professional provider services that we do not pay for:
  − Services, care, supplies or devices not prescribed by a physician;
  − Self-treatment by a professional provider and services performed by the provider to parents, siblings, spouse or children;
  − Services for cosmetic surgery when performed primarily to improve appearance (except for medically necessary services for Correction of deformities present at birth. Congenital deformities of the teeth are not covered; Correction of deformities resulting from cancer surgery including reconstructive surgery after a mastectomy; Conditions caused by accidental injuries, and − Traumatic scars);
  − Weight loss programs (unless covered elsewhere in this certificate or otherwise required by law);
  − Services provided during nonemergency medical transport;
  − Experimental treatment;
  − Prescription drug compounding kits or services provided to you related to the kits;
  − Hearing aids or services to examine, prepare, fit or obtain hearing aids;
  − Services provided by persons who are not eligible for payment or not appropriately credentialed or privileged. Providers who are not legally authorized or licensed to order or provide such services;
  − Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens;
  − Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy);
  − Infertility services that do not treat a medical condition other than infertility. This can include:
    - Artificial insemination
    - Sperm washing
    - Post-coital test
    - Monitoring of ovarian response to ovulatory stimulants
    - In vitro fertilization
    - Ovarian wedge resection or ovarian drilling
    - Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
    - Diagnostic studies done for the sole purpose of infertility assessment • Any procedure done to enhance reproductive capacity or fertility

− Sports medicine, member education (except as otherwise specified) or home exercise programs;
− Screening services (except as otherwise stated);
− Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution. (However, if a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.);

- Prescription drugs that we do not pay for:
  − drugs obtained from nonparticipating/out-of-network mail- order providers, including Internet providers;
  − 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 mail-order provider or a 90-day retail network provider. We may make exceptions if a member requires more than a 30-day supply;
  − Prescription drugs purchased from a Sam's Club or Walmart pharmacy;
  − Generally, a drug or device prescribed for uses or in dosages other than those approved by the Food and Drug Administration. (This is called the off-label use of a drug or device.);
- Dental services, treatment, care, or supplies that we do not pay for:
  − Class II Dental Services – Basic services, including restorative, oral surgery, endodontic, periodontic, adjunctive general, and basic (TypeA) prosthodontic services;
  − Class III Dental Services – Major services, including prosthodontic (Type B) services;
  − Class IV Dental services – Orthodontic and related services;
  − Charges for instruction in oral hygiene, diet, or plaque control programs.

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.

Please note these options do not apply if your coverage is through a disability based self-payment

or the Early Retiree Program and you are making self-payments because you are not eligible based on work hours.

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 you do not want to continue this coverage as 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 which begins on the first day of the first month in which you are no longer covered by your Fund's plan as a result of work hours 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 which begins on the first day of the first month in which you are no longer covered by your Fund's plan as a result of work hours 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 or BCN if you choose this option. However, if you select this option, please note 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, unless you elected retiree coverage upon retirement and later return to covered employment and have contributions made on your behalf sufficient to meet initial eligibility requirements under the Active Program.

Eligibility for Medicare

Whether or not you or your dependent (spouse or child) is eligible for coverage under Medicare may affect both 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.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Life Insurance Benefits (Certain Active Program Participants Only)

The following participants receive life insurance benefits as described in this Summary:

- Those Active Participants who have not previously retired and whose eligibility is continuing by working, and

- Those who are eligible due to work under the Non-Bargaining Unit Employee provisions (NBUEs).

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 booklet 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 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 as an Active Participant under this Plan terminates. Accordingly, your Life Insurance Benefit coverage terminates immediately upon your coverage under COBRA or the Early Retiree Program even if you continue to have other coverage under this Plan.

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 Program Participants Only)

The following participants receive accidental death and dismemberment benefits as described in this Summary:

- Those Active Participants who have not previously retired and whose eligibility is continuing by working, and

- Those who are eligible due to work under the Non-Bargaining Unit Employee provisions (NBUEs).

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 booklet 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.

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 for Life Insurance and Accidental Death and Dismemberment Benefits

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. An incomplete Participant Data Card will not be honored by the Fund if the intent of the participant is not clear to the Fund and, accordingly, the participant will not have designated a Beneficiary.

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 in accordance with MCL §§700.3983-700.3984. In the event an Active Participant dies and no person or persons qualify as beneficiary pursuant to the terms of this section, then the beneficiary shall be payable, if at all, based on the Beneficiary determination

under the relevant insurance policy.

If the benefits are payable to the participant's estate, if any payee is a minor unable to give valid receipt for any benefit due, or in the event the Trustees determine a payee is otherwise mentally or physically unable to give valid receipt for any benefit due under the Plan, such payment may, unless claim shall have been made therefor by a custodial parent, legally appointed guardian, conservator, or other legal representative, be paid to any person or institution then in the judgment of the Trustees providing for the care and maintenance of such payee. Any such payment shall be a payment for the account of the person involved and shall be a complete discharge of any liability of the Plan or the Trustees therefore.

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.

BENFIT 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 (including obtaining preauthorizations, approvals, or utilization review decisions). 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 medical claims, 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 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 claims be submitted within 12 months. The Fund requires all claims for Life Insurance and Accidental Death and Dismemberment Benefits be submitted within **90 days or one year in the case of incapacity** 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 three years after the first date you receive a determination of your rights and/or benefits under the Fund's Plan, unless a shorter period is established by applicable statute, regulation or case law; however, you must first go through the Fund's claim and appeal process before you can bring a suit in Court.

The BCN Policy requires legal action may not begin later than three years after the date of service of your claim and you must first exhaust the grievance and appeal procedures with BCN. Further, you cannot bring legal action or file a lawsuit until 60 days after you notify BCN that its decision under the grievance and appeals procedure is unacceptable.

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 if additional time is needed to resolve your claim.

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 the claim should have been covered, you should follow the procedure set out in the EOB (also summarized below) 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 in which case that entity will provide such notice). 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 the claim should have been covered, you should follow the procedure set out below to appeal 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, BCN, the Fund Office, or the commercial insurance carrier will notify you of the denial in writing. The written denial will identify the appeal process.

To appeal the denial or payment in the Active Program, you must follow these 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. However, please note a phone call is not the same as a written appeal or request for review unless the matter is an urgent claim.

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 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 appeal or request for review to the Fund Office.

"Pre-service claim" means a claim for a benefit where your plan conditions receipt of the benefit, 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 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.

Appeal / 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 request 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 in 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.

Appeal / 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.

Appeal / 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.

To appeal the denial or payment in the Early Retiree Program, you must follow these steps. BCN encourages you to first discuss the matter with your Primary Care Physician who may be able to correct the matter or contact the BCN customer service department at Blue Care Network, MC A02A, 26255 American Drive, Southfield, Michigan 48034, 1-800-662-6667 or refer to your EOB or the Blue Care Network handbook and follow the procedures set out therein. At any step in the process you may send any written materials to help BCN in its review of your claim.

You must file your grievance within 180 days from the date of discovery of a problem regarding a BCN decision.

To submit a grievance, submit a written statement of the problem to Appeals and Grievance Unit, Blue Care Network, P.O. Box 44200, Detroit, Michigan, 48244-0191, or by facsimile to 866-522-7345. The Appeals and Grievance Unit will give you a decision within 15 calendar days for a pre-service claim and within 30 calendar days for a post-service claim. If that decision is not fully favorable, BCN will provide you with a written reason for the decision, an explanation of the next step of the grievance process, and the forms to use for that next step.

Your appeal of the grievance decision must be made within 180 calendar days of your receipt of BCN's grievance determination. You must write to Appeals and Grievance Unit, Blue Care Network, P.O. Box 44200, Detroit, Michigan, 48244-0191, or by facsimile to 866-522-7345 to appeal. If you do not agree with the second decision, you may appeal to the Michigan Department of Insurance & Financial Services or provide notice of your intent to sue BCN.

As with the Active Program, an expedited review is available for certain medical conditions that would be seriously jeopardizing during the time it would take for a standard review. In that case, a decision will be made within 72 hours of receiving your grievance and your doctor's confirmation.

To appeal the denial or payment in the Early Retiree Program, you must send a letter of appeal to Blue Care Network Appeal and Grievance Unit - Mail Code C248, Blue Care Network, PO Box 284, Southfield, MI 48037-0284, call 800-662-6667, or refer to your EOB or the Blue Care Network handbook and follow the procedures set out therein.

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 to the Board of Trustees, Michigan Trowel Trades Health and Welfare Fund, 6525 Centurion Drive, Lansing, MI 48917 within 180 days of the notice of denial. The appeal generally must 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 for an appeal. Just be sure what you or 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 of 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 timely submitted, if any.

The Board of Trustees does not permit a personal appearance before the Trustees to argue a claim. The claimant may designate someone of their choice to represent them and submit their written claim at their 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, rather than eligibility, are administered by BCBSM are addressed in the prior section and are not heard by the Board of Trustees.)

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

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.***

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, later in this booklet).

- 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 identify 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 or the benefits of the participant or 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, 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 for the Western District of Michigan, 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 containing 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 you may compare the Fund's records to your pay stubs and information about your total hours worked over the last 12 month period.

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 making self-payment(s) to the Fund. 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 can 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 generally eligible for Medicare, the health program provided under Social Security, if:

- You (or any of your covered dependents) are age 65 or older;
- You (or any of your covered dependents) who are under age 65 have received Social Security Disability benefits for 24 months or longer; 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 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 Plan requires your benefit payments be coordinated with those from another group plan for services that may be payable under both plans. COB ensures 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 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 plan is primary (meaning which 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 the services covered under your Plan are also covered and payable under another group health care plan, BCBSM will combine the BCBSM payment with the payment 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 group health care plan pays first:

Contract Holder Versus Dependent Coverage
The plan covering the patient as the employee (participant or contract holder) is primary and pays before a plan covering 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 order. If no order exists, benefits are determined in the following order:

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 group health care plans 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 group health care plan first. If a balance remains after the primary plan has paid the claim, you or your provider can then submit the claim along with the primary plan'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 group health care plan. 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.

<u>Updating COB information is your responsibility.</u>
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. As soon as practicable after notification of a settlement or proposed settlement, the Fund or the BCBSM subrogation unit will provide a final subrogation lien total.

- Upon receipt of a recovery from a third party, you or your attorney must hold the entire amount in a trust account so 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 under 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:

Receive Information About Your Plan and Benefits

- 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 Group Health Plan Coverage

- 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 (note: there were limitations on plans' imposing a preexisting condition exclusion, and such exclusions became prohibited beginning in 2014 under the Affordable Care Act).

Prudent Actions by Plan Fiduciaries

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.

Enforce Your Rights

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.

Assistance with Your Questions

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, listed in your telephone directory, 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). The web site address for the Employee Benefits Security Administration of the Department of Labor is http://www.dol.gov/ebsa.

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 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 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 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") and Blue Care Network ("BCN") will use alternate identification numbers wherever feasible, including on monthly notices of contributions. TIC, BCBSM, and BCN 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 containing 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 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.

CYBERSECURITY MATTERS

What is the Fund doing to protect against cybersecurity threats?

The Fund takes cybersecurity threats seriously and has developed a policy to guard against such threats and retained experts to review the cybersecurity practices of the Fund's service providers.

What can I do to help reduce the risk of cyber fraud and loss?

The U.S. Department of Labor suggests following these basic rules to reduce the risk of fraud and loss:

1. Register, set up, and routinely monitor online accounts.

2. Use strong and unique passwords.

3. Use multi-factor authentication (multi-factor authentication requires a second code to verify your identity).

4. Keep personal contact information up to date.

5. Close or delete unused accounts.

6. Be wary of free wifi (like those at airports, hotels, or coffee shops).

7. Beware of phishing attacks (Phishing attacks try to trick you into sharing passwords and account numbers).

8. Use antivirus software and keep apps and software current.

9. Know how to report identity theft and cybersecurity incidents.

How do I report identity theft and cybersecurity incidents?

The FBI and the Department of Homeland Security have set up sites for reporting cybersecurity incidents:

- https://www.fbi.gov/file-repository/cyber-incident-reporting-united-message-final.pdf/view
- https://www.cisa.gov/reporting-cyber-incidents

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by a nonparticipating provider at a participating hospital or ambulatory surgical center, you are protected from balance or surprise billing.

What is balance billing?

Balance billing – sometimes called surprise billing – is when you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a

health care facility that doesn't participate with your health plan.

"Nonparticipating" describes providers and facilities that haven't signed a contract with your health plan. Nonparticipating providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care — such as when you have an emergency or schedule a visit at a participating facility but are unexpectedly treated by a nonparticipating provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from a nonparticipating provider or facility, the most the provider or facility may bill you is your plan's in-network out-of-pocket amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Depending on your plan, you may have additional protections under Michigan law if you receive post-stabilization services from a nonparticipating provider when you're in a participating facility. If your plan is governed by Michigan law, those providers can't balance bill you even if you give written consent.

Certain services at a participating hospital or ambulatory surgical center

When you get services from a participating hospital or ambulatory surgical center, certain providers there may be nonparticipating. In these cases, the most those providers may bill you is your plan's in-network out-of-pocket amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these participating facilities, nonparticipating providers **can't** balance bill you unless you give written consent and give up your protections. **You're never required to give up your protections from balance billing. You also aren't required to get care from a nonparticipating provider. You can choose a provider or facility in your plan's network.**

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (such as copayments, coinsurance and deductibles that you would pay if the provider or facility was in network). Your health plan will pay nonparticipating providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization)
    - Cover emergency services by nonparticipating providers
    - Base what you owe the provider or facility (out-of-pocket costs) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits
    - Count any amount you pay for emergency services or services rendered by nonparticipating providers in the circumstances outlined above toward your deductible and out-of-pocket limit

If you believe you've been incorrectly billed, contact the No Surprises Help Desk at 1-800-985-3059. Visit http://michigan.gov/difs for more information about your rights under Michigan law.