

October 2006

TO: ALL SURVIVING SPOUSE'S REMITTING SELF-PAYMENTS WITH THE
LABORERS' METROPOLITAN DETROIT HEALTH CARE PLAN

RE: BENEFIT MODIFICATIONS

Dear Participant:

In an effort to improve the benefit structure for all Surviving Spouses that participate in the Health Care Plan, at their most recent meeting, the Trustees decided to reinstate the option to elect Vision and Dental benefits. The monthly cost to add these benefits will be \$40 per month, in addition to what your current self-payment is (see chart below). This option is a one time only opportunity to enroll for these additional benefits. If you choose to add these benefits, simply complete the attached enrollment form, and return it to the Fund Office in the self-addressed envelope provided, no later than October 31, 2006. This change will be effective November 1, 2006, and self-payment rates will be adjusted beginning in November, for those choosing to do so. The enclosed Benefit Summary outlines the Dental and Vision benefits currently available.

If you fail to respond, your current level of coverage will not change. If you wish to make no change to your current Dental and Vision coverage, you need not respond, and your self-payment rate will not change. Listed below are the self-payment rates for each category, with and without Dental and Vision coverage:

Self-Payment Category	Current Rate	Rate with Dental & Vision
Surviving Spouse without Medicare	\$169.60	\$209.60
Surviving Spouse without Medicare (Family Coverage)	\$201.40	\$241.40
Surviving Spouse with Medicare	\$127.20	\$167.20
Surviving Spouse with Medicare-2 Person	\$196.10	\$236.10

Please contact the Fund Office with any questions you may have.

Sincerely,

Laborers' Metropolitan Detroit Health Care
Board of Trustees

**LABORERS' METROPOLITAN DETROIT
HEALTH CARE FUND
SURVIVING SPOUSE ELECTION OF
DENTAL AND VISION COVERAGE
EFFECTIVE NOVEMBER 1, 2006**

Dental and Vision Benefit Election - (choose only one)

- I wish to continue my coverage as is with no change
- I wish to add Dental and Vision Benefits effective
November 1, 2006.

I understand that the elections I have made above for my Dental and Vision Benefits is a one time only opportunity, and I will not have the option to terminate Dental and Vision Benefits in the future.

Surviving Spouse Name (Please Print)

Surviving Spouse Signature

Identification Number (9 Digits)

Date

***THIS FORM MUST BE RETURNED TO THE FUND OFFICE
NO LATER THAN OCTOBER 31, 2006. IF YOUR FORM IS
NOT RETURNED TO THE FUND OFFICE YOUR
COVERAGE WILL NOT CHANGE***