LABORERS' NATIONAL HEALTH AND WELFARE FUND (Jan 1, 2009)

COVERAGE	PLAN I	PLAN II
Life and Accidental. Death		
Per Employee	$20,000	$20,000
Per Dependent	$2,000	$2,000
Major Medical Annual Maximum	$175,000	$200,000
Major Medical Lifetime Maximum	$350,000	$1,000,000
Deductible's (annual)	In Network / Out of Network	In Network / Out of Network
- Individual	$200 / $40(	$200 / $40(
- Family	$400 / $80(	$400 / $80(
Out of Pocket Maximum (annual)	In Network / Out of Network	In Network / Out of Network
- Individual	$ 7,500 / N/A	$ 7,500 / N/A
- Family	$20,000 / N/A	$20,000 / N/A
Payment Level: In PPO Network	80%	90%
Out of PPO Network Area	70%	70%
Non PPO	50%	60%
Dr. Office Visits		
- MD Visits	***$10 Copay (in network)	***$10 Copay (in network)
- Chiropractic	up to 28 visits per calander year	up to 28 visits per calander year
- Physical Therapy	up to 28 visits per calander year	up to 28 visits per calander year
- Acupuncture Treatment	50% of R&C per visit up to 28 visits per calander year	50% of R&C per visit up to 28 visits per calander year
Well Child Care: (0-6 yrs old)	6 visits per year 100% R & C no ded.	6 visits per year 100% R & C no ded.
(7 - 18 years old)	3 visits per year 100% R & C no ded	3 visits per year 100% R & C no ded
Mammography & Pap Smear Screening	1 visit per calendar year payable at 100% R & C / No Deductible	1 visit per calendar year payable at 100% R & C / No Deductible
ANNUAL PHYSICAL EXAM	1 per calendar year	1 per calendar year
- PPO Provider	payable at 100% R & C / No Deductible	payable at 100% R & C / No Deductible
Emergency Room Deductible	$100 Deductible Per Incident	$100 Deductible Per Incident
Basic Hospital Benefits	In Network / Out of Area / Out of Network	In Network / Out of Area / Out of Network
- Room & Board	80% / 70% / 50%	90% / 70% / 60%
- Misc. Fees & Outpatient Expenses	80% / 70% / 50%	90% / 70% / 60%
- Surgical Benefit	80% / 70% / 50%	90% / 70% / 60%
- X-ray & Lab	$10 Copay (in network)	$5 Copay (in network)
Mental & Nervous		
- Out-Patient	***$10 Copay	***$10 Copay
Per Physican Visit	up to 28 visits per calander year	up to 28 visits per calander year
- In-Patient		
Per Physician Visit	80% / 70% / 50%	90% / 70% / 60%
Short Term Disability (Loss of Time)	26 Weeks Maximum at $125 Per Week	26 Weeks Maximum at $125 Per Week
Prescription Drug		
- Retail Generic Copay	$5 Co-pay	$5 Co-pay
- Retail Brand Formulary Copay	20% co-pay (min $10; max $35)	20% co-pay (min $10; max $35)
- Retail Brand Non-Formulary Copay	30% co-pay (min $10; max $50)	30% co-pay (min $10; max $50)
- Mail Order Generic Copay	$10 Co-pay	$10 Co-pay
- Mail Order Brand Formulary Copay	20% co-pay (min $20; max $50)	20% co-pay (min $20; max $50)
- Mail Order Brand Non-Formulary Copay	30% co-pay (min $20; max $75)	30% co-pay (min $20; max $75)
	$7,500 individual annual maximum	$10,000 individual annual maximum
Dental Provided by Delta Dental	$1,500 annual maximum	$2,500 annual maximum
Orthodonthia	$1,000 Lifetime Benefit	$1,000 Lifetime Benefit
Vision - Exams		
- Frames or Single, Bifocal,	$175 annual maximum	$175 annual maximum
- Trifocal, Lenticular & Contacts		
Eligibility Requirements	Single - 210 hours	Single - 210 hours
(Hours required for each work qtr,)	Family - 360 hours	Family - 360 hours
	***** $10 copay if PPO only**	***** $10 copay if PPO only**