

LABORERS' NATIONAL HEALTH AND WELFARE FUND

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July 1, 2006

**TO ALL PARTICIPANTS IN THE
LABORERS' NATIONAL HEALTH AND WELFARE FUND'S
BENEFIT PLAN**

Dear Participant:

Welcome to the Laborers' National Health and Welfare Fund! The Fund is a joint labor-management, non-profit trust fund established by the Laborers' International Union of North America (LIUNA) and various employers for the benefit of eligible employees and their family dependents. Your Union and Employer have agreed through collective bargaining that the Employer will contribute to the Fund to provide benefit coverage for you and other employees.

This booklet describes the medical, prescription drug, dental, vision, life insurance, and accidental death and dismemberment benefits that are available to you and your family if you have benefit coverage under this Plan 1. This booklet also describes the rules, terms and conditions under which these benefits are available.

This information is important to you and your family, so you should read it and keep it with your important papers.

More particularly, this booklet describes:

- * How you and your dependents (spouse and children) become eligible for benefit coverage, maintain coverage, and lose coverage. How changes in your life may affect your or your dependents' coverage.
- * The benefits provided for covered participants and dependents, including the limitations on and exclusions from these benefits, and any deductibles, co-payments and other cost-sharing charges.
- * How you make a claim for benefits, and appeal denials of claims.
- * How to apply for continuation of coverage on a self-pay basis ("COBRA" continuation coverage).
- * Your obligations and rights as a Participant in the Fund.
- * Other valuable information about the operation of the Fund.

The Table of Contents at the front of the booklet provides you with an outline of the information it contains. Note that several words used in the booklet have initial capital letters. These words have specific meanings that are explained in the text or in the Definitions part at the end of the booklet. You should check the definitions of these capitalized words. Other words used in the booklet also have special meanings that can be found in the Definitions part of the booklet.

The contents of this booklet reflect the rules, terms and conditions of Plan 1 as adopted and amended through July 1, 2006.

Note that the Board of Trustees reserves the right to change the rules, terms and conditions of Plan 1 at any time, with or without advance notice, or to terminate Plan 1. This includes the right to set, and to change from time-to-time, the contribution rates required for Plan 1 coverage and the amount of deductibles, co-payments and other cost-sharing charges. We encourage you to check the Fund's website for updates including changes in the Plan.

Note also that only the Board of Trustees has the authority and discretion to interpret and apply the rules, terms and conditions of the Plan, and to decide all questions of fact and law relating to the Plan and Fund. No other person or organization can answer with any binding effect questions about the Fund and Plan. Accordingly, all questions concerning the Plan and Fund should be directed to the Board of Trustees through the Fund Administrator.

Over the past year, we have re-designed Plan 1 to better meet the needs of the participants and their families while maintaining the financial soundness of this non-profit Fund. We will continue to monitor the Plan's performance in meeting your needs as well as its financial status to maintain an appropriate balance for the benefit of all who depend on the Fund for benefit coverage.

THE BOARD OF TRUSTEES

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Part 1:

ELIGIBILITY FOR COVERAGE & ENROLLMENT

1.1: Introduction

Benefits are payable under this Plan only for Participants and Dependents of Participants who are eligible for coverage and who have enrolled with the Plan, and only to the extent that the service or event for which benefits are claimed occurs while the Participant or Dependent is eligible for coverage.

This Part, and the rest of this booklet, is addressed to “you” and “your”. It assumes that “you” are an Employee and that, once you become eligible for coverage under the Plan, you are a Participant in the Plan.

This Part describes how you and your Dependents become eligible for coverage, continue coverage, and lose coverage. This includes when eligibility begins and when it ends.

This Part also describes how you and your Dependents must enroll in the Plan.

This Part also describes who is a Dependent who will be eligible for coverage if you have Family Coverage.

1.2: Eligibility and Employer Contributions

Generally, you can become eligible and remain eligible for coverage only if your Employer makes timely contributions to the Fund at the required contribution rate.

The Plan permits an Employer to make contributions for its employees at an hourly rate or at a monthly rate. The hourly contribution and monthly contribution rates required for Plan coverage are set by the Board of Trustees and may be changed annually or at other times by the Board. The collective bargaining agreement between your Union and Employer requires the Employer to contribute to the Fund for Plan 2 coverage.

If your Employer makes hourly rate contributions, your eligibility for coverage and your Dependents' eligibility for coverage depends on the number of hours for which contributions are made to the Fund for you. A certain number of hours of contributions must be received by the Fund over a three consecutive calendar month period in order for you alone, or for you and your Dependents, to become initially eligible for coverage. A certain number of hours of contributions must be received by the Fund for “rolling” three consecutive calendar month periods in order for you alone, or for you and your Dependents, to continue your eligibility for coverage. As explained below, the number of hours of contributions determines whether just you (Single Coverage) or you and your Dependents (Family Coverage) will be eligible for coverage.

If your Employer makes monthly rate contributions, your and your Dependents' eligibility for coverage depends on the Employer paying the monthly contributions when due.

The Fund Administrator will send to you periodically a statement of the hours of contributions received by the Fund on your behalf. You should carefully check these statements. If you disagree with any statement, you should immediately contact the Fund Administrator. Failure by the Fund Administrator to provide such a statement, however, will not make you eligible if you were not otherwise eligible.

1.3: Single Coverage (Employee Only) For Hourly Rate Contributions

(a) Initial Eligibility

Generally, you will become eligible for Single Coverage as of the first day of the second calendar month following an initial eligibility base period. The initial eligibility base period is the first period of three consecutive calendar months during which contributions are made to the Fund on your behalf and the contributions are for at least 210 hours. You must also enroll in the Plan to be eligible.

Single Coverage means that only you (and not your Spouse or any other Dependent) are eligible for benefits under the Plan.

Example: You became an Employee of the Employer on January 1st. The Employer contributed to the Fund on your behalf for 70 hours in January, for 82 hours in February, and for 77 hours in March. You became first eligible for Single Coverage effective May 1st. The initial eligibility base period was January, February and March, during which more than 210 hours of contributions were made to the Fund for you. The first day of the second month after March was May 1st.

New Groups: There is a special initial eligibility rule for new groups admitted to participation in the Fund. Employees in such groups for whom the Fund receives contributions for at least 70 hours for the first calendar month of participation will be deemed eligible for Single Coverage as of the first day of the next calendar month. This special rule does not apply to new Employees in already participating groups.

(b) Continuation of Eligibility

Once you earn initial eligibility, you will remain eligible for Single Coverage for each calendar month thereafter so long as contributions for at least 210 hours were made on your behalf for the preceding three consecutive calendar months period (the “rolling” continuing eligibility base period).

Example: You became an Employee of the Employer on January 1st. The Employer contributed to the Fund on your behalf for 70 hours in January, for 82 hours in February, for 77 hours in March, for 80 hours in April, for 80 hours in May, and for 82 hours in June. You became eligible for Single Coverage effective May 1st. You continued to have coverage for June because more than 210 hours of contributions were made for you during February, March and April (the continuing eligibility base period). You continued to have coverage for July because more than 210 hours of contributions were made for you during March, April and May (the continuing eligibility base period). You continued to have coverage for August because more than 210 hours of contributions were made for you during April, May and June (the continuing eligibility base period).

1.4: Family Coverage for Hourly Rate Contributions

(a) Initial Eligibility

Generally, you will become eligible for Family Coverage as of the first day of the second calendar month following an initial eligibility base period. The initial eligibility base period is the first period of three consecutive calendar months during which contributions are made to the Fund on your behalf and the contributions are for at least 360 hours. You and your Dependents must also enroll in the Plan to be eligible.

Family Coverage means that you and your Dependents are eligible for coverage.

Example: You became an Employee of the Employer on January 1st. The Employer contributed to the Fund on your behalf for 120 hours in January, for 130 hours in February, and for 125 hours in March. You became first eligible for Family Coverage effective May 1st. The initial eligibility base period was January, February and March, during which more than 360 hours of contributions were made to the Fund for you. The first day of the second month after March was May 1st.

Example: You became an Employee of the Employer on January 1st. The Employer contributed to the Fund on your behalf for 70 hours in January, for 100 hours in February, for 120 hours in March, and for 140 hours in April. You became first eligible for Single Coverage, but not Family Coverage, effective May 1st. During the initial eligibility base period of January-March, contributions were made for you, but only for 290 hours. That was enough for Single Coverage, but not Family Coverage (which requires 360 hours of contributions). However, you became eligible for Family Coverage as of June 1st because during the three-month period of February, March and April, contributions for 360 hours were made for you.

New Groups: There is a special initial eligibility rule for new groups admitted to participation in the Fund. Employees in such groups for whom the Fund receives contributions for at least 120 hours for the first calendar month of participation will be deemed eligible for Family Coverage as of the first day of the next calendar month. This special rule does not apply to new Employees in already participating groups.

(b) Continuation of Eligibility

Once you earn initial eligibility for Family Coverage, you will remain eligible for Family Coverage for each calendar month thereafter so long as contributions for at least 360 hours were made on your behalf for the preceding three consecutive calendar months period (the “rolling” continuing eligibility base period).

Example: You became an Employee of the Employer on January 1st. The Employer contributed to the Fund on your behalf for 120 hours in January, for 130 hours in February, for 125 hours in March, for 120 hours in April, for 130 hours in May, and for 120 hours in June. You became first eligible for Family Coverage effective May 1st. You continued to have coverage for June because more than 360 hours of contributions were made for you during February, March and April (the continuing eligibility base period). You continued to have coverage for July because more than 360 hours of contributions were made for you during March, April and May (the

continuing eligibility base period). You continued to have coverage for August because more than 360 hours of contributions were made for you during April, May and June (the continuing eligibility base period).

(c) Purchasing Family Coverage (Shortage of Hours)

If you have Family Coverage, but you are going to lose that coverage because contributions for less than 360 hours, but more than 319 hours, were made for you during a three-month Continuing Eligibility Period, you may self-pay contributions to the Fund to purchase a continuation of your Family Coverage.

You can purchase this continuation of Family Coverage by paying to the Fund the difference between the hours of contributions made by the Employer for you and the minimum required 360 hours of contributions (at the appropriate hourly contribution rate) for the continuing eligibility period. However, you cannot self-pay for more than 40 hours. In other words, if the Employer's contributions for you are short by more than 40 hours of the 360 hours minimum, you will not be permitted to self-pay the difference to purchase Family Coverage.

Your self-payment must be submitted to the Fund by the date set forth in the self-pay notice that the Fund Administrator will send to you.

1.5: Special "Look-Back" Eligibility Rules (Excess Hourly Contributions)

If fewer than 210 hours of Employer contributions have been received by the Fund for you during any continuing eligibility base period, your eligibility for Single Coverage will be continued nonetheless if you had enough "excess hours" of contributions over the preceding six calendar months to make up the shortfall. "Excess hours" are hours of contributions during any three consecutive months period in excess of the minimum required for eligibility (210 hours for Single Coverage).

If fewer than 360 hours of Employer contributions have been received by the Fund for you during any continuing eligibility base period, your eligibility for Family Coverage will be continued nonetheless if you had enough "excess hours" of contributions over the preceding six calendar months to make up the shortfall. "Excess hours" are hours of contributions during any three consecutive months period in excess of the minimum required for eligibility (360 hours for Family Coverage).

1.6: Family Coverage for Monthly Rate Contributions

The Fund accepts contributions at a monthly rate, but only for Family Coverage (you and your Dependents). If your Employer has agreed to make monthly rate contributions, you will first become eligible for Family Coverage effective on the first day of the second calendar month following an initial eligibility base period. The initial eligibility base period for monthly rate contributions is the first calendar month for which the Fund receives from the Employer contributions for you. You and your Dependents must also enroll in the Plan to be eligible.

Your eligibility will continue so long as the Employer continues to make the required monthly rate contributions. If the Employer fails to make contributions for a month, your eligibility will cease as of the last day of the next calendar month.

Example: You became an Employee of the Employer on January 1st. The Employer has agreed to contribute to the Fund on a monthly rate basis to provide Family Coverage for its employees. The Employer makes the Family Coverage monthly rate contribution on your behalf for January, February, and March. You became first eligible for Family Coverage effective March 1st (the first day of the second month following the initial eligibility period of January). Your eligibility continues through April 30th based on the March contributions.

1.7: Enrollment in Plan & Changes in Enrollment Information

(a) Enrollment Procedures

Enrollment in the Plan is a necessary condition of eligibility for coverage (for you, and for your Dependents if you have Family Coverage). Enrollment is the main way in which the Fund obtains your contact information and other information about you and your Dependents that is necessary to properly administer the Plan for your benefit.

To enroll in the Plan, you must complete and submit to the Fund Administrator an Enrollment Card and, if you have Family Coverage, you must also submit the following documents:

- * Copy of your and your Spouse's marriage certificate.
- * Copy of the birth certificate for each Dependent Child. If a child is adopted or if you otherwise are legally obligated to provide for the support and maintenance of the child, a copy of the adoption or support order must be provided.
- * If your Spouse's or Dependent Child's name is different than yours, you must submit a copy of your most recent federal income tax return.
- * If a Dependent Child is age 19, 20, 21 or 22 and you claim Full-Time Student status for him or her, you must submit verification that the child is a Full-Time Student at a legitimate educational institution. The verification must be in writing on the educational institution's letterhead and include the number of credit hours being taken by the child and whether courses are taken on a semester or quarterly basis.

[Note: You must submit such verification for each semester or quarter for which Full-Time Student status is claimed.]

- * If a Dependent Child is age 19 or older and you claim Incapacitated Child status for him or her, you must submit a qualified doctor's statement that describes the nature and severity of the child's physical or mental incapacity. The statement must be on the doctor's letterhead.

[Note: The Fund may require you to submit updated doctor's statements.]

- * Such additional documentation as the Fund Administrator deems necessary to determine if a spouse or child can qualify for coverage.

(b) Changes in Enrollment Information

If the enrollment information you submitted to the Fund changes, you must notify the Fund Administrator as soon as possible. Submission to the Fund Administrator of a new enrollment form will be necessary to make the changes in enrollment information. Failure to submit a new enrollment form could affect your or your Dependents' eligibility (for example, a newborn child will not be eligible until enrolled).

In particular, notify the Fund Administrator of:

- * changes in your mailing address or the mailing address of any Dependent;
- * the birth or adoption of a Dependent Child;
- * a Dependent Child attaining age 19;
- * a divorce;
- * the death of a Dependent.

(c) Qualified Medical Child Support Orders (QMCSO)

If a State court or administrative agency has issued an order requiring you to provide health benefit coverage for your Child, you should submit the order to the Fund Administrator as soon as possible.

If the order is determined to be a "Qualified Medical Child Support Order" (QMCSO), within the meaning of federal law, the Fund may be required to provide coverage under the Plan for the child.

Upon receipt of the order, the Fund Administrator will determine whether the order is a QMCSO under the Fund's procedures. A copy of the Fund's QMCSO procedures will be sent to you and the child identified in the order, without charge. In accordance with the law, an order will not be considered a QMCSO if:

- * it would require the Fund to provide any type or form of benefit, or any option, that the Plan does not provide; or
- * you are not eligible for coverage under the Plan (except in certain circumstances under Medicaid-related child support laws).

If the Fund Administrator determines that the order is a QMCSO, you and the child will be notified by the Fund Administrator of the procedures for enrolling the child in the Plan.

Even if the order is a QMCSO, neither the Child, nor any Dependent Child, shall be eligible for coverage unless the Fund receives the contributions required for Family Coverage and all other requirements for treatment as a Dependent Child are satisfied.

1.8: Termination of Eligibility: Loss of Coverage

This Section describes the reasons why your eligibility for coverage may terminate. This Section also describes the reasons why your Dependents' eligibility for coverage may terminate.

(a) Insufficient Contribution Hours (Hourly Rate Contributions)

If you have Single Coverage, you will lose eligibility for coverage if your Employer fails to make contributions to the Fund on your behalf for at least 210 hours in any continuing eligibility base period (three consecutive calendar months). If less than 210 hours of contributions are made on your behalf during any continuing eligibility base period, your eligibility for coverage will end as of the last day of the second calendar month following the end of the continuing eligibility base period.

Example: You became an Employee of the Employer on January 1st. The Employer contributed to the Fund on your behalf for a total of 210 or more hours during January, February and March, so you became first eligible for Single Coverage effective May 1st. Your Employer continued to contribute on your behalf for 80 hours each month during April, May and June. But, the Employer failed to contribute to the Fund on your behalf for July. You will lose eligibility for coverage as of August 31st because the Employer did not make at least 210 hours of contributions for you during the continuing eligibility base period of May, June and July (only 160 hours of contributions were received for May and June).

Example: You became an Employee of the Employer on January 1st. The Employer contributed to the Fund on your behalf for a total of 210 or more hours during January, February and March, so you became first eligible for Single Coverage effective May 1st. Your Employer made contributions on your behalf for 140 hours in April, for 150 hours in May, and 60 hours in June. The Employer failed to make any contributions to the Fund on your behalf for July and August. You will lose eligibility for coverage as of September 30th. The Employer made 210 hours of contributions during the continuing eligibility base period of May, June and July, which gave you continuing eligibility through September 30th. But, the Employer made contributions for only 60 hours during the continuing eligibility period of June, July and August which was insufficient to continue your eligibility into October.

If you have Family Coverage, you will lose eligibility for Family Coverage if your Employer fails to make contributions to the Fund on your behalf for at least 360 hours in any continuing eligibility base period (three consecutive calendar months). If less than 360 hours of contributions are made on your behalf during any continuing eligibility base period, your eligibility for Family Coverage will end as of the last day of the second calendar month following the end of the continuing eligibility base period (unless you self-pay the shortfall in contributions as permitted by section 1.4(c)).

If you lose Family Coverage due to insufficient contributions, you may nonetheless continue to have eligibility for Single Coverage if at least 210 hours of Employer contributions were made on your behalf for the continuing eligibility base period. You may be able to self-pay contributions to make up a shortfall in contributions hours of 40 hours or less to avoid loss of Family Coverage. See Section 1.4(c) (Purchasing Family Coverage).

A shortfall in contributions hours might also be made up using the special "look back" rules. See Section 1.5 (Special "Look Back" Eligibility Rules).

(b) Insufficient Contributions (Monthly Rate Contributions)

If your Employer contributes on a monthly rate basis, you and your Eligible Dependents will lose eligibility for coverage if the Employer fails to make the required contributions for Family Coverage for a month. If the Employer fails to make contributions for a month, eligibility will cease as of the last day of the next calendar month.

(d) Termination of Employer's Participation

If your Employer ceases to have an obligation to contribute to the Fund, your eligibility for coverage (and your Dependents' eligibility, if you have Family Coverage) will terminate as of the first day of the calendar month following the month in which the Employer's participation terminated.

An Employer's participation may terminate because its collective bargaining agreement has expired, because it went out of business, or because it was expelled from the Fund by the Board of Trustees for non-payment of required contributions or other reasons, for example.

(e) Loss of Dependent Status

If you have Family Coverage, your Spouse and / or Eligible Children will lose eligibility for coverage if they cease to be Dependents under the Plan's rules.

(f) Termination of Plan or Fund

The Board of Trustees has the right to terminate the Plan and the Fund. In the event that either the Plan or the Fund is terminated, you and, if you have Family Coverage, your Eligible Dependents will lose eligibility for coverage.

1.9: Regaining Lost Eligibility For Coverage

(a) Single Coverage for Hourly Rate Contributions

If you lose eligibility for Single Coverage due to insufficient contribution hours for a continuing eligibility base period (three consecutive calendar months), you will regain eligibility if your Employer makes at least 210 hours of contributions on your behalf during a subsequent continuing eligibility base period. Once the Fund receives contributions on your behalf for a total of at least 210 hours for a continuing eligibility base period, your eligibility for Single Coverage will be renewed as of the first day of the second month following the continuing eligibility base period. The Fund Administrator may require you to again enroll in the Plan.

Example: You became first eligible for Single Coverage effective May 1st. Your Employer made contributions on your behalf for 140 hours in April, for 150 hours in May, and 60 hours in June. The Employer failed to make any contributions to the Fund on your behalf for July and August, so you lost eligibility for coverage as of September 30th. However, your Employer begins to make contributions for you again in October and contributes for 80 hours in October, 80 hours for November and 80 hours for December. Your eligibility for Single Coverage will be renewed as of the following February 1st because more than 210 hours of contributions were made for you for the continuing eligibility base period of October, November and December and the first day of the second month following that period is February 1st.

(b) Family Coverage for Hourly Rate Contributions

If you lose eligibility for Family Coverage due to insufficient contribution hours for a continuing eligibility base period (three consecutive calendar months), you will regain eligibility if your Employer makes at least 360 hours of contributions on your behalf during a subsequent continuing eligibility base period. Once the Fund receives contributions on your behalf for a total of at least 360 hours for a continuing eligibility base period, your eligibility for Family Coverage will be renewed as of the first day of the second month following the continuing eligibility base period. The Fund Administrator may require you and your Dependents to again enroll in the Plan.

Example: You became first eligible for Family Coverage effective May 1st. Your Employer made contributions on your behalf for 140 hours in April, for 150 hours in May, and 90 hours in June. The Employer failed to make any contributions to the Fund on your behalf for July and August, so you lost eligibility for Family Coverage as of September 30th. However, your Employer begins to make contributions for you again in October and contributes for 120 hours in October, 120 hours for November and 120 hours for December. Your eligibility for Family Coverage will be renewed as of the following February 1st because more than 360 hours of contributions were made for you for the continuing eligibility base period of October, November and December and the 1st day of the 2nd month following that period is February 1st.

Note that you may be able to avoid the loss of Family Coverage by self-paying contributions. See Section 1.4(c) (Purchasing Family Coverage).

(c) Family Coverage for Monthly Rate Contributions

If you lose eligibility for Family Coverage because your Employer has failed to make the required monthly rate contributions, your eligibility for Family Coverage will be renewed if your Employer resumes making the required monthly rate contributions. If the Employer resumes making the required contributions, your eligibility will be renewed as of the first day of the second month following the month for which the Employer resumes making the required contributions.

(d) Employer's Payment of Delinquent Contributions

If you (and, if you have Family Coverage, your Eligible Dependents) lose eligibility for coverage because your Employer fails to make contributions to the Fund when due, and the Employer later pays the contributions to the Fund, the Fund may, in its discretion, retroactively reinstate eligibility for coverage so that claims incurred during the period of delinquency can be accepted.

(e) COBRA Continuation Coverage

See Part 6 concerning the rules for continuing your and your Dependents' eligibility for coverage on a self-pay basis for a temporary period if you or an Eligible Dependent would otherwise lose eligibility due to certain events.

1.10: Eligibility During Family and Medical Leave

(a) Under the federal Family and Medical Leave Act of 1993 (FMLA) you may be entitled to take up to 12 weeks of unpaid leave from your employment during any 12-month period:

- * because of the birth of your child or placement of a child with you for adoption or foster care; or
- * to care for a seriously ill spouse, parent or child; or
- * because of your own serious illness.

Your Employer is obligated under the FMLA to inform you of your rights and obligations under this law. Your Employer has to determine whether you are eligible for FMLA leave.

(b) If you have been granted FMLA leave by your Employer, your Employer is required to continue to pay contributions on your behalf to the Fund while you are on the leave to maintain your and, if you have Family Coverage, your Dependents' eligibility for coverage. If you have been granted FMLA leave, your Employer is required to notify the Fund Administrator so that you do not lose eligibility. You should also notify the Fund Administrator when you take and return from FMLA leave.

(c) If your FMLA leave ends but you do not return to work, you may be entitled to continue your eligibility for coverage under the COBRA continuation coverage rules.

1.11: Eligibility During Military Leave

(a) If you are called to service in the Armed Forces of the United States (active duty or training), your eligibility for coverage and your Dependents' eligibility (if you have Family Coverage) under the Plan may be continued for up to eighteen (18) months in accordance with the federal Uniformed Services Employment and Reemployment Rights Act (USERRA). If you are called into military service, you should contact the Fund Administrator for additional information about maintaining eligibility for yourself and your Eligible Dependents.

(b) If you serve in the Armed Forces for only (31) or fewer days, your eligibility for Single Coverage or Family Coverage will continue for that period, and your Employer will be obligated to contribute to the Fund on your behalf for that period.

(c) If you serve in the Armed Forces for more than thirty-one (31) days, you can choose to continue your and, if you have Family Coverage, your Dependents' eligibility to coverage for up to 18 months at your own expense (102% of the full cost of the coverage as determined by the Board of Trustees). If you choose to continue this coverage at your own expense, your and your Dependents' eligibility for coverage will terminate upon the earliest occurrence of the following events:

- * you fail to pay the required contributions to the Fund within thirty (30) days after the due date set by the Fund Administrator;
- * the last day of the month after eighteen (18) consecutive months of leave;

- * the end of the period during which you are eligible to apply for reemployment with your Employer in accordance with USERRA;
- * the termination of the Fund.

If you are re-employed by your Employer within the 18 month period and you regain eligibility for coverage through your Employer's contributions, your USERRA right to continuation of coverage at your own expense terminates.

- (d) Upon your discharge from military service, you are entitled under USERRA to apply to your Employer for reemployment within a certain period of time. If you are reemployed and your Employer makes contributions to the Fund on your behalf, your eligibility for coverage will be immediately reinstated.
- (e) If your military leave ends but you do not return to work, and you maintained your coverage during your military leave, you may be entitled to continue your eligibility for coverage under the COBRA continuation coverage rules. See Part 6.

1.12: Eligible Dependents

- (a) Your Dependents, for purposes of this Plan, are your Spouse and your Dependent Child (or Children). If you have Family Coverage under the Plan, your Spouse and your Dependent Child (Children) are eligible for coverage if they have been enrolled under the Plan, and are considered Eligible Dependents (Eligible Spouse and Eligible Dependent Children).

This Section explains who is your Spouse and your Dependent Child (or Dependent Children) under this Plan, and how they may lose status as your Dependents. If they lose status as your Dependent, they can no longer be eligible for coverage under the Plan, even though you may have Family Coverage (except to the extent that they elect COBRA continuation coverage under Part 6).

- (b) Your Spouse is your current husband or wife by virtue of a religious or civil ceremony recognized as a lawful marriage by the State or country in which the ceremony was performed and evidenced by a marriage certificate; except that common law and same-gender marriages are not recognized by the Fund even if they are recognized under the laws of a State or country.
 - (1) A divorced spouse is not a Spouse. If you and your Spouse become divorced while you have Family Coverage, your Spouse will lose his or her eligibility for coverage as of the last day of the calendar month during which the divorce becomes effective.
 - (2) If your Spouse loses eligibility for coverage because of divorce, he or she may be entitled to continue his or her eligibility for coverage on a self-paid basis by choosing COBRA continuation coverage. See Part 6.
 - (3) A spouse from whom you are legally separated, but not divorced, will nonetheless be considered your Spouse unless the separation agreement provides otherwise in accordance with applicable State law.

- (c) A Child is any of your unmarried children (natural child, stepchild, adopted child, prospective adoptive child placed in your home, or foster child). A Dependent Child is a Child who primarily depends on you for his or her support and maintenance, for whom you are legally obligated to provide support and maintenance, and who is less than 19 years of age (except as provided below).
- (1) Full-Time Student Exception: If your Child is a full-time student at an accredited college, university, or vocational school, he or she will be considered a Dependent Child even if he or she is age 19, 20, 21 or 22. Full-time means that he or she is taking at least 12 undergraduate credit hours or 9 graduate credit hours per semester or quarter.
 - (2) Incapacitated Child Exception: Your Incapacitated Child will be considered a Dependent Child even if he or she is older than age 18. An Incapacitated Child is a child who cannot engage in gainful employment or self-employment due to a disabling physical or mental Handicap that commenced before the child reached age 19.
- (d) A Child primarily depends on you for his or her support and maintenance if you contribute more than 50% of his or her income or living expenses during a calendar year.
- (e) If a Dependent Child reaches age 19 and is not a full-time student or Incapacitated Child, his or her eligibility for coverage terminates as of the last day of the month in which his or her 19th birthday occurs.
- (f) If a Dependent Child who is a full-time student reaches age 23, his or her eligibility for coverage terminates as of the last day of the month in which his or her 23^d birthday occurs. If the Dependent Child ceases to be a full-time student before reaching age 23, his or her eligibility for coverage terminates as of the last day of the month in which his or her status as a full-time student ends.
- (g) If a Dependent Child who is an Incapacitated Child ceases to be an Incapacitated Child, his or her eligibility for coverage terminates as of the last day of the month in which his or her status as an Incapacitated Child ends.
- (h) If a Dependent Child loses his or her eligibility for coverage due to a loss of status as a Dependent Child, he or she may be entitled to continue his or her eligibility for coverage on a self-paid basis by choosing COBRA coverage. See Part 6.

Part 2:

MEDICAL BENEFITS COVERAGE

2.1: Introduction

This Part of the booklet:

- * Describes the covered medical services, treatments and supplies for which the Fund will pay benefits, either by paying the medical provider or reimbursing you, if you are eligible for coverage and a claim is timely submitted to the Fund.
- * Describes limits on how much the Fund will pay for certain types of covered medical services, treatments and supplies, as well as a lifetime limit on benefits payable by the Fund.
- * Describes your obligation to pay some of the cost of covered medical services, treatments and supplies, and to pay the full cost of services, treatments and supplies not covered by the Plan.
- * Explains that the Fund pays more of the cost of medical services, treatment, equipment and supplies if you receive them through a Preferred Provider Organization (PPO) Network.

2.2: Covered Medical Expenses: Generally

“Covered Medical Expenses” means the cost charged for medical services, treatment, equipment or supplies that are covered by the Plan (Part 2) and are not excluded from coverage (Section 2.7). Generally, the Plan covers a certain percentage of the Covered Medical Expenses that you or your Eligible Dependents receive, if and to the extent that:

- (a) the services, treatment, equipment or supplies are Medically Necessary, as determined by the Board of Trustees, the Fund Administrator or their designee;
- (b) the costs charged for the services, treatment and supplies are Reasonable and Customary;
- (c) you have satisfied the applicable Deductible(s) (see Section 2.4);
- (d) you satisfy any other Plan conditions applicable to benefits for the particular Covered Medical Expense; and
- (e) you pay the required Co-payment or Co-insurance, if any, for the Covered Medical Expense.

You are responsible for any portion of the cost that is not paid by the Fund or that is not discounted under the Plan’s rules.

The percentage paid by the Plan for some covered medical expenses varies according to whether you received the medical service or treatment through a Preferred Provider or not. The Preferred Provider Organization (PPO) Networks used by the Plan are discussed in Section 2.8.

The Plan pays the highest percentage of covered medical expenses if you receive the medical services through a PPO Network provider (the “**In Network**” rate) The Plan pays a lower percentage of covered medical expenses if you do not live in an area where the Plan has a PPO Network provider and you receive the medical services through a provider who is not in one of the Plan’s PPO Networks (the “**No Network**” rate). The Plan pays an even lower percentage of covered medical expenses if you live in an area where the Plan has a PPO Network provider but you receive the medical services through a provider who is not in the Plan’s PPO Network for your area (the “**Out of Network**” rate).

2.3: Schedule Of Covered Medical Expenses

(a) In-Patient Hospital Services: Room & Board

For inpatient Hospital semi-private room and board with general nursing services, the Plan pays the following percentages of the Hospital’s average rate for a semi-private room, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

The Plan will pay a benefit based on the Hospital’s semi-private room rate even if you or your Eligible Dependent has a private room.

No benefits are payable if you or your Eligible Dependent are admitted to the Hospital but no bed-setting is required.

(b) In-Patient Hospital Services: X-Ray, Lab Services & Miscellaneous Fees

The Plan pays the following percentages of the Reasonable and Customary Charges for Hospital in-patient x-ray and laboratory services ordered by a Physician as well as for miscellaneous hospital fees, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

(c) In-Patient Hospital Services: Surgical Services

The Plan pays the following percentages of the Reasonable and Customary Charges for Hospital in-patient surgical services, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

(d) Emergency Transportation (Ambulance) Services

The Plan generally pays the following percentages of the Reasonable and Customary Charges for local ambulance services to the nearest appropriate Hospital or Urgent Care Facility in the case of a Medical Emergency, acute illness or inter-facility healthcare transfer, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

(e) Emergency Room / Urgent Care Facility

The Plan generally pays the following percentages of the Reasonable and Customary Charges for use of a Hospital emergency room or of an Urgent Care Facility in the case of a Medical Emergency, after the Annual Deductible has been met and the payment by you of a Special Deductible of \$100:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

However, if you are admitted to the Hospital because of the Medical Emergency, the \$100 Special Deductible will be waived by the Plan.

(f) Out-Patient Hospital Services

The Plan pays the following percentages of the Reasonable and Customary Charges for Hospital out-patient services, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

(g) Out-Patient Hospital Surgical Services

The Plan pays the following percentages of the Reasonable and Customary Charges for outpatient surgical services of a Hospital, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

(h) Out-Patient Laboratory and X-Ray Services

The Plan pays the following percentages of the Reasonable and Customary Charges for outpatient laboratory and x-ray services ordered by a Physician, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

(i) Physician Surgical Services

The Plan pays the following percentages of the Reasonable and Customary Charges for Physician Surgery services, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

(j) Anesthesia and Its Administration

The Plan pays the following percentages of the Reasonable and Customary Charges for anesthesia and its administration, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

(k) Doctor's Office Visit

The Plan pays the following percentages of the Reasonable and Customary Charges for Physician office services, unless otherwise provided in this Plan:

- * 100%, if In Network, after your payment of a \$20 Co-payment
- * 70%, if No Network (after the Annual Deductible has been met)
- * 50%, if Out of Network (after the Annual Deductible has been met)

The Plan will pay benefits only for a maximum of (28) office visits per calendar year per individual.

Benefits are payable for In Network office visits even if you have not yet satisfied the Annual Deductible for the calendar year. Visits Out of Network and No Network are subject to the Annual Deductible.

(l) Well Child Care

For Eligible Dependent Children under the age of seven (7), the Plan pays 100% of the Reasonable and Customary Charges for up to six (6) physician office well-care visits per individual per Calendar Year. This benefit is not subject to the Annual Deductible.

For Eligible Dependent Children ages seven (7) through eighteen (18), the Plan pays the following percentages of the Reasonable and Customary Charges for up to three (3) Physician office well-care visits per individual per Calendar Year:

- * 100%, if In Network, after your payment of a \$20 Co-payment
- * 70%, if No Network (after the Annual Deductible has been met);
- * 50%, if Out of Network (after the Annual Deductible has been met).

(m) Women's Health: Mammography & Pap Smears

The Plan pays 100% of the R and C Charges for 1 mammography and 1 cytological screening per person per Calendar Year. This benefit is not subject to the Deductible.

(n) Pregnancy / Maternity

The Plan pays the following percentages of the Reasonable and Customary Charges for medical services for pregnancy and pregnancy-related conditions, after the Annual Deductible has been met:

- * 80%, if In Network 70%, if No Network 50%, if Out of Network

The Plan complies with the federal law requirements regarding length of hospital stays for mothers who have given birth and their newborns. The Plan does not limit a mother's hospital stay in the event of a normal vaginal delivery to less than 48 hours, or a mother's hospital stay in the event of a cesarean delivery to less than 96 hours. The Plan does not require a provider to obtain Plan authorization for hospital stays not in excess of such lengths.

No pregnancy / maternity benefits are payable for Dependent Children, but benefits are payable (based on the schedule above) for complications of pregnancy by Eligible Dependent Children.

No benefits are payable for elective abortions, except:

- * when the individual's life would be endangered if the fetus were carried to term; or
- * for complications of an abortion.

(o) Mental Health & Substance Abuse

The Plan pays the following percentages of the Reasonable and Customary Charges for up to twenty-eight (28) outpatient visits per Calendar Year per individual to an approved Behavioral Health Practitioner for mental health and / or alcohol or drug abuse:

- * 100%, if In Network, after your payment of a \$20 Co-payment
- * 70%, if No Network (after the Annual Deductible has been met);
- * 50%, if Out of Network (after the Annual Deductible has been met).

The Plan pays the following percentages of the Reasonable and Customary Charges for in-patient Physician visits for mental health and / or alcohol or drug abuse, after the Annual Deductible has been met:

- * 80%, if In Network 70%, if No Network 50%, if Out of Network

(p) Annual Physical Exam (Participant Only)

The Plan pays 100% of the PPO allowable amount up to a maximum of \$200, after a \$20 Co-Payment by you, for one physical examination of you by an In Network provider per Calendar Year. This benefit is available only to you and not to any Eligible Dependent.

This benefit includes only the physical examination. Any other services, treatment, supplies or equipment associated with the examination (such as immunizations, x-rays, and laboratory tests) may be covered under other provisions of this Plan.

(q) Physical Therapy Services

The Plan pays the following percentages of the Reasonable and Customary Charges for Physical Therapy services, unless otherwise provided in this Plan:

- * 100%, if In Network, after your payment of a \$20 Co-payment
- * 70%, if No Network (after the Annual Deductible has been met);
- * 50%, if Out of Network (after the Annual Deductible has been met).

The Plan will pay benefits only for a maximum of twenty-eight (28) visits per Calendar Year per individual.

Benefits are payable for Physical Therapy services only when the services are ordered by a Physician and are provided by a Licensed Physical Therapist (LPT) or a Registered Physical Therapist (RPT).

(r) Chiropractic Services

The Plan pays the following percentages of the Reasonable and Customary Charges for chiropractic services, unless otherwise provided in this Plan:

- * 100%, if In Network, after your payment of a \$20 Co-payment
- * 70%, if No Network (after the Annual Deductible has been met);
- * 50%, if Out of Network (after the Annual Deductible has been met).

The Plan will pay benefits only for a maximum of (28) visits per Calendar Year per individual.

(s) Acupuncture Services

The Plan pays 50% of the Reasonable and Customary Charges for Acupuncture services, unless otherwise provided in this Plan, after the Annual Deductible has been met.

The Plan will pay benefits only for a maximum of 28 visits per Calendar Year per individual.

(t) Organ Transplants

The Plan pays the following percentages of the Reasonable and Customary charges for organ transplants, unless otherwise provided in this Plan, after the Annual Deductible has been met:

- * 80%, if In Network 70%, if No Network 50%, if Out of Network

You must obtain prior authorization from the Fund Administrator or its designee before obtaining the organ transplant as a condition of coverage.

The Plan does not pay any benefits for the organ donor.

(u) Speech Therapy

The Plan pays the following percentages of the Reasonable and Customary charges for speech therapy services by a licensed speech therapist, unless otherwise provided in this Plan, after the Annual Deductible has been met:

- * 100%, if In Network, after your payment of a \$20 Co-payment
- * 70%, if No Network (after the Annual Deductible has been met);
- * 50%, if Out of Network (after the Annual Deductible has been met).

The Plan will pay benefits only for a maximum of 28 visits per Calendar Year per individual. Benefits are payable for speech therapy services only when the services are ordered by a Physician and are necessary for restoration of lost speech due to a diagnosed Illness or Injury.

(v) Hospice Care

The Plan pays the following percentages of the Reasonable and Customary Charges for hospice care by a Qualified Hospice Care Program, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

Hospice care benefits are payable only when the patient has a life expectancy of four (4) months or less. Hospice benefits are payable for a maximum of (120) days per Covered Individual.

You must obtain prior authorization from the Fund Administrator or its designee for the hospice care services as a condition of coverage.

(w) Private Duty Nursing

The Plan pays the following percentages of the Reasonable and Customary charges for private duty nursing services, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

Benefits are payable for private duty nursing services (1) only with prior authorization from the Fund Administrator or its designee, (2) only when the services are ordered by a Physician, and (3) only for services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) other than a nurse who normally lives in your home or is a member of your or your Spouse's immediate family.

(x) Durable Medical Equipment

The Plan pays the following percentages of the Reasonable and Customary charges for the rental of Durable Medical Equipment, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

NOTE: You must obtain authorization from the Fund Administrator before renting the equipment, as a condition of coverage.

The benefits payable for such equipment shall not exceed the purchase cost of the equipment.

Durable Medical Equipment includes wheelchairs and hospital-type beds.

(y) Corrective Appliances

The Plan pays the following percentages of the Reasonable and Customary Charges for Corrective Appliances, unless otherwise provided in this Plan, after the Annual Deductible has been met:

* 80%, if In Network 70%, if No Network 50%, if Out of Network

Corrective Appliances include trusses, braces or supports, casts, splints and crutches. Corrective Appliances do not include dental appliances.

(z) Hearing Aids

The Plan generally pays 100% of the Reasonable and Customary Charges, after the Annual Deductible has been met. This benefit is limited to \$500 per hearing aid, and two hearing aids within thirty-six (36) months per Covered Individual.

You must obtain prior authorization from the Fund Administrator or its designee for a hearing aid as a condition of coverage.

(aa) Prosthetic Appliances

The Plan pays the following percentages of the R and C Charges for Prosthetic Appliances, unless otherwise provided in this Plan, after the Deductible has been met:

*	80%, if In Network	70%, if No Network	50%, if Out of Network
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This benefit includes the initial purchase, fitting, repair and replacement of fitted prosthetic devices that replace body parts, subject to the provisions of Section 2.7(33).

2.4: Deductibles

(a) A Deductible is the portion of your covered medical expenses that you must pay before the Fund pays for any portion of your medical expenses. Only Covered Medical Expenses can be used to satisfy a Deductible requirement. The Plan provides for Annual Deductibles and for Special Deductibles.

(b) Annual Deductibles:

- (1) There are two types of Annual Deductibles: an Individual Deductible and a Family Deductible.
- (2) The Annual Individual Deductible is the amount of Covered Medical Expenses that any one Covered Individual (you or an Eligible Dependent) must pay during a calendar year before the Plan pays any portion of the Covered Medical Expenses for that Covered Individual. The amount of this Annual Individual Deductible is three hundred dollars (\$300) of In-Network Covered Medical Expenses, and four hundred dollars (\$400) of Out-of-Network Covered Medical Expenses.
- (3) The Annual Family Deductible is the amount of Covered Medical Expenses that a family of two or more Covered Individuals (you and one or more Eligible Dependents) must collectively pay during a calendar year before the Plan pays any portion of the Covered Medical Expenses for any of those Covered Individuals. The amount of this Annual Family Deductible is six hundred dollars (\$600) of In-Network Covered Medical Expenses, and eight hundred dollars (\$800) of Out-of-Network Covered Medical Expenses; but the Annual Family Deductible will not be satisfied unless you or one of your Eligible Dependents has met the Annual Individual Deductible for the year.
- (4) Once the Annual Family Deductible for the year has been satisfied, the Annual Individual Deductible for the year will be deemed as satisfied for all Covered Individuals in your family.

- (5) If you do not satisfy the Annual Individual Deductible or Family Deductible in a calendar year, the Covered Medical Expenses incurred by you and your Dependents during the last three months of the year will be applied towards your Annual Deductibles for the next calendar year.
 - (6) Benefits are provided for some specified Covered Medical Expenses even if the Annual Deductible has not been satisfied. If a Deductible does not apply to a particular benefit, the Schedule of Covered Medical Expenses will say so.
- (c) A Special Deductible is a Deductible that applies to certain types of benefits. The Special Deductible must be paid before the Plan will pay any portion of the cost for a benefit to which a Special Deductible applies. If a Special Deductible applies to a benefit, the benefit's description in the Schedule of Covered Medical Expenses will say so.
- (d) Examples:

Example: You have Single Coverage under the Plan. The Annual Individual Deductible applicable to you is \$300 (In-Network), \$400 (Out-of-Network). In November and December 2005, you incurred \$150 of Covered Medical Expenses with an In-Network provider. You were responsible for paying the entire \$150 to the provider because you did not satisfy the Annual Individual Deductible. In January and February 2006, you incurred \$100 of Covered Medical Expenses with an In-Network provider. To satisfy your Individual Deductible for 2006, the \$150 paid by you in November and December 2005 would be carried forward to help satisfy the 2006 Annual Deductible, so you would be only responsible to pay the first \$50 of your 2006 expenses before your benefits would be payable by the Plan.

Example: You have Family Coverage under the Plan. The Annual Family Deductible is \$600 (In-Network). You and your Eligible Dependents incur the following Covered Medical Expenses In-Network in 2005:

You	\$300
Spouse	\$100
Dependent Child	\$200

The In-Network Family Deductible has been satisfied because you met the Individual Deductible for the year (\$300 In-Network) and you and your Dependents have collectively incurred \$600 in Covered Medical Expenses In-Network. Note that if you or your Eligible Dependents incur Covered Medical Expenses for services from an Out-of-Network provider, no benefit would be payable unless and until the Annual Family Deductible for Out-of-Network (\$800) has been met.

Example: You have Family Coverage. The Annual Family Deductible is \$600 (In-Network). You and your Eligible Dependents incur the following Covered Medical Expenses In-Network in 2005:

You	\$ - 0 -
Spouse	\$50
Dependent Child	\$500

Your Eligible Dependent Child has satisfied the Individual Deductible of \$300 (In-Network). The remaining \$200 of Covered Medical Expenses incurred by the Eligible Dependent Child would be paid according to the Schedule of Covered Medical Expenses. No benefits would be payable for your Spouse's Covered Medical Expenses because the Annual Family Deductible of \$600 (In-Network) has not been met.

2.5: Your Share Of The Medical Expenses

- (a) In addition to the Deductibles described in Section 2.4, you are responsible for paying:
- (1) The percentage of the cost of Covered Medical Expenses not payable under the Plan (called "Co-insurance"), including any additional Co-insurance imposed for failure to use the Plan's utilization management program when required to do so.
 - (2) Any applicable Co-payment, including any additional Co-payment imposed for failure to use the Plan's utilization management program when required to do so. Co-payments are normally paid directly to a PPO provider.
 - (3) The full cost of medical expenses not covered by the Plan because they are excluded medical expenses (exclusions);
 - (4) Charges for Covered Medical Expenses that exceed the Reasonable and Customary Charge for such expenses (excess cost);
 - (5) Covered Medical Expenses that exceed any annual or benefit-specific limitations on benefits in the Plan; and
 - (6) The cost of all medical expenses, including Covered Medical Expenses, once you exceed the Plan's annual and lifetime maximum payable benefit limits (Section 2.6).
- (b) Out-of-Pocket PPO Maximum: There is a limit on the total amount of co-payments and co-insurance that you are required to pay for Covered Medical Expenses for each calendar year to the extent that you and your Eligible Dependents receive your medical services, treatment, equipment or supplies from PPO Network providers. This Annual Out-of-Pocket Maximum amount is ten thousand dollars (\$10,000) per Covered Individual and twenty-five thousand (\$25,000) per family of Covered Individuals.

2.6: Annual and Lifetime Maximum Medical Benefits

- (a) Annual Major Medical Maximum Limit: The maximum amount of benefits for Covered Medical Expenses that is payable under the Plan with respect to each Covered Individual (you or your Eligible Dependent) in any calendar year is seventy-five thousand dollars (\$75,000). Covered Medical Expenses do not include prescription drug, dental and vision benefits covered by Parts 3, 4 and 5; nor do they include any life insurance, accidental death and dismemberment, and short term disability benefits under Parts 8 and 9.
- (b) Lifetime Major Medical Maximum Limit: The maximum amount of benefits for Covered Medical Expenses that is payable under the Plan with respect to each Covered Individual (you or your Eligible Dependent) over the course of the Covered Individual's lifetime is two hundred fifty thousand dollars (\$250,000). Covered Medical Expenses do not include prescription drug, dental and vision benefits covered by Parts 3, 4 and 5; nor do they include any life insurance, accidental death and dismemberment, and short term disability benefits under Parts 8 and 9.

2.7: Exclusions: Medical Expenses For Which No Benefits Are Payable

The Plan will not pay any benefits for the following types of situations, services, treatments, equipment and supplies. They are all excluded from coverage by the Plan.

1. Attempted Suicide or Self-Inflicted Injury: Expenses incurred by any Covered Individual arising from an attempt at suicide or from a self-inflicted Injury or Illness, regardless of whether the Covered Individual was sane or insane, and any complications thereof.
2. Autopsy: Expenses for an autopsy and any related expenses, except as required by the Fund Administrator or its designee.
3. Cosmetic Surgery: Expenses for plastic surgery, cosmetic surgery or other services primarily intended to improve or preserve the patients physical appearance, except as required because of: (1) an accidental bodily injury occurring while covered; (2) reconstruction surgery, when service is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved part; or (3) reconstruction surgery due to a congenital disease or abnormality of an Eligible Dependent Child which has resulted in a functional physiological defect. Cosmetic surgery does not include the reconstruction of a breast following a mastectomy necessitated by disease, Illness or Injury.
4. Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.
5. Custodial Care: Expenses for Custodial Care, whether provided in the home or in any facility whatsoever, that is determined by the Fund Administrator to be primarily domiciliary or custodial, except as provided under a Qualified Hospice Care Program.

6. Dental Care or Treatment: Expenses for dental care or treatment, except as provided in Part 3 (Dental Benefits).
7. Dental Surgery: Expenses for surgery for the teeth, gums or jaws, except for (1) the removal of tumors or cysts; or (2) the treatment due to an accidental injury performed within 12 months from the date of the accident.
8. Eye Refractions: Expenses for diagnosis and treatment of refractive errors, except as provided in Part 4 (Vision Benefits).
9. Educational Services: Expenses for educational services, supplies or equipment, including computers, software, printers, books, tutoring, visual aides, auditory aides, speech aids, etc., even if they are required because of an Injury, Illness or disability of a Covered Individual.
10. Elective Abortions: Expenses for or relating to elective abortions are not payable except: (1) when the covered woman's life would be endangered if the fetus were to be carried to term; or (2) for complications of an abortion.
11. Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation, annual maximum, or lifetime maximum.
12. Expenses Exceeding Reasonable and Customary charges: Any charge to the extent that is determined by the Fund Administrator or its designee to exceed the Reasonable and Customary charge for service, treatment, supplies or equipment.
13. Expenses for Which a Third Party is Liable: Expenses relating to an Injury or Illness for which a third party is or may be liable. See Part 7.
14. Expenses Incurred Before or After Coverage: Expenses incurred
 - * before the patient became eligible under the Plan; or
 - * after the date the patient's eligibility ends.
15. Experimental and/or Investigational Services: Expenses for any medical services, supplies, drugs or medicines that are determined by the Fund Administrator or its designee to be Experimental and/or Investigational.
16. Expenses for Injury or Illness Contracted While on Military Duty: Expenses for treatment, services or supplies that are required as a result of an injury or illness while on military duty of any country or international organization.
17. Fertility Services: Expenses incurred by any Covered Individual in connection with assistive reproductive procedures, including artificial insemination, in vitro fertilization, embryo or ovum transfers and gamete intra-fallopian tube transfer, zygote intra-fallopian tube transfer, or cryogenic or other preservation techniques used in these or similar devices. Care and treatment, including office visits and diagnostic services, related to fertility services are excluded. Medication management for non-covered fertility drugs is also excluded.

18. Hair Loss: Expenses incurred for the care and treatment for hair loss including wigs, transplants or any treatment that promises hair growth.
19. Illegal Act: Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of his or her commission or attempted commission of an illegal act.
20. Maintenance Therapy: Expenses for services, treatment, equipment or supplies in connection with speech therapy, occupational therapy or physical therapy that is maintenance therapy for a chronic disease or condition.
21. Marriage and/or Family Therapy or Counseling: Expenses incurred by any Covered Individual in connection with marriage and/or family therapy.
22. Maternity Expenses for Eligible Dependent Child: Maternity expenses of a Dependent Child are not covered under this Plan. However, it does cover benefits for an Eligible Dependent Child's Complications of Pregnancy.
23. Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Physician or other Health Care Practitioner, Covered Individual or family member of a Covered Individual.
24. Non-Medically Necessary Expenses: Expenses for services, treatments, equipment and supplies that are determined by the Fund Administrator or its designee to not be "Medically Necessary".
25. Not Specified as Covered: Expenses for services, treatments, equipment and supplies not specified as covered under the Plan in this document.
26. Operation of a Vehicle While Intoxicated: Expenses incurred by any Covered Individual for injuries caused in a motor vehicle accident if the Covered Individual was operating the vehicle and had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred.
27. Organ Donor Expenses: All donor expenses related to organ transplant.
28. Physical Examinations or Tests for Employment, School, etc.: Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party, except Well Care Benefits and Employee-Only Physical Exams, as provided in the Schedule of Medical Benefits in the Medical Expense Coverage Chapter.
29. Private Duty Nursing: Expenses for private duty nursing, unless the service's of a private duty nurse is certified as Medically Necessary by the Fund Administrator or designee.
30. Private Room in a Hospital or Specialized Health Care Facility: The use of a private room in a Hospital or other Health Care Facility, unless its use is certified as Medically Necessary by the Fund Administrator or its designee.

31. Radial Keratotomy: Expenses for medical or surgical treatment of myopia (nearsightedness) or hyperopia (farsightedness), including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.
32. Recreational or Leisure Therapy: Any expenses for such therapy that is recreational or leisurely in nature, including but not limited to, health clubs, swimming pools, cruises, etc.
33. Replacement of Correctional and Prosthetic Appliances: Expenses for replacement of corrective and prosthetic appliances, unless the Fund or its designee certifies that replacement is Medically Necessary because there has been substantial change in the Covered Individual's physical condition to make the original appliance no longer functional.
34. Reproductive Counseling and Contraceptive Devices: All care, treatment and other services relating to contraceptive management or reproductive counseling including medical visits, all contraceptive devices, and sterilization.
35. Services Covered by Workers' Compensation: Expenses for the treatment of conditions covered by workers' compensation or occupational disease law.
36. Services for Patient Convenience: Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, VCR, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
37. Services Not Prescribed by a Physician: Expenses for services, treatment, equipment or supplies that are not ordered or prescribed by a Physician, except for covered services provided by a Health Care Practitioner, as permitted in the Plan.
38. Services Provided by Government: Expenses for services, treatment, equipment, and supplies when benefits for them are provided to a Covered Individual:
 - * under any plan or program established under the laws or regulations of any government, including the federal, state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any other country; or
 - * under any plan or program in which any government participates other than as an employer; unless the governmental program provides otherwise. However, this exclusion does not apply to Reasonable and Customary charges for Covered Medical Expenses that are incurred by a Covered Individual at a Veteran's Administration facility or in a military hospital, provided that the Expenses are not related to military service.
39. Services Provided by Relatives: Expenses for services, treatment, equipment and supplies provided by any Physician or other Health Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or you.

40. Services Provided Without Cost to Recipient: Expenses for services, treatment, equipment and supplies provided for which:
- * a Covered Individual is not required to pay or which are obtained without cost; or
 - * there would be no charge if the Covered Individual receiving the treatment were not eligible under this Plan.
41. Services Required Because of Failure to Follow Medical Advice:
- * Failure to Comply with Medically Appropriate Treatment: Expenses incurred by any Covered Individual who fails to comply with medically appropriate treatment, as determined by the Fund Administrator or its designee.
 - * Leaving a Hospital Contrary to Medical Advice: Hospital or other Health Care Facility expenses if a Covered Individual leaves the facility against the medical advice of the attending Physician within 72 hours after admission.
 - * Travel Contrary to Medical Advice: Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.
42. Sexual Reassignment and Dysfunction: Expenses incurred for sexual reassignment, any treatment related to sexual dysfunction, or reversals of voluntary (elective) sterilization procedure.
43. Surrogate Parenting: Any expenses as a result of surrogate parenting.
44. Telephone Calls: Any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any purpose whatsoever.
45. Temporomandibular Joint Disorder (TMJ) Expenses for treatment, services or supplies in connection with Temporomandibular Joint Disorder (TMJ).
46. Expenses for which a third-party is responsible.
47. Travel or Accommodations: Expenses for travel or accommodations, whether or not recommended by a physician, except for Ambulance charges covered by this Part.
48. Vocational Rehabilitation and Employment Counseling: Any expenses associated with vocational rehabilitation and employment counseling.
49. War, Insurrection or Riot: Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of war, insurrection or riot.
50. Weight Management and Physical Fitness Treatments: All expenses relating to fitness programs, weight control programs, physical, pulmonary conditioning programs or other programs involving exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education.

51. Obesity Treatments: All expenses relating to weight reduction or obesity treatments, including surgical procedures such as gastric stapling, are excluded from coverage; except where (a) prior approval of the Fund Administrator or its designee is obtained, (b) the treatment or services are medically necessary for the treatment of morbid obesity, and (c) in the case of surgery, no alternative treatments are available or medically appropriate.

2.8: Preferred Provider Organization (PPO) Networks

- (a) A PPO Network is a group of physicians, hospitals, and other health care providers who agree to charge lower fees for services, treatment, equipment and/or supplies provided to members of a health plan that contracts with the PPO. Generally, a PPO agrees to charge lower fees because the health plan will encourage its members to use the providers in the PPO and these providers will have more patients as a result. A health plan contracts with a PPO because the lower fees charged by a PPO save both the plan and its members money.
- (b) The Fund has contracted with PPO Networks in many States and local areas where Participants in this Plan live and work. A listing of the areas covered by PPO Networks and of the doctors, hospitals, and/or other providers in each PPO Network is available to you on the Fund's website (www.Inhwf.org). A hard copy of the listing may be obtained from the Fund Administrator. This information may change frequently, so the website is the best source for updated information.

It is your responsibility to determine whether the Plan has a PPO Network in your area.

You should contact the Fund Administrator or check the Fund's website to learn whether there is a Plan PPO Network in the area where you live or work. If there is a Network, you should review the doctors, hospitals and other providers in the Network and select the providers that you wish to use in the event that you or your covered Dependents need medical services, treatment, equipment or supplies.

You do not need to register with any Network Physicians, Hospitals, and other Health Care Providers in advance of needing their services. If and when you need the Network provider's services, your Plan identity card will identify you as entitled to the reduced fees.

The PPO Networks, the areas covered, and the providers participating in a particular PPO Network can and do change from time-to-time. You are encouraged to often check the status of the PPO Network in your area on the Fund's website.

- (c) The Plan is designed to encourage you to use Physicians, Hospitals, and other Health Care Providers in the Plan's PPO Networks. The advantages of using a PPO Network provider include the following:
- (1) Claims forms are not required if you and your Eligible Dependents use a Plan PPO Network provider. If you use any Physicians, Hospitals, and other Health Care Providers not in a Plan PPO Network, a claim form has to be submitted to the Plan by you or the provider.
 - (2) Your Co-payment / Co-insurance for the service, treatment, equipment or supplies you or your covered Dependents receive from a Plan PPO Network provider is significantly lower than if the provider is not in a PPO Network. See Sections 2.2 and 2.3 concerning the difference between In-Network and Out-of-Network costs.

- (d) If a Plan PPO Network Physician, Hospital, and other Health Care Provider are available in the area where you live or work and you or your Eligible Dependent uses a provider that is not in the Plan PPO Network, the Out-of-Network benefit will apply to the Covered Medical Expenses incurred. A Plan PPO Network provider is considered available to you and your Eligible Dependent if the provider's facility is within a 50-mile radius of where you live or work.
- (e) If a Plan PPO Network Physician, Hospital, and other Health Care Provider is not available within a 50-mile radius of where you live or work, and you or your Eligible Dependent uses a Physician, Hospital, and other Health Care Provider who is not in a Plan PPO Network, the No-Network benefit will apply to the Covered Medical Expenses incurred. The No-Network benefit payable by the Plan is higher than the Out-of-Network benefit but is less than the In-Network benefit.
- (f) When you use Plan PPO Network Physicians, Hospitals, and other Health Care Providers, you are responsible for paying the provider the applicable Co-payment / Co-insurance.

2.9: Utilization Review Program: Including Requirement For Pre-certification Before Hospitalization

- (a) The Plan has certain procedures designed to minimize unnecessary costs for the Plan and you while enabling you and your Eligible Dependents to receive necessary and appropriate medical services, treatment, equipment and supplies. These procedures are called a Utilization Review Program. The Utilization Review Program consists of the following procedures:
 - (1) Pre-certification of the Medical Necessity of the following services where the services are not an emergency:
 - * admission to a Hospital or other Health Care facility;
 - * admission to a skilled nursing facility; and
 - * hospice care.
 - (2) Retrospective review of the Medical Necessity of medical and/or surgical services provided on an emergency basis or in other situations where there was no pre-certification.
 - (3) Concurrent review, based on the admitting diagnosis, of services requested by the Physician.
 - (4) Certification of services and planning for discharge from a Health Care Facility or completion of medical treatment.
 - (5) Review and audits of the charges for services.

The Utilization Review Program is not intended to be the practice of medicine or to substitute the Fund's judgment for the medical judgment of any attending Physician or other Health Care Practitioner.

(b) Pre-certification (Approval) Required Before Non-Emergency Hospital Admission

Before you or your covered Dependent is admitted to a Hospital or other Health Care Facility, you are required to obtain a pre-certification (approval) from the Plan's Utilization Review Provider, unless the admission is for a Medical Emergency.

The procedures for obtaining pre-certification from the Plan's Utilization Review provider and for appealing a denial of pre-certification are set forth in a separate Utilization Review Procedures document. That document may be obtained from the Fund's website (www.Inhwf.org) or by contacting the Fund Administrator.

2.10: Case Management

Case Management is used to coordinate, monitor and manage complex and costly cases, usually involving serious Illnesses or Injuries. Serious Illnesses or Injuries include: chronic illnesses, acute catastrophic injury, infectious diseases, burns, terminal illnesses, neonatal complications, and AIDS and AIDS-related cases.

A Case Manager will be assigned and will contact you and your family to discuss your medical care needs. Your Case Manager can help you and your physician arrange and coordinate needed services after your discharge. They will also review your case to determine how your health needs can best be met within your existing Plan Benefits. If special benefits are required, the Case Manager may recommend alternate levels of care (such as a Skilled Nursing Facility or a Qualified Hospice Program) and identify additional medical resources that may be available to you. These are recommendations only and the patient, the attending physician and the patient's family must all agree.

2.11: 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 (WHCRA). For individual 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.
- * Protheses.
- * Treatment of physical complications of the mastectomy, including lymphadema.

These benefits will be provided subject to the same Deductibles, Co-payments and Co-insurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, contact the Fund Administrator.

2.12: 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).

2.13: Benefit Claims

See Part 10 (Claims & Appeals) for information about submitting claims and appealing a denial of benefits.

Part 3:

DENTAL BENEFITS COVERAGE

3.1: Dental Benefits Covered: Generally

The Plan pays benefits for Covered Dental Charges incurred by you and, if you have Family Coverage, your Eligible Dependents:

- (a) if the dental services or supplies are furnished or recommended by a Dentist, and are listed in the Plan's Schedule of Covered Dental Procedures and are not excluded;
- (b) to the extent that the Covered Dental Charges are Reasonable and Customary charges;
- (c) up to the Maximum Amount shown in the Schedule of Covered Dental Procedures;
- (d) subject to an annual maximum limit on dental benefits payable under the Plan of one thousand dollars (\$1,000) per Covered Individual (Section 3.3) and the orthodontic services lifetime maximum (Section 3.4, VIII).

You are responsible for any portion of the charges not paid by the Fund under the Plan.

3.2: Pre-Treatment Estimate Requirement

If you or your Eligible Dependent expects to undergo a course of dental treatments that will cost more than three hundred dollars (\$300), you must submit a Pre-Treatment Estimate to the Fund Administrator before undergoing the treatment, except in the case of a Medical Emergency. The Pre-Treatment Estimate should be in the form of a completed dental claim form that describes the proposed treatment and the estimated cost of the treatment.

After reviewing the Pre-Treatment Estimate, the Fund Administrator will notify you and your Dentist as to the amount of the benefit payable under the Plan for the treatment.

3.3: Annual Maximum Benefit Payable

The Plan will pay no more than one thousand dollars (\$1,000) per Covered Individual in a calendar year for covered dental benefits. Orthodontic benefits are not included in this annual maximum limit.

3.4: Schedule of Covered Dental Expenses

The Plan will pay 100% of the Reasonable and Customary charge for one oral exam in any period of six (6) consecutive calendar months per Covered Individual.

The Plan will pay 100% of the Reasonable and Customary charge for one prophylaxis (cleaning), including polishing, in any period of six (6) consecutive calendar months per Covered Individual.

The Plan will pay 100% of the Reasonable and Customary charge for the dental services or supplies listed in the following schedule of covered dental procedures, up to the applicable Maximum Amount in accordance with the \$1,000 annual maximum:

Code	Maximum Amount
I. DIAGNOSTIC/PREVENTIVE SERVICES	
00150 Initial oral examination.....	\$50.00
00120 Periodic Oral Exam.....	\$32.00
00140 Emergency Oral Exam.....	\$45.00
00210 Intraoral X-Rays - complete series including bitewings.....	\$95.00
00220 Intraoral periapical - single first film.....	\$16.00
00230 Intraoral periapical - each additional film.....	\$19.00
00240 Intraoral occlusal, each film.....	\$25.00
00250 Extraoral - single first film.....	\$50.00
00260 Extraoral - each additional film.....	\$32.00
00270 Bitewing - single film.....	\$18.00
00272 Bitewing - two films.....	\$29.00
00273 Bitewing - three films.....	\$35.00
00274 Bitewing - four films.....	\$42.00
00275 Bitewing - each additional film.....	\$12.00
00290 Posteroanterior, lateral skull & facial bone survey film.....	\$100.00
00321 Temporomandibular joint film.....	\$150.00
00330 Panoramic - maxilla and mandible film.....	\$70.00
00340 Cephalometric film.....	\$60.00
00460 Pulp vitality tests.....	\$36.00
00470 Diagnostic casts.....	\$59.00
00471 Diagnostic photographs.....	\$30.00
01110 Prophylaxis - adults.....	\$75.00
01120 Prophylaxis - children.....	\$50.00
01201 Topical application of fluoride (including prophylaxis) Child.	\$70.00
01202 Topical application of fluoride (including prophylaxis) Adult.	\$70.00
01203 Topical application of fluoride (no prophylaxis)-Child	\$35.00
01211 Topical application of sodium fluoride.....	\$70.00
01231 Topical application of acid fluoride phosphate.....	\$65.00
01330 Oral hygiene instruction.....	\$33.00
01340 Training and preventative dental care.....	\$65.00
01350 Topical application of sealant per quadrant.....	\$49.00
01351 Sealant per tooth.....	\$42.00
II. RESTORATIVE - SIMPLE	
02110 Amalgam - one surface, primary.....	\$75.00
02120 Amalgam - two surfaces, primary.....	\$99.00
02130 Amalgam - three surfaces, primary.....	\$110.00
02131 Amalgam - four surfaces, primary.....	\$130.00
02140 Amalgam - one surface, permanent.....	\$85.00

02150 Amalgam - two surfaces, permanent.....	\$112.00
02160 Amalgam - three surfaces, permanent.....	\$129.00
02161 Amalgam - four surfaces (or more) permanent.....	\$180.00
02190 Pin retention, exclusive of amalgam.....	\$60.00
02210 Silicate cement per restoration.....	\$54.00
02310 Acrylic, plastic or composite resin.....	\$60.00
02330 Composite resin - one surface.....	\$100.00
02331 Composite resin - two surfaces.....	\$135.00
02332 Composite resin - three surfaces.....	\$162.00
02334 In retention, exclusive of composite.....	\$200.00
02335 Acrylic, plastic or composite resin (involving incisal angle or 4 or more surfaces).....	\$185.00
02391 Composite resin-one surface posterior.....	\$115.00
02392 Composite resin-two surfaces posterior.....	\$155.00
02393 Composite resin-three surfaces posterior.....	\$190.00
02940 Fillings (sedative).....	\$75.00

III. RESTORATIVE - MAJOR

02410 Gold foil - one surface.....	\$534.00
02510 Gold inlay - one surface.....	\$560.00
02540 Gold only - per tooth (in addition to above).....	\$120.00
02710 Crown - plastic (acrylic).....	\$460.00
02711 Crown - plastic - prefabricate.....	\$380.00
02720 Crown - plastic with gold (high and medium noble).....	\$730.00
02721 Crown - plastic with non-precious metal (base metal).....	\$780.00
02740 Crown - porcelain.....	\$800.00
02750 Crown - porcelain with gold (high and medium noble).....	\$800.00
02751 Crown - porcelain with non-precious metal (base metal).....	\$648.00
02752 Crown - porcelain with semi-precious metal (low metal).....	\$850.00
02790 Crown - gold (full cast-high and medium noble).....	\$800.00
02791 Crown - non-precious metal (full cast-low metal).....	\$670.00
02792 Crown - semi-precious metal (full cast-low metal).....	\$715.00
02810 Crown - gold (3/4 cast-high and medium noble).....	\$630.00
02910 Recrement inlays.....	\$70.00
02920 Recrement crowns.....	\$70.00
02930 Crown - stainless steel prefabricated-primary.....	\$150.00
02950 Crown buildup-including pins.....	\$185.00
02952 Cast post and core in addition to crown.....	\$295.00
02954 Cast post and core (prefab) in addition to crown.....	\$230.00
02970 Crown - temporary (fractured tooth).....	\$120.00

IV. ENDODONTICS

03110 Pulp cap - direct (excluding final restoration).....	\$50.00
03120 Pulp cap - indirect (excluding final restoration).....	\$50.00
03220 Vital pulpotomy.....	\$110.00
03310 Root canal therapy-anterior (excluding final restoration).	\$485.00
03320 Root canal therapy - premolar (excluding final restoration)	\$575.00
03330 Root canal therapy - molar (excluding final restoration).....	\$695.00
03340 Apexification (may extend over 6 - 18 month period).....	\$800.00
03410 Apicoectomy (per root) - separate surgical procedure).....	\$415.00
03420 Apicoectomy (per root) - performed with endodontic procedure).....	\$225.00
03430 Retrograde filling.....	\$150.00
03440 Apical curettage.....	\$285.00
03450 Root resection	\$285.00
03920 Hermisection.....	\$285.00
03940 Recalcification (perforations, root resorption).....	\$36.00
03960 Bleaching of discolored teeth.....	\$300.00

V. PERIODONTICS

04210 Gingivectomy or gingivoplasty - per quadrant.....	\$400.00
04220 Gingival curettage - per quadrant	\$125.00
04240 Gingival flap procedure	\$440.00
04250 Mucogingival surgery - per quadrant.....	\$360.00
04260 Osseous surgery (including flap entry, closure/donor site) .	\$680.00
04261 Osseous graft-single site (including flap entry, closure and donor site).....	\$520.00
04270 Pedicle soft tissue grafts	\$500.00
04271 Free soft tissue grafts (including donor site).....	\$500.00
04320 Provisional splinting - intracoronal.....	\$310.00
04321 Provisional splinting - extracoronal.....	\$300.00
04330 Occlusal adjustment (limited).....	\$ 65.00
04331 Occlusal adjustment (complete).....	\$120.00
04340 Periodontal scaling and root planning - entire mouth.....	\$ 95.00
04341 Periodontal scaling and root planning - per quadrant.....	\$115.00
04355 Full mouth debridement to enable comprehensive evaluation/ diagnosis.....	\$130.00
04360 Special periodontal appliance (including occlusal guard).....	\$400.00

04500	TYPE I - CASE PATTERN	
	1. All necessary diagnostic procedures	
	2. Training in personal preventive dental care	
	3. Mouth preparation procedures	
	4. Routine finishing procedures	
	5. Post treatment evaluation.....	\$300.00
04600	TYPE II - CASE PATTERN	
	1. All necessary diagnostic procedures	
	2. Training in personal preventive dental care	
	3. Mouth preparation procedures	
	4. Occlusal adjustment (if necessary)	
	5. Surgical procedures usually involving curettage and/or Gingivectomy	
	6. Routine finishing procedures	
	7. Post treatment evaluation.....	\$1,100.00
04700	TYPE III - CASE PATTERN	
	1. All necessary diagnostic procedures	
	2. Training in personal preventive dental care	
	3. Mouth preparation procedures	
	4. Occlusal adjustment	
	5. Surgical procedures usually involving flap entry and Osseous procedures	
	6. Routing finishing procedures	
	7. Post-treatment evaluation.....	\$1,250.00
04800	TYPE IV - CASE PATTERN	
	1. All necessary diagnostic procedures	
	2. Training in personal preventive dental care	
	3. Mouth preparation procedures	
	4. Occlusal adjustment	
	5. Surgical procedures usually involving complex techniques	
	6. Routine finishing procedures	
	7. Post-treatment evaluation.....	\$1,800.00
04900	Preventive periodontal prophylaxis.....	\$65.00

VI. DENTURES - FULL AND PARTIAL

05110	Denture, complete upper.....	\$735.00
05120	Denture, complete lower.....	\$735.00
05130	Denture, immediate upper.....	\$720.00
05140	Denture, immediate lower.....	\$1,000.00
05210	Denture, upper/lower, no clasps - acrylic base.....	\$420.00
05213	Denture, upper/lower, with rests - acrylic base.....	\$1,100.00

05214 Mandibular partial denture-cast metal framework with resin denture basis (including any conventional clasps, rests and teeth).....	\$1,100.00
05281 Bridge, removable - unilateral.....	\$420.00
05295 Bridge, partial upper/lower - full cast with tow clasps.....	\$1,000.00
05315 Additional units - tooth or clasps beyond 10.....	\$85.00
05415 Denture adjustment - complete or partial, upper or lower.....	\$85.00
05510 Repair broken complete/partial denture no teeth damage.....	\$145.00
05620 Repair broken denture, complete or partial, with the replacement of one broken tooth.....	\$180.00
05630 Reattaching damaged clasp on denture.....	\$150.00
05640 Replace broken tooth on denture - no other repairs.....	\$100.00
05650 Adding tooth to partial denture to replace extracted tooth - each tooth (not involving clasp or abutment tooth).....	\$115.00
05660 Adding tooth to partial denture to replace extracted tooth - each tooth (involving clasp or abutment tooth).....	\$135.00
05680 Replacing broken clasp with new clasp on denture.....	\$165.00
05690 Each additional clasp with rest.....	\$85.00
05710 Rebase complete maxillary denture.....	\$350.00
05711 Rebase complete mandibular denture.....	\$350.00
05720 Rebase maxillary partial denture.....	\$425.00
05721 Rebase mandibular partial denture.....	\$425.00
05725 Rebase or upper/lower denture - partial or complete.....	\$450.00
05730 Reline complete maxillary denture (office).....	\$255.00
05731 Reline complete mandibular denture (office).....	\$255.00
05735 Denture reline, complete partial, upper/lower-office.....	\$300.00
05740 Reline maxillary partial denture (office).....	\$210.00
05741 Reline mandibular partial denture (office).....	\$160.00
05750 Reline complete maxillary denture (lab).....	\$250.00
05751 Reline complete mandibular denture (lab).....	\$300.00
05760 Reline maxillary partial denture (lab).....	\$300.00
05761 Reline mandibular partial denture (lab).....	\$300.00
05810 Temporary interim complete denture (maxillary).....	\$425.00
05811 Temporary interim complete denture (mandibular).....	\$440.00
05815 Denture - temporary upper/lower – complete	\$290.00
05820 Interim partial denture (maxillary).....	\$350.00
05821 Interim partial denture (mandibular).....	\$350.00
05825 Denture - temporary, upper/lower - partial - stay plate.....	\$300.00
05850 Tissue conditioning.....	\$150.00
06210 Pontic, cast gold (high and medium noble).....	\$800.00
06211 Pontic, cast non-precious (base metal).....	\$700.00
06212 Pontic, cast semi-precious (low noble).....	\$740.00
06230 Pontic, slotted.....	\$730.00
06240 Pontic, porcelain fused to gold (high and medium noble).....	\$730.00
06241 Pontic, porcelain fused to non-precious metal (base metal).	\$700.00

06242 Pontic, porcelain fused to semi-precious metal (low noble)..	\$730.00
06250 Pontic, plastic processed to gold (high and medium noble).	\$730.00
06251 Pontic, plastic processed to non-precious metal	\$700.00
06252 Pontic, plastic processed to semi-precious metal	\$710.00
06540 Crown, plastic (acrylic).....	\$1,200.00
06545 Crown, plastic processed to gold (high and medium noble).	\$225.00
06721 Crown, porcelain processed to non-precious metal	\$700.00
06740 Crown, porcelain.....	\$725.00
06750 Crown, porcelain fused to gold (high and medium noble)....	\$750.00
06751 Crown, porcelain fused to non-precious metal (base metal).	\$700.00
06752 Crown, porcelain fused to semi-precious metal (low noble)..	\$775.00
06780 Crown, gold (3/4 cast-high and medium noble).....	\$750.00
06790 Crown, gold (full cast-high and medium noble).....	\$940.00
06791 Crown, non-precious metal (full cast, base metal).....	\$700.00
06792 Crown, semi-precious metal (full cast, low noble).....	\$720.00
06930 Recement bridge.....	\$100.00
06950 Precision adjustment.....	\$350.00
06973 Dowel pin - metal.....	\$155.00

VII. OTHER SERVICES

01510 Space management - fixed - unilateral type.....	\$230.00
01515 Space management - fixed - bilateral type.....	\$255.00
01525 Space management - removable bilateral type.....	\$280.00
01550 Space management - recementation (repair).....	\$55.00
07110 Extraction - single tooth, including local anesthesia.....	\$100.00
07120 Extraction - each additional tooth.....	\$120.00
07140 Extraction-erupted tooth (elevation and/or forceps removal	\$105.00
07210 Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.....	\$170.00
07250 Root Recovery (surgical removal of residual root).....	\$200.00
07281 Surgical exposure of impacted or unerupted tooth to aid eruption.....	\$125.00
07310 Alveoplasty - per quadrant, in conjunction with extraction.....	\$175.00
07320 Alveoplasty - per quadrant, not in conjunction with extraction.	\$275.00
07340 Stomatoplasty, including revision of soft tissue on ridges, muscle reattachment, tongue, palate and oral soft tissue.....	\$600.00
09110 Palliative treatment of dental pain, minor procedures.....	\$80.00
09230 Analgesia.....	\$45.00
09240 Intravenous sedation.....	\$375.00
09310 Consultation.....	\$75.00
09940 Nightguard.....	\$360.00

Note: The codes used for dental procedures change from time-to-time. Accordingly, the Plan may cover the dental procedures on the schedule above under new codes.

VIII. ORTHODONTICS

The Plan will pay 50% of the Reasonable and Customary charge for orthodontic services for Eligible Dependents who are age nineteen (19) or younger.

There is a separate, individual lifetime maximum on this orthodontic benefit. The Plan will pay no more than one thousand dollars (\$1,000) per Covered Individual's lifetime for orthodontic services.

3.5: Exclusions: Dental Expenses For Which No Benefits Are Payable

The Exclusions set forth in Part 2, Section 2.7 apply to dental as well as medical benefits. In addition to those exclusions and any other exclusion set forth in this Part, the following are excluded from coverage and no benefits are payable under the Plan:

- (a) **Services Not Performed by a Dentist or Dental Hygienist:** Expenses for dental services not performed by a Dentist (except for services of a Dental Hygienist that are supervised and billed by a Dentist and are for cleaning or scaling of teeth or for fluoride treatments).
- (b) **Replacement of Lost or Stolen Appliances:** Expenses for lost or stolen bridgework or dentures (appliances).
- (c) **Replacement of Dentures and Bridgework:** Expenses for replacement of dentures and bridgework more often than once every five (5) years.
- (d) **Orthodontic Treatment:** Expenses for braces and straightening of teeth.
- (e) **Non-Eligible Dental Expenses:** Expenses for any service, supply or procedure which is not specifically listed in the Schedule of Eligible Dental Expenses or exceeds the Maximum Amount in the Schedule of Eligible Dental Expenses.
- (f) **Dental Services Not Medically Necessary:** Except for Diagnostic/Preventive Services, expenses for dental services or supplies determined by the Fund Administrator or its designee not to be Medically Necessary as described in the Medical Expense Coverage Chapter of this document.

3.6: Benefit Claims

See Part 10 (Claims & Appeals) for additional information about submitting claims and appealing a denial of benefits.

Part 4:

VISION BENEFITS COVERAGE

4.1: Vision Benefits

The Plan will pay 100% of the actual cost of covered vision care services, treatment, equipment or supplies up to a maximum of one hundred twenty-five dollars (\$125) in a calendar year per Covered Individual (you and, if you have Family Coverage, each of your Dependents).

Covered vision care services, treatment, equipment and supplies are examinations and other services performed by a licensed optometrist or ophthalmologist, prescribed eyeglass lenses, frames, and prescribed contact lenses.

You are responsible for any portion of the cost not paid by the Fund under the Plan.

4.2: Filing Claims for Vision Benefits

Vision benefits are payable only upon submission of a claim for reimbursement to the Fund Administrator in such form as it may require. See Part 10 (Claims & Appeals) for additional information concerning claims and appeals.

Part 5:

PRESCRIPTION DRUG COVERAGE

5.1: Prescription Drug Benefits: Generally

The Plan pays benefits for Covered Prescription Drug Expenses incurred by you and, if you have Family Coverage, your Eligible Dependents, subject to the rules set forth in this Part 5.

Covered Prescription Drug Expenses are Federal Legend Drugs, State Restricted Drugs, and injectable insulin which are obtainable only through a Physician's written prescription and dispensed by a licensed Pharmacist or Hospital Pharmacy for take-home drugs.

The drugs must be prescribed for you or your Eligible Dependent by a Physician for treatment of an Illness or Injury, and must be Medically Necessary.

The Plan pays no benefits for drug expenses that are not Covered Prescription Drug Expenses. The Plan pays no benefits for drug expenses that are excluded from coverage under this Plan (Section 5.3).

5.2: Annual Maximum Benefit

The Plan will pay no more than five thousand dollars (\$5,000) per calendar year per Covered Individual (you and, if you have Family Coverage, your Eligible Dependent) for prescription drug benefits.

5.3: Exclusions: Prescription Drug Expenses For Which No Benefits Are Payable

The Exclusions set forth in Part 2, Section 2.7 apply to prescription drug benefits as well as medical benefits. In addition to those exclusions and any other exclusion's set forth in this Part, the following are excluded from coverage and no prescription drug benefits are payable under the Plan for them:

1. Contraceptives, oral or other, whether medication or device, regardless of use.
2. Growth hormones.
3. Sexual dysfunction drugs.
4. Levonorgestrel (Norplant).
5. Minoxidel, Rhogaine, Rhogam and similar drugs.
6. Non-federal legend drugs & non-state restricted drugs, other than injectable insulin.
7. Immunization agents.
8. Fertility drugs (injectable or oral).

9. Retinoid and Retina-A for persons age 25 or older.
10. Blood or plasma.
11. Any charge for the administration or injection of a drug or insulin.
12. Investigational or Experimental drugs, even if a charge is made to the individual.
13. Medication which is to be taken by or administered to a Covered Individual, in whole or in part, while he or she is a patient in a Hospital or other Health Care Facility which operates on its premises a facility for dispensing pharmaceuticals.
14. Drugs which are lawfully obtainable without a prescription, except injectable insulin.
15. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, elastic stockings and other non-medical items regardless of their use.
16. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.
17. Immunization agents or biological sera, except Beta Sermon and Alone.
18. Prescription drugs which may be properly received without charge under local, state or federal programs, including workers' compensation programs.
19. Drugs used to treat obesity and anorexia or assist weight reduction.
20. Drugs used for cosmetic purposes.
21. Any charge where the Reasonable and Customary Charge is less than the Covered Individual's Co-payment.
22. Any charge above the Reasonable and Customary Charge or the advertised or posted price, whichever is less.
23. Vitamins, whether federal legend or not, except pre-natal vitamins.
24. Bee sting kits.
25. Diagnostic drugs.
26. Injectable, except injectable insulin.
27. Serums.
28. Yohimbine and similar drugs.
29. Drugs which are not Medically Necessary.

5.4: Generic Drug Use

Many drugs are available in both a brand name and generic form. A generic drug is a drug known by its chemical name. A brand name drug is a drug known by the trade name used for marketing the drug. The quality, strength and purity of generic drugs are regulated by the U.S. Food and Drug Administration. Generic drugs contain the same active ingredients and are equivalent in strength and dosage as the brand name form of the drug.

You and your Eligible Dependents are encouraged to ask your Physician to prescribe the generic form of the drugs you need, if possible. You may be required to pay a higher co-payment for brand name drugs than for generic drugs. Use of generic forms of drugs can be less costly for you and for the Plan.

If there is a generic form of a drug available, it will be dispensed by the Pharmacist if your Physician does not indicate that the brand name form of the drug is required.

5.5: Mail Service Pharmacy: Mandatory for Maintenance Medications

If you or your Eligible Dependent are taking a prescribed drug on an ongoing basis (“maintenance medication”), you are required to use the Plan’s Mail Service Pharmacy.

Maintenance medications are often used to treat chronic conditions such as high blood pressure, cholesterol problems, diabetes, arthritis, depression, thyroid conditions, osteoporosis, heart disease and asthma.

The Mail Service Pharmacy may also be used for covered prescriptions other than maintenance medications.

If you use the Mail Service Pharmacy, you may be charged a lower Co-payment than if you use a retail pharmacy to fill your prescriptions. Mail service prescriptions may be filled for longer periods, requiring fewer re-fills (and fewer Co-payments).

If you use the Mail Service Pharmacy to fill prescriptions, you will not have to submit any benefit claims forms. You need only to pay the applicable co-payment to the Pharmacy.

Contact the Fund Administrator for instructions on how to use the Mail Service Pharmacy.

5.6: Participating Retail Pharmacies

The Fund Administrator maintains a list of Participating Retail Pharmacies that will accept the Fund’s coverage. No claim forms are required if your or your Eligible Dependent’s prescription is filled at a Participating Retail Pharmacy. You need only to pay the applicable Co-payment to the Pharmacy.

Contact the Fund Administrator for the name of the Participating Retail Pharmacies in your area.

5.7: Limitation on Supplies of Drugs

The amounts of prescribed drugs that may be provided by a pharmacy at one filling are limited as follows:

Retail Pharmacy: 34-day supply or 100 units, whichever is less.

Mail Service Pharmacy: 90-day supply

5.8: Formulary

The Fund has contracted with a pharmacy benefits manager (PBM) through which prescription drugs may be obtained at a lower cost, mostly because the PBM negotiates volume discounts with drug makers. The PBM maintains a “formulary”, which is simply a list of generic and brand name prescription drugs that are considered safe and effective for patients and that can be obtained through it at a lower cost.

A drug that is listed in the PBM’s formulary is called a formulary drug. A drug that is not listed in the PBM’s formulary is called a non-formulary drug. The PBM’s formulary may be obtained from the Fund’s website or by contacting the Fund Administrator.

5.9: Co-Payments

A Co-payment, for purposes of this Part, is the amount (dollar amount or percentage of cost) that you or your Eligible Dependent must pay for each prescription filled or re-filled for a covered prescription drug expense. The Co-payment amounts are different according to whether the prescription is for a generic or brand name drug, whether you used the mail service pharmacy or a retail pharmacy, and whether the prescribed drug is a formulary or non-formulary drug.

<u>Co-payment Amount</u>	<u>Type of Drug / Type of Pharmacy</u>
\$5	Generic / Retail
20% of cost (\$10 minimum, \$35 maximum)	Brand-Formulary / Retail
30% of cost (\$10 minimum, \$50 maximum)	Brand-Non-Formulary / Retail
\$10	Generic / Mail Service
20% of cost (\$10 minimum, \$50 maximum)	Brand-Formulary / Mail Service
30% of cost (\$20 minimum, \$75 maximum)	Brand-Non-Formulary / Mail Service

5.10: Filing Claims for Drug Benefits

If you or your Eligible Dependent utilizes the Mail Service Pharmacy or a Participating Retail Pharmacy to fill prescriptions, you will not have to submit any claim forms to receive benefits. You need only to pay the applicable Co-payment to the Pharmacy.

If your prescription is filled at a pharmacy that is not the Mail Service Pharmacy or a Participating Retail Pharmacy, you will have to pay the full cost of the prescription to the Pharmacy and submit a claim form to the Fund for reimbursement of that part of the cost payable by the Plan. See Part 10 (Claims & Appeals) for more information concerning claims and appeals.

Part 6:

LOSS OF ELIGIBILITY: “COBRA” TEMPORARY CONTINUATION OF ELIGIBILITY & CERTIFICATION OF COVERAGE

6.1: COBRA Rights Generally

A federal law commonly called “COBRA” (for the “Consolidated Omnibus Budget Reconciliation Act”) generally requires the Fund, as a group health plan, to offer you and / or your Eligible Dependent(s) an opportunity to purchase at special group rates a continuation of coverage under the plan for a temporary period of time if you and / or your Eligible Dependent(s) would otherwise lose eligibility under the Plan because of certain “Qualifying Events”.

This Part describes your and, if you have Family Coverage, your Eligible Dependents’ COBRA rights to choose to pay for a temporary continuation of eligibility under the Plan for medical, prescription drug, dental and vision benefits (“COBRA continuation coverage”) if you and / or your Eligible Dependent(s) would otherwise lose eligibility because of a Qualifying Event. Note that COBRA continuation coverage is voluntary for you and / or your Eligible Dependents.

The intent of this Part is to fully, but only, comply with the requirements of COBRA and of the government regulations implementing COBRA. This Part is to be interpreted and applied consistent with that intent.

The COBRA Administrator under this Plan is the same as the Fund Administrator whose address and telephone number follows:

Zenith Administrators, Inc.
5565 Sterrett Place, Suite 210
Columbia, MD 21044
Telephone: 1-800-235-5805 or 1-410-884-1440

To maximize your COBRA rights, it is very important that you keep the Fund Administrator informed of your, your Eligible Spouse’s and your other Eligible Dependents’ current mailing addresses. Important notices may have to be sent by the Fund Administrator to these addresses.

6.2: Eligibility for COBRA Coverage

- (a) You, as an eligible Participant, will have a right to choose COBRA continuation coverage under the Plan if you lose eligibility under the Plan because of any of the following Qualifying Events:
- (1) your Covered Employment ends for any reason other than your gross misconduct (including your Employer ceases to have an obligation to contribute to the Fund);

- (2) insufficient hours of contributions are made on your behalf (e.g. your hours of Covered Employment are reduced);
 - (3) the end of a period of Family and Medical Leave.
- (b) If you have Family Coverage, your Spouse will have a right to choose COBRA continuation coverage under the Plan if he / she loses eligibility under the Plan because of any of the following Qualifying Events:
- (1) you die;
 - (2) your Covered Employment ends for any reason other than your gross misconduct (including your Employer ceases to have an obligation to contribute to the Fund for you);
 - (3) insufficient hours of contributions are made on your behalf (e.g. your hours of Covered Employment are reduced);
 - (4) you become entitled to Medicare benefits (under Medicare Part A, Part B, or both); or
 - (5) you become divorced or legally separated from your Spouse.
- (c) If you have Family Coverage, your Eligible Dependent Child will have a right to choose COBRA continuation coverage under the Plan if he / she loses eligibility under the Plan because of any of the following Qualifying Events:
- (1) you die;
 - (2) your Covered Employment ends for any reason other than your gross misconduct (including your Employer ceases to have an obligation to contribute to the Fund for you);
 - (3) insufficient hours of contributions are made on your behalf (e.g. your hours of Covered Employment are reduced);
 - (4) you become entitled to Medicare benefits (under Medicare Part A, Part B, or both);
 - (5) you become divorced or legally separated from your Eligible Spouse; or
 - (6) the Dependent ceases to qualify as your Eligible Dependent Child under the Plan (for example: he / she loses eligibility due to age).
- (d) To be eligible for COBRA continuation coverage, you or your Eligible Dependent must “lose eligibility” under the Plan due to a Qualifying Event. “Lose eligibility” means that you or the Eligible Dependent had eligibility on the day before the Qualifying Event and that eligibility was lost because of the Qualifying Event. The loss of eligibility need not occur immediately following the Qualifying Event, but it must occur before the end of the applicable Maximum Period of COBRA continuation coverage measured from the date of the Qualifying Event.

- (e) If a Child is born to you, or is placed with you for adoption, while you or your Eligible Dependant is on COBRA continuation coverage, you may elect COBRA continuation coverage for the Child for the duration of the COBRA continuation coverage Maximum Period.
- (f) The taking of Family and Medical Leave does not itself constitute a Qualifying Event. However, if you do not return to work upon completion of such leave and your eligibility terminates, then the last day of your leave will constitute a Qualifying Event entitling you and your Eligible Dependents to a maximum of (18) months of COBRA continuation coverage.

6.3: Required Notice to the Fund of a Qualifying Event

- (a) The Fund will offer COBRA continuation coverage to you and / or your Eligible Dependents only if the Fund Administrator is notified in writing that a Qualifying Event has occurred and that notice is received within the time limit set by this Section. If the Fund Administrator does not receive written notice within the applicable notice period, you and / or your Eligible Dependent(s) may lose any right to choose COBRA continuation coverage.

It is very important that timely notice of a Qualifying Event be given to the Fund Administrator by you, your Dependent(s) or your Employer.

- (b) You must give written notice to the Fund Administrator within sixty (60) days after any of the following Qualifying Events occurs or, if later, by the date on which eligibility would be lost because of the Qualifying Event:

- (1) you become divorced or legally separated from your Eligible Spouse;
- (2) your Eligible Dependent Child ceases to qualify as your Eligible Dependent under the Plan.

- (c) Your Employer must notify the Fund Administrator in writing within thirty (30) days after any of the following Qualifying Events occurs:

- (1) you die;
- (2) your Covered Employment ends for any reason other than your gross misconduct;
- (3) insufficient hours of contributions are made on your behalf (e.g. your hours of Covered Employment are reduced); or
- (4) you become entitled to Medicare benefits (under Medicare Part A, Part B, or both).

Even though your Employer is required to notify the Fund Administrator of these Qualifying Events, you or your Dependent(s) should confirm with the Employer or the Fund Administrator that timely notice has been given. You or your Dependent(s) may notify the Fund Administrator of any Qualifying Event.

- (d) The Fund Administrator may require you, your Dependent or your Employer to provide additional information needed to determine eligibility for COBRA continuation coverage or to otherwise properly administer the provisions of this Part.

6.4: Choosing COBRA Continuation Coverage

- (a) Once the Fund Administrator receives written notice that a Qualifying Event has occurred, the Fund Administrator will determine whether you and / or your Eligible Dependant(s) are eligible for COBRA continuation coverage. If the Fund Administrator determines that you and / or your Eligible Dependant(s) are not eligible for COBRA continuation coverage, the Fund Administrator will send to you and / or your Eligible Dependant(s) a written explanation.

If the Fund Administrator determines that you and / or your Eligible Dependant(s) are eligible for COBRA continuation coverage, the Fund Administrator will send to you and / or your Eligible Dependents(s) written information on how to choose COBRA continuation coverage. That information will contain a notice of rights and an election form.

- (b) If you and /or your Eligible Dependents wish to choose COBRA continuation coverage, the election form must be completed and returned to the Fund Administrator within sixty (60) days after the date on which you and / or your Eligible Dependent's eligibility would end because of the Qualifying Event or, if later, within sixty (60) days after the date you receive the notice of rights and election form (the "60-day election period").

If the completed election form is not returned to the Fund Administrator within the 60-day election period, you and / or your Eligible Dependent(s) will lose any and all right to COBRA continuation coverage.

- (c) You and each of your Eligible Dependents has an individual right to elect COBRA continuation coverage. For example, this coverage may be elected by you but not by any Eligible Dependant, or by an Eligible Dependent but not by you, or by one Eligible Dependent but not by any other. You, as the parent of an Eligible Dependent Child, may elect COBRA continuation coverage for him or her. You or your Eligible Spouse may elect COBRA continuation for you and all Eligible Dependents.
- (d) If you and / or your Eligible Dependent(s) waive COBRA continuation coverage during the 60-day election period, the waiver may be revoked and COBRA continuation coverage elected if the revocation and a new, completed election form are submitted to the Fund Administrator before the 60-day election period ends. However, in this case, your COBRA continuation coverage will not begin until the date you submit the new election form to the Fund Administrator; the coverage will not be retroactive to the loss of coverage.

6.5: Content of COBRA Continuation Coverage

- (a) The COBRA continuation coverage will keep you and / or your Eligible Dependent(s) eligible for the same benefit coverage as similarly situated active Participants and their Eligible Dependents for whom a Qualifying Event has not occurred. Usually this is the same coverage that you had immediately before your COBRA continuation coverage begins.
- (b) If the benefit coverage for active Participants and their Eligible Dependents is changed in any respect during your and / or your Eligible Dependent's COBRA continuation coverage, those changes will be applied to you and / or your Eligible Dependent(s). If those changes result in an increase or decrease in the cost of coverage, the COBRA premium may be accordingly increased or decreased by the Fund during the COBRA continuation coverage period.

6.6: Cost of COBRA Continuation Coverage to You (COBRA Premium)

- (a) You and / or your Eligible Dependent(s) must pay for COBRA continuation coverage on a monthly basis. Your Employer will not be making contributions to the Fund for you and / or your Dependents to have this coverage. The monthly amount that you and / or your Eligible Dependent(s) have to pay for this coverage is called the “COBRA Premium”.
- (b) The Fund Administrator will notify you as to the amount of the monthly COBRA Premium. In general, the COBRA Premium will be 102% of the cost of the coverage as determined by the Fund. The Fund sets COBRA Premium rates yearly, based on professional advice. Any change (increase or decrease) in the COBRA Premium rates during your and / or your Eligible Dependent’s COBRA continuation coverage will apply to you and / or your Eligible Dependent(s).
- (c) The COBRA Premium owed for the months of lost eligibility before you and / or your Eligible Dependent(s) elected the continuation coverage is due immediately. But, you and / or your Eligible Dependent(s) will be given a grace period of forty-five (45) days from the date of the COBRA election within which to pay that retroactive COBRA Premium. If you and / or your Eligible Dependent(s) fail to pay this COBRA Premium within the grace period, you and / or your Eligible Dependent(s) will not have COBRA continuation coverage.
- (d) COBRA Premium payments are due on the first day of each month. You and / or your Eligible Dependent(s) will be given a grace period of thirty (30) days from the due date within which to pay each monthly COBRA Premium. If you and / or your Eligible Dependent(s) fail to pay any COBRA Premium bill within the grace period, your and / or your Eligible Dependent’s(s’) COBRA continuation coverage will terminate.
- (e) If you and / or your Dependent’s COBRA continuation coverage is extended because of entitlement to Social Security disability benefits, as described in Section 6.8(c)(3), the COBRA Premium for that extension period will be 150% of the cost of the coverage as determined by the Fund.
- (f) If the Fund Administrator does not receive a COBRA Premium payment by the due date, the Fund may suspend eligibility as of the due date and then reinstate eligibility retroactive to the due date if the payment is received within the grace period. If the Fund Administrator is asked by any health care provider to confirm your and / or your Dependent’s eligibility during any grace period, the Fund Administrator may conditionally confirm eligibility pending timely receipt of the COBRA Premium that is due but yet unpaid.

6.7: Start of COBRA Continuation Coverage

If COBRA continuation coverage is timely elected and the required premium is timely paid, the continuation coverage will be effective retroactive to the date on which eligibility would have been lost because of the Qualifying Event.

6.8: Maximum Period of COBRA Continuation Coverage

- (a) COBRA continuation coverage is temporary. There is a maximum number of months for which COBRA continuation coverage may be kept by you and / or your Eligible Dependents. This Maximum Period varies somewhat according to the type of Qualifying Event that caused your and / or your Dependent's eligibility, as explained below. The Maximum Period begins with the date of the Qualifying Event even if eligibility is not lost until a later date.

Your and / or your Dependent's COBRA continuation coverage may terminate before the applicable Maximum Period expires (see Section 6.9).

- (b) Generally, the Maximum Periods are as follows:
- (1) If the Qualifying Event is the termination of your Covered Employment or insufficient hours of contributions (*e.g.* a reduction in your hours of Covered Employment, the Maximum Period is eighteen (18) months).
 - (2) If the Qualifying Event is your death, the Maximum Period is thirty-six (36) months.
 - (3) If the Qualifying Event is your divorce or separation from your spouse, the Maximum Period is thirty-six (36) months.
 - (4) If the Qualifying Event is your eligibility for Medicare, the Maximum Period is thirty-six (36) months.
 - (5) If the Qualifying Event is your Dependent loses status as a Dependent Child, the Maximum Period is thirty-six (36) months.
- (c) Under the following exceptional circumstances, the eighteen (18) month Maximum Period may be extended for additional months. The Maximum Period will never exceed thirty-six (36) months.

- (1) If you and your Eligible Dependent(s) are on COBRA continuation coverage with a Maximum Period of eighteen (18) months and another Qualifying Event with a thirty-six (36) month Maximum Period occurs, the Maximum Period for your Eligible Dependents will be extended to thirty-six (36) months, if you and / or your Eligible Dependent(s) give written notice of the second Qualifying Event to the Fund Administrator within sixty (60) days after the second Qualifying Event. This extension applies only if the second Qualifying Event would have caused a loss of eligibility had the first Qualifying Event not occurred.

For example: Your Covered Employment ended and you elected COBRA continuation coverage for you and your Eligible Dependents (a Maximum Period of eighteen (18) months). While that coverage was in effect, you die. Your Eligible Dependents will be entitled to a Maximum Period of thirty-six (36) months from when your Covered Employment ended.

For example: Your Covered Employment ended and you elected COBRA continuation coverage for you and your Eligible Dependents (a Maximum Period of eighteen (18) months). While that coverage was in effect, you and your spouse divorce. Your Eligible Dependents will be entitled to a Maximum Period of thirty-six (36) months from when your Covered Employment ended.

- (2) If the Qualifying Event is the termination of your Covered Employment or insufficient hours of contributions, but you had become eligible for Medicare benefits within eighteen (18) months before that Qualifying Event, your Eligible Dependents will be entitled to elect COBRA continuation coverage for a Maximum Period of thirty-six (36) months after the date of your Medicare eligibility or for a Maximum Period of eighteen (18) months from the date of the Qualifying Event, whichever is longer.
 - (3) If you and your Eligible Dependent(s) are on COBRA continuation coverage with a Maximum Period of eighteen (18) months, and you or any of your Eligible Dependents is determined to be eligible for Social Security disability benefits during the first sixty (60) days of your continuation coverage, the Maximum Period may be extended by eleven (11) months to twenty-nine (29) months if the disability continues as of the end of the initial eighteen (18) month period. However, you and / or your Eligible Dependents must give written notice of the disability determination to the Fund Administrator within sixty (60) days after the disability determination and before the end of the 18-month Maximum Period.
- (d) The occurrence of a second Qualifying Event with a eighteen (18) month Maximum Period during COBRA continuation coverage with a eighteen (18) month Maximum Period will not extend the Maximum Period beyond eighteen (18) months.

For example: Insufficient contributions for hours Covered Employment on your behalf causes a loss of eligibility and you elect COBRA continuation coverage. Your Covered Employment ends during the eighteen (18) month Maximum Period. Your eighteen (18) month Maximum Period will not be extended.

6.9: Early Termination of COBRA Continuation Coverage

- (a) Your and / or your Eligible Dependent's COBRA continuation coverage may be ended before the applicable Maximum Period has expired under the following circumstances:
- (1) The COBRA Premium is not paid within the grace period.
 - (2) Your Employer no longer provides any medical coverage for its employees.
 - (3) During the COBRA continuation coverage, you and/ or your Eligible Dependent become covered under another group health plan that does not have a pre-existing condition exclusion or limitation that would affect you and / or your Eligible Dependent. This does not apply if the group health plan coverage was obtained prior to electing the COBRA continuation coverage.
 - (4) During the COBRA continuation coverage, you and / or your Eligible Dependent become entitled to Medicare benefits (Part A, Part B, or both). This does not apply if the Medicare coverage began prior to electing the COBRA continuation coverage.
 - (5) The Fund is terminated by the Board of Trustees.

- (6) If your Employer or former Employer ceases to participate in the Fund and commences participation in another group health plan, the new group health plan will assume responsibility for your and / or your Eligible Dependent's COBRA continuation coverage and your and / or your Eligible Dependent's COBRA continuation coverage under the Fund will cease, except to the extent otherwise required by applicable law.
- (7) Your and/or your Eligible Dependent's COBRA continuation coverage may be discontinued for any reason for which a Participant's or Dependent's regular eligibility could be terminated, including fraud and failure to provide the Fund with information needed to properly administer the Plan.
- (b) If your COBRA continuation coverage ends because you become eligible for Medicare benefits, your Eligible Dependent's COBRA continuation coverage will not be affected for this reason. If your Eligible Dependent's COBRA continuation coverage ends because he /she becomes eligible for Medicare benefits, your COBRA continuation coverage will not be affected for this reason.
- (c) If the Fund Administrator determines that your and / or your Eligible Dependent's COBRA continuation coverage will be terminated before the expiration of the applicable Maximum Period, a notice of the termination will be sent to you and / or your Eligible Dependent(s) as soon as practicable. The notice will include the reason for the early termination and the date of termination. The notice may be combined with the HIPAA Certification of Credible Coverage.

6.10: Certification of Coverage (HIPAA)

- (a) If within sixty-two (62) days after eligibility under this Plan ends, you and/or your Eligible Dependent(s) become eligible for coverage under another group health plan or an individual health insurance policy, a Certificate of Coverage from this Plan may be necessary to reduce or eliminate any pre-existing condition exclusions applicable to you and/or your Eligible Dependent(s) under the new group health plan or health insurance policy.
- (b) If you and/or your Eligible Dependent(s) lose eligibility for medical benefits under the Plan, you are entitled by law to, and will be provided with, a "Certificate of Coverage". This Certificate of Coverage describes, among other things, the period of time that you and/or your Eligible Dependents were covered under this Plan. Such a Certificate will be provided by first class mail shortly after the Fund Administrator knows or has reason to know of the loss of eligibility.
- (c) If you and/or your Eligible Dependent(s) elect COBRA continuation coverage under the Plan, another Certificate of Coverage will be sent to you (or your Dependents, if COBRA continuation coverage is provided only to them) by first class mail shortly after the COBRA continuation coverage ends for any reason.
- (d) In addition, the Fund Administrator will provide a Certificate of Coverage to you and or your Eligible Dependent(s) upon receipt of a written request from you and or them within two (2) years after the date eligibility ended.

Part 7:

DUPLICATE COVERAGE OF COVERED EXPENSES & BENEFITS

7.1: Coverage Under Multiple Health Plans: General Coordination Of Benefits Rules

(a) When and How Coordination of Benefits (COB) Applies

- (1) Coordination of Benefits (or “COB”, as it is usually called) applies if you and/or your Eligible Dependents are covered under this Plan and another Health Plan. The term “Health Plan” means this Plan and any other health maintenance organization or any policy, contract or plan which provides medical, dental or vision benefits, whether insured or self-funded, and which is a Group Plan. A “Group Plan” provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage. “Group Plan” does not include any policy, contract or plan that is issued on an individual basis, including a policy, contract or plan for specified diseases or an intensive care policy.
- (2) When you and/or your Eligible Dependents are covered by two or more Health Plans and received medical, dental or vision services and/or supplies that are covered by this Plan and the other Health Plan, the benefits under this Plan will be coordinated with the other Health Plan to prevent more than one plan from paying for the same health services and/or supplies. The COB rules described below determine which one of the Health Plans will be the “primary plan” and pay its benefits first and which one of the Health Plans will be the “secondary plan” and pay second (less those benefits paid for by the primary plan).
- (3) This Plan will coordinate benefits with your (or your Eligible Dependent’s) other Health Plan. If this Plan is the primary plan, we will ignore the benefits of the secondary plan in paying your claims. If this Plan is the secondary plan, we will pay “Allowable Expenses” which were not paid (or provided for) by the primary plan. “Allowable Expenses” means any Medically Necessary Expenses which are Reasonable and Customary Charges for services, supplies or treatment covered, in whole or in part, by at least one of the Health Plans. When a Health Plan provides benefits in the form of services, rather than in cash, the reasonable cash value of each service rendered will be covered as an “Allowable Expense”, whether or not a claim is filed under that Health Plan.
- (4) If you and an Eligible Dependent are both covered under this Plan as Participants (i.e., contributions are being made on behalf of both of you to the Fund), the benefits under this Plan will be coordinated as if you and your Eligible Dependents are covered by two or more Health Plans.
- (5) When medical payments are available under a party’s vehicle insurance, this Plan shall pay excess benefits only.

(b) Which Plan Pays First: Order of Benefit Determination Rules

- (1) Group Plans determine the sequence in which they pay benefits, or which Health Plan pays first, by applying uniform order of benefit determination rules. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-funded plans. Any Group Plan that does not use these same rules will always be the primary plan.
- (2) If the first rule does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The rules are:

Rule 1: Non-Dependent/Dependent

- A. The Health Plan that covers a person as an active employee or retiree (that is, other than as a dependent) pays first; and the Health Plan that covers the same person as a dependent pays second.
- B. There is one exception to Rule 1. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:
 1. secondary to the Health Plan covering the person as a dependent; and
 2. primary to the Health Plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee),then the Health Plan covering the person as a dependent pays first; and the Health Plan covering the person other than as a dependent (that is, as a retiree) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

- A. The Health Plan that covers the parent whose birthday falls earlier in the Calendar Year pays first; and the Health Plan that covers the parent whose birthday falls later in the Calendar Year pays second, if:
 1. the parents are married;
 2. the parents are not separated (whether or not they ever have been married); or
 3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

- B. If both parents have the same birthday, the Health Plan that has covered one of the parents for a longer period of time pays first; and the Health Plan that has covered the other parent for the shorter period of time pays second.
- C. The word “birthday” refers only to the month and day in a Calendar Year, not the year in which the person was born.
- D. If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the Health Plan of that parent has actual knowledge of the terms of that court decree, the Health Plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s current spouse does, the Health Plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply when Benefits were actually paid or provided before the Health Plan had actual knowledge of the specific terms of that court decree.
- E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the Health Plans of the parents and their spouses (if any) is:
 - 1. The Health Plan of the custodial parent pays first;
 - 2. The Health Plan of the spouse of the custodial parent pays second; and
 - 3. The Health Plan of the non-custodial parent pays third; and
 - 4. The Health Plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

- A. The Health Plan that covers a person either as an Active Employee (that is, an employee who is neither laid-off nor retired), or as that Active Employee’s dependent, pays first; and the Health Plan that covers the same person as a laid-off employee or retiree, or as that laid-off employee’s or retiree’s dependent, pays second.
- B. If the other Health Plan does not have this rule, and if, as a result, the Health Plans do not agree on the order of benefits, this rule is ignored.
- C. If a person is covered as a laid-off employee or retiree under one Health Plan and as a dependent of an active employee under another Health Plan, the order of benefits is determined by Rule 1.

Rule 4: Continuation of Coverage

- A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another Health Plan, the Health Plan that covers the person as an employee or retiree (or as that person's dependent) pays first, and the Health Plan providing continuation coverage to that same person pays second.
- B. If the other Health Plan does not have this rule, and if, as a result, the Health Plans do not agree on the order of benefits, this rule is ignored.
- C. If a person is covered other than as a dependent (that is, as an employee, former employee or retiree) under a right of continuation coverage under federal or state law under one Health Plan and as a dependent of an active employee under another Health Plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

- A. If none of the four previous rules determines the order of benefits, the Health Plan that covered the person for the longer period of time pays first; and the Health Plan that covered the period for the shorter period of time pays second.
- B. To determine how long a person was covered by a Health Plan, two Health Plans are treated as one if the person was eligible for coverage under the second Health plan within 24 hours after the first Health Plan ended.
- C. The start of a new Health Plan does not include a change:
 - 1. in the amount or scope of a Health Plan's benefits;
 - 2. in the entity that pays or administers the Health Plan; or
 - 3. from one type of Health Plan to another (such as from a single employer Health Plan to a multi employer Health Plan).
- D. The length of time a person is covered under a Health Plan is measured from the date the person was first covered under that Health Plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the Health Plan presently in force.

(c) How Much This Plan Pays When It is Secondary

When this Plan pays second, it will pay the same Benefits that it would have paid had it paid first, less whatever payments were actually made by the Health Plans that paid first.

(d) Administration of COB

To administer COB, the Plan reserves the right to:

- * exchange information with other Health Plans involved in paying claims;
- * require that you or your Health Care Provider furnish any necessary information;
- * reimburse any Health Plan that made payments this Plan should have made; or
- * recover any overpayments from your Health Care Provider, other Health Plan, other insurance company, or you or your Dependent.

7.2: Medicare and Other Government Programs

(a) Medicare

- (1) Generally, anyone age sixty-five (65) or older is entitled to Medicare coverage. Anyone under age sixty-five (65) who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.
- (2) If you, your Spouse or Dependent Child becomes covered by Medicare, either because of disability or age, you may either retain or cancel your coverage under this Plan.
- (3) If you, your Spouse and/or your Dependent Child are covered by this Plan and by Medicare, and you retain your coverage under this Plan by remaining Actively Employed, this Plan will continue to provide the same Benefits and the contributions for coverage will remain the same. Generally, this Plan pays 1st and Medicare pays 2nd. However, this Plan will not pay 1st on medical claims submitted by you and your Eligible Dependents who are Medicare-eligible based on age if your Employer has 20 or fewer employees during the Calendar Year. In that case, claims should be submitted to Medicare to pay 1st and this Plan will pay 2nd.
- (4) If you cancel your coverage under this Plan, your Spouse and/or your Dependent Child(Ren)'s coverage will terminate, but they will be entitled to COBRA continuation coverage. See the chapter on When Your Medical, Prescription Drug, Dental and Vision Coverage Ends for further information about COBRA continuation coverage.
- (5) However, if you become Totally Disabled and entitled to Medicare because of your Total Disability, you will no longer be considered to remain Actively Employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second.
- (6) If, while you are Actively Employed, you or any of your Covered Dependents become entitled to Medicare because of end-stage renal disease (ESR), this Plan pays first and Medicare pays second for a limited period of time (from 18 to 21 consecutive months) starting the earlier of:

- * the month in which Medicare ESR coverage begins; or
- * the first month in which the individual receives a kidney transplant.

Then, starting with the 19th month after Medicare ESR coverage begins, or the 22nd month following a kidney transplant, Medicare pays first.

(b) Medicaid

If you are covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

(c) TRACER

If you are covered by this Plan and TRACER, this Plan pays 1st and TRACER pays 2nd.

(d) Services Received in a U.S. Department of Veterans Affairs Facility

- (1) If you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
- (2) If you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not military service-related illness or injury, benefits are payable by the Plan to the extent those services are medically necessary and the charges are reasonable and customary.

(e) Other Coverage Provided by State or Federal Law

If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

7.3: Workers' Compensation Benefits

- (a) This Plan does not provide benefits if the medical, prescription drug, dental or vision expenses are covered by workers' compensation or occupational disease law.
- (b) If your Employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your Eligible Dependent must execute a subrogation and reimbursement agreement acceptable to the Fund Administrator or its designee.

7.4: Motor Vehicle No-Fault Coverage

If you are covered for medical, dental or vision benefits under both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

7.5: Third Party Liability For Causing Your Injury Or Illness: Your Obligation To The Fund (Fund's Right Of Subrogation)

(a) Subrogation and Reimbursement

- (1) Under this Plan, you and/or your Eligible Dependents (hereinafter called "Covered Individuals"), may accept payments of any Plan benefits that arise from or are related to an Illness, Injury, or medical condition that was caused by a third party. However, by accepting any such payment of Plan benefits, all Covered Individuals are deemed to agree that the Fund will be subrogated to any Covered Individual's right of recovery and entitled to reimbursement of any Plan benefits paid in accordance with this Plan document and applicable law. Otherwise, the Covered Individual would be unjustly enriched to the detriment of the Fund and its participants and beneficiaries as a whole. The contribution rates take into account subrogation and reimbursement recoveries by the Fund.
- (2) Plan benefits include medical, prescription drug, dental, and vision benefits as well as accidental death and dismemberment benefits and short term disability benefits. The Fund's subrogation and / or reimbursement rights extend to the insurers for the life insurance, accidental death and dismemberment benefits and short term disability benefits provided under the Plan.
- (3) The Fund's subrogation and/or reimbursement rights will include all claims, demands, actions and rights of recovery of all Covered Individuals against any third party or insurer, including workers' compensation insurer or governmental agency, and will apply to the extent of any and all payments of Plan benefits made or to be made by the Fund.
- (4) These rights provide the Fund with a first dollar priority to any recovery paid by any third party or insurer, over any other claims or expenses and regardless of whether the Covered Individual would be deemed made whole by the recovery. The Fund shall not be responsible for any portion of the Covered Individual's attorney's fees and litigation costs, except to the extent mandated by applicable federal law.
- (5) As used in this document, "subrogation" means the right of the Fund to be substituted in place of a Covered Individual with respect to the Covered Individual's lawful claim, demand, or right of action against any third party who may be liable for the Covered Individual's Injury, Illness or medical condition that resulted in a payment of Plan benefits. The third party need not be the actual tortfeasor, and may include an insurer to whom the Covered Individual has paid premiums.
- (6) As used in this document, "reimbursement" means the right of the Fund to recover directly from the Covered Individual, who receives any payments from a liable third party that arise from or are related to an Illness, Injury or medical condition that was caused by a third party and for which Plan Benefits were paid. The third party need not be the actual tortfeasor, and may include an insurer to whom the Covered Individual has paid premiums.
- (7) As a self-funded, ERISA-covered employee benefit plan, the Fund is not subject to State anti-subrogation laws.

(b) Subrogation and/or Reimbursement Agreement

- (1) All Covered Individuals must execute and deliver any and all instruments and papers requested by or on behalf of the Fund, and must do whatever is necessary to protect all of the Fund's subrogation and/or reimbursement rights. As a condition precedent to the payment of benefits by the Fund, all Covered Individuals and their attorneys must, upon request, execute a subrogation and/or reimbursement agreement in a form to be provided by or on behalf of the Fund.
- (2) However, failure by any Covered Individual or his/her attorney to execute any such subrogation and/or reimbursement agreement will not waive, compromise, diminish, release, or otherwise prejudice any of the Fund's subrogation and/or reimbursement rights. The agreement supplements the obligations of Covered Individuals and their attorneys and agents that arise under this Plan document.
- (3) No Covered Individual or his attorney will do anything, either before or after any Illness, Injury or medical condition, to waive, compromise, release or otherwise prejudice the Fund's subrogation and reimbursement rights.

(c) Cooperation with the Fund by the Covered Individuals

- (1) The Fund may start any legal action or administrative proceeding it deems necessary to protect its right to recover Plan benefits paid, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Individuals. However, in doing so, the Fund will not represent, or provide legal representation for, any Covered Individual with respect to that Covered Individual's damages to the extent those damages exceed any Plan benefits paid.
- (2) The Covered Individuals agree to notify and consult with the Fund, its Fund Administrator or designee, before starting any legal action or administrative proceeding or entering into any settlement agreement relating to claims the Covered Individuals have against a third party.
- (3) The Covered Individuals also agree to keep the Fund, its Fund Administrator or designee informed of all material developments with respect to any such claims, actions, or proceedings.
- (4) The Covered Individuals also agree to have their legal representative acknowledge the Fund's lien in writing and submit it to the Fund Administrator or designee.
- (5) The Fund may intervene in any such claims, actions, or proceedings started by any Covered Individuals.

(d) All Recovered Proceeds are to be Applied to Reimbursement of the Plan

- (1) The Fund shall have a lien on all amounts recovered up to the total amount of Plan benefits provided to the Covered Individual. The Fund may give notice of lien to any party who may be liable for the Covered Individual's Injury, Illness or Medical Condition.

- (2) The Covered Individuals, jointly and severally, will reimburse the Fund for all Plan benefits paid, applying any and all amounts paid or payable to them by any third party or insurer by way of settlement or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized in the settlement or judgment as being paid on account of the medical prescription, dental or vision expenses for which Plan benefits were paid.
 - (3) The Fund shall be entitled to recover the payments which are due the Fund from the Covered Individuals. If the Covered Individuals fail to reimburse the Fund, or work out a reasonable repayment arrangement with the Fund, the Fund shall be entitled to withhold and offset future benefit payments or use legal or administrative proceedings to recover the amount not reimbursed.
 - (4) The Fund shall also be entitled to file any legal or equitable action in a court to recover from the Covered Individuals the amount owed to the Fund under these subrogation and reimbursement provisions.
- (e) Fiduciary Status of Covered Individuals and their Attorneys and Agents

Any recovery from a third party or insurer, up to the total amount of Plan benefits provided to the Covered Individual, shall be deemed to be held in trust for the exclusive benefit of the Fund by the Covered Individual as well by any attorney or agent of the Covered Individual who has custody or control over the recovery.

Such recovery shall be considered assets of the Fund (plan assets) and the Covered Individual, as well as any attorney or agent of the Covered Individual who has custody or control over the recovery, shall be considered a fiduciary with respect to the Fund within the meaning of ERISA Section 3(21), 29 U.S.C. §1002(21), and shall be subject to fiduciary duties with respect to the recovery under ERISA Section 404(a), 29 U.S.C. §1104(a) that may be enforced by the Fund under ERISA Section 502(a)(2), 29 U.S.C. §1132(a)(2), in addition to any other cause of action provided by law.

Part 8:

LIFE INSURANCE & ACCIDENTAL DEATH AND DISMEMBERMENT

8.1: Life Insurance Benefit

- (a) If you die from any cause while eligible under the Plan, a life insurance benefit of ten thousand dollars (\$10,000) will be paid to your Beneficiary or Beneficiaries by an insurance company from which the Fund has purchased a group insurance policy for this purpose.
- (b) If an Eligible Dependent dies from any cause while eligible under the Plan, a life insurance benefit of two thousand dollars (\$2,000) will be paid to you unless you have died before the Eligible Dependent.
- (c) The benefits will be paid in a single lump sum unless other arrangements are made with the insurance company by the Beneficiary or Beneficiaries
- (d) The detailed terms and conditions of this benefit are set forth in the life insurance policy, a copy of which may be obtained upon request from the Fund Administrator.
- (e) The life insurance benefit is payable in the event of your death in addition to any AD&D death benefit that may be payable under Section 8.2.

8.2: Accidental Death & Dismemberment Benefit (AD&D)

- (a) If you die or suffer another type of permanent loss listed in this section as a direct result of an accident, and independent of all other causes, while you are eligible under this Plan, an AD&D benefit will be paid to you or, in the event of your death, to your Beneficiary or Beneficiaries, by an insurance company from which the Fund has purchased a group insurance policy for this purpose.
- (b) The losses for which AD&D benefits are payable and the amount of the benefits payable are as follows:

<u>Permanent Loss Of:</u>	<u>Benefit</u>
(1) life	\$10,000
(2) two hands	\$10,000
(3) two feet	\$10,000
(4) sight of two eyes	\$10,000
(5) one hand and one foot	\$10,000
(6) one hand and sight of one eye	\$10,000
(8) one foot or one hand	\$5,000
(9) sight of one eye	\$5,000

- (c) The loss of a hand means that the limb is severed at or above the wrist joint. The loss of a foot means that the limb is severed at or above the ankle joint. The loss of sight in an eye means an irrecoverable and complete loss of sight in the eye.

- (d) Timing Of Loss: No AD&D benefit is payable unless the loss occurred within ninety (90) calendar days after the date of the accident.
- (e) Multiple Losses: If you suffer more than one loss in a single accident, an AD&D benefit will be payable only for the loss for which the largest benefit is payable.
- (f) Exclusions: No AD&D benefit is payable if your death or other loss is caused, directly or indirectly, in whole or in part, by any of the following:
 - (1) bodily or mental illness or disease of any kind;
 - (2) ptomaines or bacterial infections, except infections caused by a pyogenic organism that occurs with and through an accidental cut or wound;
 - (3) hernia;
 - (4) suicide or self-inflicted injury while sane or insane;
 - (5) participation in the commission of a felony;
 - (6) war or act of war, or service in the Armed Forces of any country when that country is engaged in war; or
 - (7) police duty as a member of any military, naval or air organization.
- (g) The benefits will be paid in a single lump sum unless other arrangements are made with the insurance company by you or your Beneficiary or Beneficiaries.
- (h) The detailed terms and conditions of this benefit are set forth in the life insurance policy, a copy of which may be obtained upon request from the Fund Administrator.

8.3: Beneficiary Rules

- (a) To be eligible under the Plan, you must fill out and submit to the Fund Administrator an Enrollment Card. The Enrollment Card is used to name your Beneficiary or Beneficiaries—the person or persons to whom any life insurance or AD&D death benefits for which you are eligible will be paid if you die while eligible. If you wish to change your Beneficiary or Beneficiaries at any time, you must submit a new Enrollment Card naming the new Beneficiary or Beneficiaries to the Fund Administrator. The change will not be effective until the new Enrollment Card is received by the Fund Administrator.
- (b) If your Beneficiary dies before you, the Beneficiary's interest automatically terminates.
- (c) If you name more than one Beneficiary, the total amount of benefits due will be divided equally among the surviving Beneficiaries.
- (d) If no named Beneficiary is surviving at the time of your death, or if you did not name a Beneficiary, the life insurance benefit or AD&D death benefit will be paid to the first surviving class in the following order of preference:

- (1) your spouse;
 - (2) your children in equal shares;
 - (3) your parents in equal shares;
 - (4) your siblings in equal shares;
 - (5) executors or administrators on your estate.
- (e) If your Eligible Dependent dies before you, any benefit payable upon the death of the Eligible Dependent will be paid to the Eligible Dependent's estate or as otherwise determined to be appropriate by the Fund Administrator.

8.4: Claims For Benefits

- (a) Life insurance and accidental death and dismemberment benefits must be claimed by you or your Beneficiary or Beneficiaries by contacting the Fund Administrator for a claim form. It will inform you as to the documentation required. The required documentation will include proof of death or other loss that is satisfactory to the Fund and to the insurance company.

All life insurance and accidental death and dismemberment benefit claims must be submitted to the Fund Administrator within sixty (60) days after death or other covered loss.

See Part 10 (Claims & Appeals) for more information about submitting claims and appealing a denial of benefits.

- (b) Life insurance and accidental death and dismemberment benefits may be paid directly by the insurance company to you or your Beneficiary or Beneficiaries.

8.5: Extension Of Life Insurance If You Become Totally Disabled

- (a) If you become Totally Disabled while eligible under the Plan before age sixty (60), you will nonetheless remain eligible for the life insurance benefit provided by this Plan for as long as the Total Disability continues, subject to the provisions of this Section.

- (b) Total Disability means that you are completely unable, due to injury or illness, to engage in any business, occupation or employment for which you are qualified or become qualified by reason of education, training or experience for pay, profit or compensation.

- (c) Your eligibility for the life insurance benefit will terminate after an initial period of twelve (12) months from the date of your Total Disability unless you remain Totally Disabled and you submit to the Fund Administrator, within that twelve (12) month period, written proof that is satisfactory to the Fund and the insurance company:

- (1) that you are Totally Disabled;
- (2) that the Total Disability began while you were eligible under the Plan;
- (3) that the Total Disability began before you attained age sixty (60); and
- (4) that the Total Disability has existed continuously for nine (9) months.

- (d) If the proof conditions of subsection (c) are satisfied, your eligibility for life insurance will continue for successive twelve (12) month periods if:
 - (1) you remain Totally Disabled; and
 - (2) written proof of your continuing Total Disability that is satisfactory to the Fund and the insurance company is submitted to the Fund Administrator within three (3) months of each anniversary of the Fund Administrator's receipt of the initial proof.
- (e) In the event of your death while this continuation of eligibility is in effect, written proof of your continuous Total Disability through date of death, that is satisfactory to the Fund and the insurance company, will also be required for benefits to be payable to your Beneficiary or Beneficiaries.
- (f) The Fund, as a condition of continuation of eligibility under this Section, may require you to be examined by a doctor of the Fund's or insurance company's choice and at the insurance company's expense, at any reasonable time during the course of your Total Disability. The purpose of the examination would be to confirm that you are or remain Totally Disabled.

8.6: Conversion Of Life Insurance Benefit To Individual Policy

- (a) If you cease to be eligible for the life insurance benefit under the Plan, you have a right to convert to an individual life insurance policy, other than a term policy, offered by the insurance company without a medical examination or other proof of good health. If your Eligible Dependent ceases to be eligible for the life insurance benefit under the Plan, he or she has a right to convert to an individual life insurance policy, other than a term policy, offered by the insurance company without a medical examination or other proof of good health. The individual policy would be issued by the insurance company directly to you or your Eligible Dependent, and you or your Eligible Dependent would be responsible for paying the premiums for the policy to the insurance company.
 - (1) An application form for conversion to an individual policy must be submitted to the insurance company, along with your first premium payment, no later than thirty-one (31) calendar days after your or your Eligible Dependent's eligibility under the Plan terminates.
 - (2) The face value of the individual policy cannot exceed the amount of the life insurance benefit for which you or your Eligible Dependent was entitled under the Plan. The premium rate for the individual policy will be set by the insurance company based on various risk factors, including age and amount and type of policy.
- (b) If the Fund's life insurance policy with the insurance company terminates or if your group terminates coverage under the Plan, you have a right to convert to an individual life insurance policy, other than a term policy, offered by the insurance company without a medical examination or other proof of good health if you has then been continuously eligible under the Plan for at least five (5) years. The face value of the individual policy would be limited to the lesser of:

- * two thousand dollars (\$2,000), or
 - * the amount of life insurance benefit for which you were eligible under the Plan, less any amount for which you are or become eligible under the Plan or any other group insurance policy within thirty-one (31) days after the date of termination of eligibility.
- (c) If you or your Eligible Dependent dies during the thirty-one (31) day period after loss of eligibility under the Plan, life insurance benefits will be payable regardless of whether an application for conversion to an individual policy was submitted.

Part 9:

SHORT TERM DISABILITY (WEEKLY INCOME) BENEFITS

9.1: Introduction

In general, if you become Disabled while eligible under the Plan, you are entitled to a Weekly Income Benefit of one hundred twenty-five dollars (\$125), after completing a Benefit Waiting Period, for the duration of your Disability up to a maximum of twenty-six (26) weeks, subject to the provisions of this Part.

9.2: Disability

For purposes of this Part, “Disabled” and “Disability” means:

- (a) you are unable to perform the essential duties of your regular occupation or a reasonable employment option offered to you by the Fund,
- (b) because of a change in your functional capacity to work due to sickness or accidental injury,
- (c) as a result, you are unable to earn more than 80% of your weekly earnings,
- (d) and, you are receiving regular and appropriate care.

“Essential duties” are duties that are normally required for the performance of an occupation as it is normally performed in the national economy and which cannot be reasonably omitted or modified.

“Regular occupation” means the work that you were performing immediately prior to your sickness or accidental injury and for which contributions were made to the Fund.

“Sickness” means any physical illness, mental disorder, normal pregnancy or complication of pregnancy.

“Accidental injury” means bodily injury resulting from a sudden, violent, unexpected and external event, as well as an infection resulting from a cut or wound caused by an accident. Accidental injury does not include any other type of infection, poisoning, or disease.

“Regular and appropriate care” means: (1) you personally visit a doctor as often as is medically required consistent with generally accepted medical standards to effectively manage and treat your sickness or injury, (2) you are receiving care that conforms to generally accepted medical standards for treating your sickness or injury, (3) the care is rendered by a doctor whose specialty or experience is the most appropriate for your sickness or injury according to generally accepted medical standards, and (4) you are receiving or actively seeking appropriate physical or psychological rehabilitative services.

9.3: Waiting Period

The Benefit Waiting Period is the seven (7) day period that you must be continuously disabled before you can qualify to receive any benefits. You must complete the Benefit Waiting Period before any benefits are payable.

- (a) Exception: you may return to work for up to five (5) days during the Benefit Waiting Period without having to begin a new Benefit Waiting Period. The days you work (and are, therefore, not disabled) do not count toward meeting the Benefit Waiting Period requirement, however.
- (b) The Benefit Waiting Period begins on the first day that you see a doctor and the doctor states in writing that you are disabled because of sickness or accidental injury.

9.4: Benefit

The benefit is one hundred twenty-five dollars (\$125) per week. The benefit is paid at the end of each week for the period during which you are Disabled following the Benefit Waiting Period up to the maximum period for which benefits are payable (twenty-six (26) weeks).

9.5: Exclusions

Exclusions: No benefit is payable if your Disability results from:

- (a) sickness or injury that occurs in any armed conflict, whether or not a declared war;
- (b) sickness or injury that occurs while you are in the military service for any country;
- (c) intentionally self-inflicted injury or illness, whether you are sane or insane;
- (d) injury that occurs while you are committing or attempting to commit a felony;
- (e) injury suffered during a fight in which you were the aggressor;
- (f) sickness or injury due to cosmetic or reconstructive surgery, except for surgery necessary to correct a deformity caused by sickness or accidental injury;
- (g) sickness or accidental injury for which you had or have a right to payment under workers compensation law or similar law; or
- (h) sickness or accidental injury arising out of or in the course of work for pay, profit or gain.

No benefits are payable for any period of Disability during which you are confined to a penal or correctional facility as a result of conviction for a criminal or other public offense. No additional benefit is payable if the Disability is caused by multiple sicknesses and/or accidental injuries.

9.6: Benefit Claims

Benefits are not automatically payable. You must submit written notice of disability to the Fund Administrator as soon as reasonably possible and normally within twenty (20) days after you become disabled.

- (a) Upon receipt of the notice, the Fund Administrator will send to you a claim form. You will have to complete the claim form and return it to the Fund Administrator as soon as possible but no later than ninety (90) days after you are disabled. No benefit is payable unless the claim form is completed and submitted to the Fund Administrator.

- (b) The Fund Administrator or the Fund's insurer may require additional information to prove your claim for benefits. In addition, you may be required to submit to examination by one or more doctors or vocational experts of the Fund's or insurer's choosing if the Fund or the insurer reasonably believes it necessary to properly evaluate your claim or potential for rehabilitation. Failure to cooperate with such an examination may result in the denial, loss, deferral or suspension of Benefits.
- (c) See Part 10 (Claims & Appeals) for more information about submitting claims and appealing a denial of benefits.
- (d) Benefits may be paid directly by the insurance company to you or your Beneficiary or Beneficiaries.

Part 10:

CLAIMS AND APPEALS: HOW TO CLAIM BENEFITS & APPEAL ANY DENIAL OF BENEFITS

10.1: Payment of Plan Benefits in General (Claim Forms)

- (a) Generally, a claim on a Fund-approved Claim Form must be submitted to the Fund Administrator before payment of benefits under the Plan will be considered and made by the Fund, except as otherwise provided in another Part of this document.

A major exception to this general rule is that no Claim Form is required when you or your Eligible Dependent used a PPO provider under the Plan.

- (b) The Fund Administrator is:

Laborers' National Health and Welfare Fund
c/o Zenith Administrators, Inc.
5565 Sterrett Place, Suite 210
Columbia, MD 21044
1 (800) 235-5805
1 (410) 884-1440

- (c) Claim Forms may be obtained from the Fund's website (www.lnhwf.org) or from the Fund Administrator.
- (d) A Claim Form for benefits payable to or for you or for an Eligible Dependent may be submitted by you or by your Authorized Representative. You may designate an Authorized Representative for this purpose by completing the Fund's Representative Authorization Form and submitting it to the Fund Administrator. You may obtain the Representative Authorization Form from the Fund's website or by contacting the Fund Administrator.
- (e) The Fund Administrator may accept a claim directly from a health care provider in a paper or electronic form other than the Fund's Claim Form if the Fund Administrator is satisfied that you have assigned your benefits to the provider or authorized the provider to submit the claim on your behalf and that the form is otherwise acceptable.
- (f) A Beneficiary claiming life insurance or accidental death benefits should contact the Fund Administrator as to the appropriate Claim Form or other documentation required for claiming such benefits.
- (g) Each Claim Form includes instructions. The Claim Form must be completed in accordance with the instructions, and any documentation required by the instructions must be submitted with the Claim Form.
- (h) If you have any questions about how to complete a Claim Form, or any questions concerning eligibility to make a claim or the status of a claim, you should contact the Fund Administrator.

- (l) You should review any bills that you receive from doctors or other health care providers before submitting them with a Claim Form for payment. If you believe that a bill contains charges for services or supplies which you did not receive, report this to the Fund Administrator. Your help in finding billing errors reduces costs to you and the Fund.

10.2: Time Limit For Submitting Claims

- (a) All health care benefits (medical, dental, prescription drug, and vision) claims must be submitted to the Fund Administrator within one hundred eighty (180) days after the treatment, services or equipment to which the claim relates were received, except as otherwise provided in this document.
- (b) All Life Insurance, Accidental Death and Dismemberment, or Short Term Disability benefits claims must be submitted to the Fund Administrator within sixty (60) days after death or other covered loss.
- (c) To claim Short Term Disability benefits, you must submit written notice of disability to the Fund Administrator as soon as reasonably possible and normally within twenty (20) days after you become disabled.
- (d) Benefits will not be payable unless a claim is submitted to the Fund Administrator within the applicable time limit.

10.3: Processing Of Claim By Fund Administrator

- (a) When a claim for health care benefits is received by the Fund Administrator, the Fund Administrator will review it to verify the eligibility of the Claimant (you, your Dependent, or Beneficiary) and to determine the extent to which benefits are payable under the Plan's rules for the claim.
- (b) The Fund Administrator may contact you, your Eligible Dependent, your Authorized Representative, the provider, your Beneficiary and / or other persons for additional information needed to correctly process the claim.
- (c) If the Fund Administrator determines that benefits are payable on a claim for health care treatment, services or equipment, payment of the benefits will be made directly to the provider if the Fund Administrator determines that you or your Eligible Dependent properly assigned the benefits payable by the Fund to the provider. Otherwise, payment of the benefits will be made by the Fund to you.
- (d) Generally, a decision on all health care claims will be made by the Fund Administrator within thirty (30) days after the Fund receives the completed Claim Form, and a written explanation will be sent to you.
 - (1) The Fund Administrator may extend this period for up to an additional fifteen (15) days, provided that the extension is necessary due to matters beyond the control of the Fund and the Fund Administrator notifies you of the extension prior to the end of the initial 30-day period. This notice will describe the reasons for the extension and the date by which the Fund Administrator expects to make its decision.

- (2) However, if the extension is necessary because you or your provider failed to provide sufficient information to decide the claim, the extension notice will describe the specific information needed to decide the claim, and you will be given at least forty-five (45) days to provide such information. In such case, the Fund Administrator will notify you of its benefit determination as soon as possible after you provide the required information, but not later than fifteen (15) days after the Fund receives such information.
- (e) Claims relating to Life Insurance benefits, Accidental Death and Dismemberment benefits and Short Term Disability benefits will be submitted by the Fund Administrator to the insurance company from which the Fund has purchased insurance policies for such benefits. The claims will be processed and, if appropriate, paid by the insurance company directly to the Claimant.

10.4: Right To Appeal Denial Of Health Care Benefits

- (a) If your or your Dependent's health care benefits (medical, dental, prescription drug, or vision) claim is denied in whole or in part, the following information will be provided to you in the notice of denial of claim:
- * specific reason(s) for the denial;
 - * reference to the specific Plan provisions on which the denial was based;
 - * description of any additional materials or information necessary to process the claim and an explanation of why such material or information is necessary;
 - * description of the Plan's procedures for a full and fair review, including the applicable time limits in which you may file an appeal and a statement of your right to bring a civil action under Section 502(a) of ERISA;
 - * if the denial is based on an internal rule, guideline, protocol or other similar criteria or a statement that such information will be provided to you without charge upon your request; and
 - * if the denial is based on Medical Necessity or Experimental or Investigational treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the denial applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you without charge upon your request.
- (b) If a claim is denied in whole or in part, or if you disagree with the amount paid on a claim, you may appeal for a review of the claim by the Board of Trustees. Your request for a review of a denied claim must be submitted in writing to the Board of Trustees within one hundred eighty (180) days after you receive written notice of the denial. Your request for review should be sent to the following address:

Board of Trustees
Laborers' National Health and Welfare Fund
5565 Sterrett Place, Suite 210, Columbia, MD 21044

- (c) Your appeal must state clearly the reason(s) for your appeal. You must submit with the appeal any documents or other proof that you have to support your appeal.
- (d) Your appeal will be reviewed by the Board of Trustees or by a committee of the Board of Trustees to which authority to review appeals has been delegated by the Board of Trustees. Ordinarily, the Board of Trustees will review the appeal at the next regularly scheduled quarterly meeting immediately following receipt of your appeal. If you submit the appeal within thirty (30) days of the next quarterly meeting, the Board of Trustees will review the appeal by no later than the date of the second quarterly meeting following receipt of the appeal.
- (e) Once the Board of Trustees' makes a decision on the appeal, a written notice and explanation of that decision will be sent to you, usually within five (5) days after the decision is made. If the decision is to deny the appeal in whole or in part, the notice and explanation will include the following information:
- * specific reason(s) for the denial;
 - * reference to the specific plan provisions on which the denial was based;
 - * statement that you are entitled to receive, upon request and free of charge reasonable access to, and copies of all Relevant Documents;
 - * the following statement: "You and your plan may have voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your U.S. Department of Labor office and your State insurance regulatory agency."
 - * statement of your right to bring a civil action under Section 502(a) of ERISA;
 - * if the denial is based on an internal rule, guideline, or other similar criteria, either the internal rule, guideline, or other similar criteria or a statement that such information will be provided to you without charge upon your request;
 - * if the denial is based on medical necessity or experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided to you without charge upon your request; and
 - * statement that the identity of any health experts consulted (without regard to whether the advice was relied on in making the determination) will be provided to you without charge upon your request.
- (f) You may review any relevant documents held by the Fund that are applicable to your claim free of charge upon your request.
- (g) The Board of Trustees, in reviewing your appeal, will not defer to the initial adverse benefit determination and will take into account all comments, documents, records and other information submitted by the claimant and/or obtained by the Fund Administrator. In addition, if the decision on review involves a medical judgment, including determinations with

regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Board of Trustees will consult with a Health Care Practitioner with appropriate training and experience in the field of medicine involved in the medical judgment.

10.5: Right To Appeal Denial Of Insurance Benefits

- (a) If a claim for Life Insurance, Accidental Death and Dismemberment, or Short Term Disability benefits is denied in whole or in part by the insurance company from which the Fund has purchased group insurance for such benefits, you or another claimant may appeal the denial to the Board of Trustees in the same manner as provided in Section 10.4(b) and (c). The Board of Trustees will review the appeal with the insurance company. A written notice and explanation of the decision on the appeal will be sent to you or other claimant within a reasonable period.
- (b) If the decision is to deny the appeal in whole or in part, the notice and explanation will include the following information:
- * specific reason(s) for the denial;
 - * reference to the specific plan provisions on which the denial was based;
 - * statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all Relevant Documents;
 - * the following statement: "You and your plan may have voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your U.S. Department of Labor office and your State insurance regulatory agency."
 - * statement of your right to bring a civil action under Section 502(a) of ERISA;
 - * if the denial is based on an internal rule, guideline, protocol, or other similar criteria, either the internal rule, guideline, or other similar criteria or a statement that such information will be provided to you without charge upon your request;
 - * if the denial is based on medical necessity or experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided to you without charge upon your request; and
 - * statement that the identity of any health experts consulted (without regard to whether the advice was relied on in making the determination) will be provided to you without charge upon your request.

10.6: Requirement That Claims & Appeals Procedure Be Exhausted Before A Lawsuit Is Filed; Time Limit For Commencing Lawsuits

- (a) No lawsuit claiming a wrongful denial of benefits under the Plan may be commenced in any court by you or another claimant unless and until the Plan's claims and appeals procedure has been exhausted: a claim has been properly submitted to the Fund Administrator, the Fund Administrator has given notice of denial of the claim or the time for such notice has expired, an appeal of the denial of the claim has been submitted to the Board of Trustees, and the Board of Trustees has given notice of denial of the appeal or the time for such notice has expired.
- (b) A lawsuit claiming a wrongful denial of benefits under the Plan may not be commenced more than two (2) years after the Board of Trustees has given notice of denial of the appeal or the time for such notice has expired.

Part 11:

MISCELLANEOUS PROVISIONS

11.1: Authority of The Board of Trustees

- (a) The Board of Trustees, as the Fund's named fiduciary and sponsor, has absolute discretionary authority to determine and decide all questions of fact or law concerning the Plan and Fund including the content, interpretation and application of the Plan's and Fund's benefits, documents, rules, requirements, practices, regulations, forms and procedures. The Board's decisions shall be final and binding on all persons.
- (b) The benefit design of the Plan (including the content, conditions and limitations of benefits provided under the Plan and the eligibility rules) has been adopted by the Board of Trustees in its capacity as the Plan's sponsor and is not subject to ERISA's fiduciary standards.
- (c) The Board of Trustees has absolute discretionary authority and non-reviewable right to waive application of the Plan's rules, regulations, requirements, practices or procedures to prevent or correct a manifest injustice, if it so chooses. The Board of Trustees has absolute discretion to compromise and settle any dispute concerning the Plan or Fund.
- (d) The Board of Trustees has absolute discretionary authority to amend this Plan at any time, for any lawful reason and in any respect, and to set the effective date for any such amendment. The Board of Trustees also has absolute discretionary authority to terminate this Plan at any time.
- (e) The Board of Trustees has absolute discretionary authority to set contribution and COBRA Premium rates, and to change any such rates from time-to-time, with or without advance notice, as the Board deems necessary or appropriate to pay and fund benefits, defray the expenses of Fund administration, and maintain reserves.
- (f) The Board of Trustees has absolute discretionary authority to deny participation in the Fund or Plan to any group or employer, and to expel any group or employer from participation in the Fund, when it deems necessary or appropriate to protect the interests of the Fund.
- (g) The grant of such broad discretionary authority to the Board of Trustees reflects the circumstances of the Fund as a self-funded, non-profit, collectively bargained, multiemployer plan. The Fund depends primarily on collectively bargained employer contributions for funding of promised benefits. All assets of the Fund are pooled and are available for payment of benefits for all eligible participants and beneficiaries and the reasonable expenses of administration.

11.2: Legal Compliance

The Board of Trustees' intend that this Plan and the Fund, both in content and operation, comply in all respects with applicable law and government regulations including the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and the Mental Health Parity Act. The Plan will be interpreted and applied to comply with all applicable laws.

11.3: Fund's Right To Information Needed To Properly Administer Plan

The Fund is entitled to obtain from you and any other claimant seeking benefits under the Plan, as well as from your Health Care Providers, any and all information that is reasonably needed to properly process a claim for benefits, including verification of eligibility, of services provided and charges for services. To enforce this right to information, the Fund may withhold payment of any benefits until it obtains needed information.

11.4: Right To Recover Mistaken Payments

- (a) If the Fund makes payments to which the recipient of the payments is not entitled, or that are in excess of the amount to which the recipient is entitled, the Fund shall have an absolute right to recover the erroneous payments from the recipient and the recipient shall be obligated to return to the Fund the erroneous payments. Otherwise, the recipient would be unjustly enriched.
- (b) Erroneous payments remain assets of the Fund, and the recipient of such a payment is a fiduciary with respect to the Fund within the meaning of ERISA. The recipient holds an erroneous payment in constructive trust for the benefit of the Fund, and has a fiduciary duty to return the payment to the Fund.
- (c) To enforce the fiduciary duty and recover the erroneous payment, the Fund may withhold all or any portion of benefits due under the Plan, and may commence legal proceedings in law or equity including an action under ERISA.

11.5: No Vesting Of Benefits

No participant, beneficiary or other person shall have or be deemed to have any vested rights or entitlements to benefits under this Plan, except with regard to benefits that have been actually and properly paid. Benefits are payable from the Fund only to the extent that the Fund has assets, or benefits are payable by an insurance company under a policy of insurance issued to the Fund. No organization other than the Fund shall be liable for benefits or other liabilities of the Fund, except to the extent that benefits or liabilities are payable by an insurance company under a policy of insurance issued to the Fund.

11.6: Incapacity

If the Fund Administrator determines that you are comatose, incompetent or incapacitated, it may, in its discretion, pay benefits to which you are entitled under the Plan directly to the provider of health care services, supplies or equipment for which the benefits are payable, or to any other person who is providing for your care or support. Any such payment will completely discharge the Fund's obligations to the extent of that payment, and neither the Fund, the Board of Trustees, nor the Fund Administrator will be required to investigate or monitor the application of the money so paid.

Part 12:

ADDITIONAL INFORMATION ABOUT THE FUND

Federal law requires that the following additional information concerning the Fund be included in this Summary Plan Description:

12.1: Names, Address and Telephone Number of the Fund:

Laborers' National Health and Welfare Fund
c/o Zenith Administrators, Inc.
5565 Sterrett Place, Suite 210
Columbia, MD 21044
1 (800) 235-5805
1 (410) 884-1440

12.2: Plan Identification Number: 52-1601994

12.3: Plan Number: 001

12.4: Type of Fund / Plan:

The Fund is an employee welfare benefit plan and a multiemployer plan under ERISA. It is also a joint labor-management trust fund. The Fund's Board of Trustees has designed and adopted multiple plans of benefits for groups of participants and beneficiaries of the Fund. Under this Plan, the following types of benefits are provided: medical, dental, prescription drug, vision, life insurance, accidental death and dismemberment, and short term disability benefits.

12.5: Type of Administration:

The Fund is a trust established by an Agreement and Declaration of Trust for the exclusive purpose of providing benefits to participants and beneficiaries who are eligible for benefits under the terms of the benefit plans provided by the Fund. The Fund is governed by a Board of Trustees, consisting of Union and Management Trustees, in accordance with the Agreement and Declaration of Trust that established the Fund.

The Board of Trustees has sole and absolute authority to design, adopt, amend, interpret and apply the Fund's benefit plans and programs as well as to manage the Fund and decide all questions concerning the Fund and Plan, including all questions of interpretation and application of the terms of Plans and related questions of fact and law.

The Board of Trustees is the "sponsor", "plan administrator," and primary "named fiduciary" of the Fund within the meaning of ERISA.

The Board of Trustees has delegated responsibility for the Fund's day-to-day operations to a third-party administration company, Zenith Administrators, Inc., 5565 Sterrett Place, Suite 210, Columbia, MD 21044, which is referred to as the "Fund Administrator."

The Board of Trustees has engaged various professional advisors to assist in the administration and management of the Fund, including attorneys, auditors, consultants, investment consultants, and investment managers.

The Board of Trustees consists of the following individuals as of January 1, 2006:

ARMAND E. SABITONI, Co-Chairman
General Secretary-Treasurer
Laborers' International Union of North America
905 16th Street, N.W., Washington, D.C. 20006

PAUL FAYAD, Co-Chairman
President & CEO, HHA Services
22622 Harper Avenue
St. Clair Shores, MI 48080

VERE O. HAYNES
Vice President
Laborers' International Union of North America
905 16th Street, N.W., Washington, D.C. 20006

GINO DECONTI
261 NW Toscane Trail
Port St. Lucie, FL 34986

ROCCO DAVIS
Vice President & Regional Manager
Laborers' International Union of North America
905 16th Street, N.W. Washington, D.C. 20006

NOEL C. BORCK
Executive Vice President, NEA
1501 Lee Highway, Suite 202
Arlington, VA 22209

VINCENT R. MASINO
Vice President
Laborers' International Union of North America
226 South Main Street
Providence, Rhode Island 02903

JOHN D. O'REILLY III, Esq.
O'Reilly, Grosso & Gross, P.C.
1671 Worcester Road, Suite 205
Framingham, Massachusetts 01701

JAMES C. HALE
Vice President & Regional Manager
Laborers' International Union of North America
25 Century Blvd., Suite 305
Nashville, TN 37214

ANTONIO RANGEL
President & CEO, TRDI, Inc.
4502 Crestview Drive, Suite 225
San Antonio, TX 78228

12.6: Agent for Service of Process

The Board of Trustees has designated the Fund Administrator, Zenith Administrators, Inc., as the Fund's agent for receipt of process. They are located at the Fund Office. Service of process may be made on the Fund Administrator at 5565 Sterrett Place, Suite 210, Columbia, MD 21044 or any Trustee.

12.7: Funding and Contributions

The Fund generally obtains the money with which to pay benefits from the following sources: (1) employer contributions made in accordance with various collective bargaining agreements, (2) income and gain from investments of the Fund's assets; and (3) participant and beneficiary self-contributions in limited circumstances.

All contributions and investments are pooled in a common trust fund and held in trust by the Board of Trustees for the exclusive purpose of providing promised benefits and paying the reasonable expenses of administering the Fund. All assets are available to pay all benefit and expense obligations of the Fund.

Plan benefits are generally payable only from the pooled assets of the Fund, and are not insured by any insurance company. However, the Life Insurance, Accidental Death and Dismemberment, and Short Term Disability benefits are insured under group insurance policies purchased and maintained by the Fund as a policyholder.

The insurance company by which the Fund's current Life Insurance and Accidental Death and Dismemberment insurance policy has been issued is Union Labor Life Insurance Company, 1625 Eye Street, N.W., Washington, D.C. 20006, (202) 682-0900. The group policy number is G-8214.

The insurance company by which the Fund's current Short Term Disability insurance policy has been issued is Reliastar Life Insurance Company, Minneapolis, Minnesota 55440. The group policy number is 62931-Disability.

12.8: Investments and Other Assets

The Fund's assets are prudently invested in diversified portfolios by various professional investment managers selected by the Board of Trustees on the recommendation of the Fund's professional investment consultant. The Fund's assets are held in custody by Amalgamated Bank of Chicago, One West Monroe Street, Chicago, Illinois 60603.

12.9: Contributing Employers and Sponsoring Unions

Participants and beneficiaries may obtain from the Fund Administrator, upon written request, information as to whether a particular employer contributes to the Fund for coverage under this Plan or whether a particular Union is party to a collective bargaining agreement requiring employers to contribute to the Fund for coverage under this Plan. The Fund Administrator will provide the address of such a contributing employer or Union sponsor.

12.10: Relevant Collective Bargaining Agreements

The Fund is maintained pursuant to multiple collective bargaining agreements between the Laborers' International Union of North America (LIUNA) or affiliated Local Unions and District Councils of LIUNA and various employers that require the employers to make contributions to the Fund at certain periodic (hourly or monthly) rates. The Fund sets minimum acceptable contribution rates, and the Fund's Board of Trustees may refuse to accept or expel any group or employer whose collective bargaining agreement fails to require an acceptable rate of contributions.

Copies of the collective bargaining agreements may be obtained by a Fund participant or beneficiary upon written request to the Fund Administrator. A reasonable charge for copies may be required.

A list of contributing employers may also be obtained by a Fund participant or beneficiary upon written request to the Fund Administrator or may be examined at the offices of the Fund Administrator upon reasonable notice.

12.11: Fiscal / Plan Year

The Fund's fiscal year and plan year is the calendar year ending on December 31st.

12.12: Obtaining Information and Answers

Information concerning the Fund, including copies of the Summary Plan Description, annual reports, and summary annual reports, can be obtained by contacting the Fund Administrator.

Participants and their family members are particularly encouraged to contact the Fund Administrator if they have any questions concerning the Fund, their eligibility for benefits, or their rights and responsibilities.

Part 13:

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Regulations issued by the U.S. Department of Labor require that pension plan's summary plan description include the following statement of ERISA rights and responsibilities.

As a Participant in the Laborers National Pension Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration).

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Coverage / Creditable 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. Review this summary plan description and the documents governing the plan on the rules governing your COBRAS continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your 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, or 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 employee benefit plan. The people who operate your plan, 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 employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit 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 this was done, 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 the above rights. For instance, if you request a copy of plan documents or the latest annual report 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 administrator. If you have a claim for benefits which 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’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 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 is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act, or other laws affecting employee health plans, and or if you need assistance in obtaining documents from the plan administrator, 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, 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 of the U.S. Department of Labor. You may also visit the EBSA’s website at www.dol.gov/ebsa for additional information concerning EBSA offices and ERISA.

Part 14:

INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) grants you certain privacy rights with respect to the Health Information about you that is maintained by the Laborers National Health and Welfare Fund (the Fund). In addition, HIPAA requires that the Fund comply with rules designed to protect this information from improper uses and disclosures. One of your rights under HIPAA is to know how the Fund handles your Health Information. This Notice explains how the Fund uses and discloses your Health Information, and what rights you have with respect to your Health Information. The Fund may change this Privacy Notice in the future, but it must always follow the terms of the Privacy Notice in effect.

Zenith Administrators, Inc. (Zenith), a third-party administration company, is the Fund Administrator. Zenith's responsibilities for the day-to-day administration of the Fund and Plan include maintaining the Fund's records and processing and payment of benefit claims.

If you have any questions about this notice, please contact the HIPAA Compliance Director at Zenith Administrators, Inc 5565 Sterrett Place, Suite 210, Columbia, Maryland 21044, telephone: 1-800-235-5805 or 1-410-884-1440

WHO SEES MY HEALTH INFORMATION?

The Fund Administration Team includes all Individuals who must see Health Information that can be linked to an Individual ("Protected Health Information") in order to operate the Fund. Certain members of the Team are Zenith employees. Certain members of the Team are employees of outside businesses that help operate the Fund, such as professional consultants, attorneys, and auditors to the Fund, utilization reviewers and case managers, and insurers. In addition, the Fund has an Organized Health Care Arrangement, within the meaning of federal privacy rules, with insurance companies that insure certain benefits provided under the Plan.

Trustees of the Fund are also Fund Administration Team members in that they have governing responsibility for the Fund and Plan and they have full discretionary, fiduciary responsibility to hear benefit denial appeals under Part 10. Protected Health Information may be used by Trustees only for purposes of determining claims and appeals.

All Team Members are prohibited by law from using Protected Health Information for improper purposes. Each Team Member understands that a violation of the Fund's privacy and security procedures may result in disciplinary actions. Therefore, Team Members take the privacy of your information very seriously. As Fund Administration Team Members, we understand that your health and medical information is private information. The Fund is 100 percent committed to using the Health Information we obtain about you only for the purposes of treatment, paying benefits, operating the Fund and as expressly permitted or required by law. We will only use the Protected Health Information we obtain for a different purpose if you expressly authorize us to do so.

OTHER PRIVACY NOTICES

Your doctors, nurses, hospitals or other health care providers may provide you with privacy notices required by HIPAA as well. These privacy notices will differ from this one because they discuss how the health care providers use your Health Information. Please note that this notice applies only to the Protected Health Information obtained and maintained by the Fund. Therefore, it describes your rights with respect to the Health Information about you that is maintained by the Fund, and how the Fund may use and disclose that Health Information.

HOW WE USE AND DISCLOSE THE HEALTH INFORMATION WE OBTAIN

Team Members only use and disclose Protected Health Information in ways that are expressly permitted by HIPAA. The sections entitled Treatment, Payment and Health Care Operations describe how we use and disclose the Health Information we obtain about you (your "Health Information"). Some of these uses and disclosures are routine, and are necessary in order to run the Fund, and to provide assistance to the health care providers who treat you. Others are not routine, but are required by law or necessary due to special circumstances. The Fund has developed procedures for all of these uses and disclosures. Inasmuch as the Fund is a member of an Organized Health Care Arrangement, the Fund may share your information with members of that Organized Health Care Arrangement for purposes of Treatment, Payment and Health Care Operations.

Treatment: Team Members may use or disclose your Health Information to facilitate medical treatment or services by your health care providers such as doctors, nurses, technicians, medical students, other hospital personnel or pharmacists who are involved in taking care of you.

Payment: Team Members may use and disclose your Health Information in order to determine your eligibility for Fund benefits, to process claims for payment for your treatment, or to determine whether any other plan or party might be responsible for paying for the treatment. For example, a Team Member must review Health Information about you that is contained on a bill for Treatment in order to determine whether the Treatment is a covered expense under the Fund. Sometimes a Team Member might need to obtain information from the health care provider and from your existing file to determine whether the Treatment provided was medically necessary, or experimental and investigative. One Team Member might need to send the information to another Team Member who is a medical specialist to get a medical opinion about the nature of the claim. These are just some examples of how Team Members use and disclose your Health Information in order to make sure the Fund pays benefits properly.

Health Care Operations: Team Members may use and disclose your Health Information in order to operate the Fund. For example, Team Members may review your Health Information in order to:

1. Conduct quality assessment and improvement activities;
2. Perform underwriting, premium rating, and other activities related to Fund coverage;
3. Submit claims for stop-loss (or excess loss) coverage;
4. Conduct or arrange for medical review, legal services, audit services, and fraud and abuse detection programs;

5. Learn about ways to manage costs; and to
6. Manage the business of the Fund and make sure it is administered properly and effectively.

Required By Law: Team Members will disclose your Health Information when required to do so by federal, state or local law. For example, a Team Member will disclose information about medical bills submitted by your Health Care Provider pursuant to a court order in a litigation proceeding alleging that the provider has fraudulent billing practices.

To Prevent Serious Threats to Health or Safety: Team Members may use and disclose your Health Information in order to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any such disclosure would only be to a person who is able to help prevent the threat.

Fund Administrative Office: As mentioned above, certain employees of Zenith serve as Fund Administration Team Members. Your Protected Health Information will only be used and disclosed by these employees for plan administrative purposes.

SPECIAL SITUATIONS

Organ and Tissue Donation: If you are an organ donor, we may release your Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, in order to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces of the United States or any other country, we may release your Health Information if Laborers National Health and Welfare Fund is required to by the appropriate military command authorities.

Workers' Compensation: Team Members may release your Health Information if required to in order to comply with workers' compensation laws.

Health Oversight Activities: Team Members may disclose your Health Information to a Health Oversight Agency for Activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, Team Members may disclose your Health Information in response to a court or administrative order. Team Members may also disclose your Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. If asked to do so by a Law Enforcement Official, a Team Member may release your Health Information under circumstances in response to a court order, subpoena, warrant, summons or similar process.

Coroners, Medical Examiners and Funeral Directors. Team Members may release your Health Information to a coroner or medical examiner. This may be necessary, for example, to identify you if you die or to determine the cause of your death. Team Members may also release your Health Information to funeral directors as necessary to carry out their duties.

YOUR RIGHTS REGARDING THE HEALTH INFORMATION ABOUT YOU THAT WE MAINTAIN

You have the following rights regarding the Health Information the Fund maintains about you:

Right to Inspect and Copy: You have the right to inspect and copy your Health Information that may be used to make decisions about your Fund benefits. To inspect and copy medical information that may be used to make decisions about you, you must complete the Form entitled “Request for Access to Protected Health Information” and submit the Form to the HIPAA Compliance Director. If you request a copy of the information, you may be charged a fee for the costs of copying, mailing or supplies associated with your request.

Right to Amend: If you feel the Fund has medical information about you that is incorrect or incomplete, you may ask the Fund to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Fund.

To request an amendment, you must complete a Form entitled “Request for Amendment of Protected Health Information”. This Form is available upon request from the HIPAA Compliance Director. Your request for an amendment may be denied if you do not complete this Form. In addition, your request may be denied if you ask us to amend information that:

1. Is not part of the medical information kept by or for the Fund;
2. Was not created by the Fund, unless the person or entity that created the information is no longer available to make the amendment;
3. Is not part of the information which you would be permitted to inspect and copy; or
4. Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures” where such disclosure was made for any purpose other than Treatment, Payment, or Health Care Operations.

To request this list or accounting of disclosures, you must complete the Form entitled “Request for an Accounting of Disclosures of Protected Health Information” and submit the Form to the HIPAA Compliance Director. Your request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). This first list you request within a twelve (12) month period will be free. If additional lists are requested, the Fund may charge you for the costs of providing the lists. You will be notified of the cost and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information the Fund uses or discloses about you for Treatment, Payment or Health Care Operations. You also have the right to request a limit on the medical information the Fund discloses about you to someone who is involved in your care or the Payment for your care, like a family member or friend. For example, you could ask that we not use or disclose to your spouse information about a previous surgery you had.

To request restrictions, you must submit to the HIPAA Compliance Director a written request for restriction in such form as he / she may require. The Fund will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You may obtain a copy of this notice or any of the request forms at our website, or to obtain a copy, contact the HIPAA Compliance Director.

CHANGES TO THIS NOTICE

The Fund reserves the right to change this notice. A copy of the current notice is posted on the Fund's website.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Laborers Health and Safety Fund or with the Secretary of the Department of Health and Human Services. To file a complaint with the Funds, contact the HIPAA Compliance Director.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the Fund will be made only with your written authorization. If you provide the Fund authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time.

If you revoke your authorization, the Fund will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Fund is unable to take back any disclosures already made with your authorization.

To request authorization for use or disclosure of your Protected Health Information, you must submit a written request to the HIPAA Compliance Director in such form as he / she may require.

Part 15:

DEFINITIONS

The following are definitions of specific terms and words used in this document.

Active Employee: An Employee Actively at Work is deemed an Active Employee.

Actively At Work or Active Employee: To be Actively at Work, an Employee must be performing all of the regular duties of his/her employment in the customary manner either at the Employer's regular place of business or at some other location to which the Employer's business requires employees to travel. An Employee will be deemed to be Actively at Work on each day of a regularly paid vacation, holiday, sick leave or annual leave, as long as the Employee is not Totally Disabled and is able to perform all of the regular duties of his/her occupation in the customary manner.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: The practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, and for other therapeutic purposes.

Acupuncturist: A person who is legally licensed and authorized to practice Acupuncture under the laws of the state or jurisdiction where the services are rendered.

Alcohol and Substance Abuse: Any pattern of regular excessive compulsive drinking of alcohol and/or the physical habitual dependence or non-dependence on drugs that results in an acute or chronic disorder affecting physical health and/or personal, social, or occupational functioning. This does not include dependence on tobacco and ordinary caffeine - containing drinks.

Allowable Expense: A health care service or expense, including Deductibles, Coinsurance and Co-payments, that is covered in whole or in part by a health care plan under which you and/or your Eligible Dependents have coverage. Any expense or service, or portion thereof, that is not covered by any such plan is not an Allowable Expense. When a health plan provides benefits in the form of services, rather than in cash, the reasonable cash value of each service rendered will be covered as an Allowable Expense whether or not a claim is filed under that Health Plan.

Ambulance: A legally licensed vehicle, helicopter, or airplane certified for emergency patient transportation.

Ambulatory Surgical Facility: A public or private surgical facility, either free-standing or Hospital-based, licensed and operated according to law, that does not provide services for a patient to stay overnight, and that admits and discharges patients from the facility on the same day.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (local anesthesia). Anesthetics are commonly administered by injection or inhalation by a physician or professional anesthetist.

Authorized Representative: An individual whom you authorize to act on behalf of you or your Eligible Dependent with respect to the pre-certification process, claims filing process or claims appeal process. Such authorization will be effective once you complete the Representative Authorization Form at the back of this booklet and return it to the Fund Administrator. However, in the event of a claim for Urgent Care, a Health Care Practitioner with knowledge of your medical condition will be permitted to act as your Authorized Representative, without regard to whether a completed Representative Authorization Form is on file.

Behavior Health Disorders: Disorders, conditions and diseases are defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-9-CM) manual, published by the U.S. Department of Health and Human Services ('HHS'), or are listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Behavioral Health Practitioners: A psychiatrist, psychologist or certified social worker who:

1. is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and
2. acts within the scope of his or her license; and
3. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Beneficiary: A person designated by you or under the terms of the Plan to receive benefits payable under the plan upon your death. See Section 8.3.

Behavioral Health Treatment Facility: A public or private facility licensed and operated according to law, that provides a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders by one or more Physicians or Behavioral Health Practitioners.

Benefit or Benefit Payment: The amount of money payable for a claim after applying the Plan's rules including calculation of all Deductibles, Coinsurance and Co-payments, and after determination of the Plan's exclusions, limitations and maximums.

Birthing Center: A public or private licensed health facility which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. The facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre-or post-delivery confinement.

Board of Trustees, Board: The Board of Trustees consisting of individual Trustees. The Board is the sponsor of the Fund and governs the administration of the Fund.

Calendar Year: The 12-month period beginning January 1 and ending December 31.

Case Management: A process administered by the Utilization Management Company whose medical professionals work with the patient, family, caregivers, Health Care Practitioners and Providers, and the Claims Administrator to coordinate a timely and cost-effective treatment program. Case Management services are most often used when the patient needs complex, costly, and/or long-term services, and when assistance is needed to determine how the patient's health needs can be met within the existing health care benefits.

Case Manager: The medical professional assigned to you and your family members by the Utilization Management Company to coordinate monitor and manage complex, costly, and/or long-term cases, usually involving serious Injury or Illness.

Child: See Part 1, Section 1.12.

Chiropractic Care/Spinal Manipulation: Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Chiropractor to remove nerve interference from, distortion, misalignment or subluxation of, or in, the vertebral column.

Chiropractor: A person who:

1. holds the degree of Doctor of Chiropractic (DC); and
2. is legally licensed and authorized to provide chiropractic care; and
3. acts within the scope of his/her license; and
4. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Claim for Urgent Care: Any claim for medical care or treatment with respect to which application of the time periods for making a pre-certification decision involving non-urgent care –

- * could seriously jeopardize your life or health or your ability to regain maximum function, or
- * in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the requested care or treatment.

Any claim that a physician (with knowledge of your medical condition) determines is a Claim for Urgent Care will be treated by the Plan as a Claim for Urgent Care. In the absence of a determination by your physician, the determination of whether a claim involves urgent care is to be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Claims Administrator: A person or company retained by the Fund to administer the claims payment responsibilities of the Plan.

Complications of Pregnancy: Means:

- a. conditions that require Hospital confinements (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy; or which are caused by pregnancy, such as: acute nephritis, nephrosis; cardiac decompensation; missed abortion; and similar medical conditions of comparable severity; and
- b. non-elective Caesarean section; entopic pregnancy which is terminated; and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

“Complications of Pregnancy” does not include: false labor; occasional spotting; Physician-prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum; preclampsia; and similar conditions which are associated with the management of a difficult pregnancy but do not constitute a nosologically distinct complication of pregnancy.

Concurrent Review: A Managed Care Program designed to assure that Hospitalization and other Health Care Facility admissions and length of stay, surgery or other Ancillary Services are Medically Necessary by having the Utilization Management Company conduct an ongoing assessment of the health care as it is being provided.

Congenital Abnormality: A defective development, abnormality, or malformation of a part of the body which is determined by a Physician to have been present at the time of birth, including cleft lip and cleft palate. Abnormality refers to a medical condition which is contrary to the body’s usual size, location, condition, or system and which prevents normal bodily functions.

Contribution Rate: The rate at which an Employer or, in the case of a self-payment, a Participant is required to contribute to the Fund. The contributions rates are set by the Board of Trustees and may be changed from time-to-time, with or without advance notice, as the Board deems necessary or appropriate to meet the Fund’s needs.

Convalescent Care Facility or Hospital: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determine how Plan Benefits are payable when a person is covered by two or more group health care plans. Coordination of Benefits also applies to individual no-fault or Personal Injury Protection Motor Vehicle Insurance Coverage. See Part 7.

Corrective Appliances: Corrective Appliances means an externally worn brace which supports, aligns or corrects deformities to or improves the function of a limb or other moving body part. Corrective braces, casts, slings and crutches are examples of Corrective Appliances.

Cosmetic Surgery or Treatment: Surgery or medical treatment provided primarily to improve or preserve physical appearance, but not physical function, as distinguished from surgery or medical treatment to correct defects resulting from trauma, infection, or other diseases or the consequences of treatment of trauma, infection/or other diseases/or to correct a Congenital Abnormality of a Covered Dependent Child that causes a functional defect. Cosmetic surgery does not include the reconstruction of a breast following a mastectomy necessitated by disease, illness/ accidental injury.

Coverage: Means the types of benefits provided under the Plan to you and your Eligible Dependents if the conditions for payment of the benefits are met.

Covered Charges: Eligible Medical, Prescription Drug, Dental and Vision Expenses that are payable under the Plan.

Covered Employment: Employment with an Employer for which the Employer is required to make contributions to the Fund pursuant to a collective bargaining agreement or other agreement that is deemed acceptable by the Board of Trustees to allow participation in the Fund.

Covered Individual: You or an Eligible Dependent.

Covered Medical Expenses: See Part 2, Sections 2.2 and 2.3.

Custodial Care: Care and services (including room and board needed to provide that care or services) given mainly for personal hygiene or for assistance in activities of daily living. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Some examples of Custodial Care are training or helping patients to get in and out of bed, helping patients with bathing, dressing, feeding or eating, use of the toilet, ambulating, or taking drugs or medicines that can be self-administered, routine changing of dressing, or preparation of special diets. These services are Custodial Care regardless of where the care is given or who recommends or directs the care.

Deductible: See Part 2, Section 2.4.

Dental: Refer to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics, prescribed by a Dentist, even if the services or supplies are necessary because of symptoms, illness or injury affecting another part of the body.

Dental Hygienist: A person specifically trained in dental prophylaxis who works under the direct supervision of a Dentist and who is legally licensed and authorized to be a Dental Hygienist under the laws of the state or jurisdiction where the services are rendered. Dental Hygienists' functions include scaling and polishing the teeth, dental radiography, and teaching oral hygiene.

Dentist: A person who has received a degree from an accredited school of dentistry and is legally licensed and/or legally authorized to practice dentistry by a state board of dental examiners under the laws of the state or jurisdiction where the services are rendered.

Dependent: See Part 1, Section 1.12.

Durable Medical Equipment: Means equipment that:

1. is prescribed by the Physician as essential in the treatment of the Injury or Illness; and
2. can withstand repeated use; and
3. is not generally useful in the absence of an Injury or Illness; and
4. is appropriate for use in the home; and
5. is not disposable or non-durable; and
6. is Medically Necessary for the care and treatment of the Covered Individual's Injury or Illness.

Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails), electric and manual wheelchairs, home dialysis equipment, respirators, nebulizers, oximeters, oxygen and supplies, and ventilators.

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of bodily function.

Eligible: A Participant or Dependent that has satisfied and continues to satisfy the requirements for eligibility for coverage under Part 1.

Emergency Hospitalization or Confinement: An admission into a Hospital or some other Health Care Facility that takes place within (24) hours of the sudden and unexpected severe symptom of an Illness or within twenty-four (24) hours of an accidental Injury causing a life-threatening situation.

Emergency Surgery: A surgical procedure performed within twenty-four (24) hours of the sudden and unexpected severe symptom of an Illness or within twenty-four (24) hours of an accidental Injury causing a life-threatening situation.

Employee: A person employed by an Employer as a common law employee and working in Covered Employment.

Employer: An employer that is required to make contributions to the Fund on behalf of employees pursuant to a collective bargaining agreement or other agreement that is deemed acceptable by the Board of Trustees and which employer has been accepted into participation by the Fund by the Board of Trustees. Employer does not include an employer that has been expelled from participation in the Fund by the Board of Trustees, except this shall not be deemed to excuse any former Employer from any indebtedness to the Fund incurred before it was expelled.

Exclusions: Specific conditions, circumstances, services, treatments, equipment, supplies under or for which no benefits are payable under the Plan.

Experimental and/or Investigational: Drugs, services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, and relevant segment of the medical community or government oversight agencies at the time the services were rendered. The Fund Administrator or its designee has the discretion and authority to determine if a service, supply, care and treatment is or should be classified as Experimental and Investigational. A drug, service, supply, care and/or treatment will be deemed to be Experimental and Investigational if, in the opinion of the Fund Administrator or its designee, it is determined to be:

- * not approved by the U.S. Food and Drug Administration to be lawfully marketed for the proposed use and not identified in the "United States Pharmacopeia Dispensing Information" or the "American Hospital Formulary Service" as appropriate for the proposed use; or
- * subject to review and approval by the treating facility's Institutional Review Board of other body serving a similar function, or if federal law requires such review or approval for the proposed use; or

- * the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- * not demonstrated through prevailing peer-review medical and scientific literature as being safe and effective for treating or diagnosing the condition, Injury or Illness for which its use is proposed whether it is permitted by law to be used in testing or other studies on humans.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Family Coverage: See Part 1, Section 1.4.

Full-Time Student: A Child who is between the ages of nineteen (19) through twenty-two (22) and attends an accredited college, university or vocational school on a full-time basis (i.e. takes at least twelve (12) undergraduate or nine (9) graduate credit hours per semester or quarter).

Fund: The Laborers' National Health and Welfare Fund, the trust fund that offers this Plan.

Fund Administrator: Zenith Administrators, Inc., 5565 Sterrett Place, Suite 210, Columbia, MD 21044. Telephone: 1-800-235-5805.

Handicap or Handicapped (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, provided the condition was diagnosed by a Physician, and accepted by the Fund Administrator or its designee, as a permanent and continuing condition. See the definition of Totally Disabled.

Health Care Facility: A Hospital, an Ambulatory Surgical Facility, a Behavioral Health Treatment Facility, a Birthing Center, a Convalescent Care Facility, a Hospice or Qualified Hospice Care Program, or a Skilled Nursing Facility licensed or certified (or both) and operating according to the law of the state or the jurisdiction in which it is located.

Health Care Practitioner: A Physician, Acupuncturist, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, Podiatrist, Physical or Speech Therapist or Speech Pathologist, or Ophthalmologist or Optometrist, as those terms are defined in this chapter, who:

1. is legally licensed and/or legally authorized to practice or provide certain health care services under the law of the state/jurisdiction where the services are rendered; and
2. acts within the scope of his or her license and/or scope of practice; and
3. is not the patient or parent, spouse, sibling (by birth or marriage) or child of the patient.

Health Care Provider: A Health Care Practitioner, a Health Care Facility, or a Home Health Care Agency, as those terms are defined in this Definitions chapter.

Home Health Care: Services and supplies provided under a Home Health Care Plan which include part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.), part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, speech or other therapy; medical supplies; and laboratory services by or on behalf of a Hospital.

Home Health Care Agency: A public or private organization, licensed and operating according to law, that is federally certified as a Home Health Care Agency, and that provides Home Health Care.

Home Health Care Plan: A formal written plan made by the patient's attending Physician which is reviewed every 30 days. The plan must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the patient.

Hospice or Qualified Hospice Care Program: A facility or organization licensed and operating according to law and certified by Medicare that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 4 months or less, as determined by a Physician. Hospice care is intended to let the terminally ill spend their last days with their families at home or in a home-like setting. The emphasis shifts from curing to keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family.

Hospital: A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that is accredited by the Joint Commission on Accreditation of Hospitals and Healthcare Organizations (JCAHHO) and that provides care and treatment by Physicians and Nurses on a 24-hour basis for Illness or Injury through the medical, surgical and diagnostic facilities on its premises. A Hospital may include facilities for mental, nervous and/or substance abuse treatment that are licensed and operated according to law. Any portion of a Hospital used as a Convalescent Care Facility, an Extended Care Facility, a Subacute Care Facility, a Skilled Nursing Facility, or a place for rest, or Custodial Care shall not be regarded as a Hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any Congenital Abnormality of a newborn Child, as diagnosed by a Physician and as compared to the person's previous condition. Your or your Spouse's pregnancy will be considered to be an Illness for the purpose of coverage under this Plan, but not the pregnancy of a Dependent Child.

Incapacitated Child: See Part 1, Section 1.12.

Injury: Any damage to a body part resulting from trauma from an external source.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

Maintenance Care: Services, treatment, equipment and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care Program: A program adopted by the Board of Trustees consisting of procedures designed to help control health care costs by avoiding unnecessary services or services that are more expensive than other services that are just as appropriate.

Medical Emergency: A sudden unexpected onset of a medical condition, not normally treatable in a Physician's office, that manifests itself by such acute symptoms of sufficient severity, including severe pain, that urgent and immediate medical attention is required either to prevent (1) placing the patient's health in serious jeopardy; (2) serious impairment of bodily functions; (3) serious and/or permanent impairment or dysfunction of any body organ or part; (4) in the case of a pregnant

woman, serious jeopardy to the health of the fetus. Examples of such conditions include, but are not limited to heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions and other acute medical conditions.

Medically Necessary: A service, treatment, equipment or supply will be determined to be "Medically Necessary" by the Fund Administrator or its designee if it:

- * is provided by or under the direction of a Physician or a Dentist who is authorized to provide or prescribe it (except for Chiropractic, Acupuncture and Mental or Nervous benefits which must be provided by or under the direction of a qualified Health Care Practitioner); and
- * is determined by the Fund Administrator or its designee to be necessary for the prevention, diagnosis or treatment of the Injury or Illness for which it is prescribed or performed; and
- * is determined by the Fund Administrator or its designee to be the most appropriate medical supply, treatment, or level of service that can be provided safely to the Eligible Employee or Dependent; and, if the Eligible Employee or Dependent is an inpatient, cannot be provided safely on an outpatient basis; and
- * meets generally accepted medical standards in the community in which it is performed.

All of these criteria must be met; merely because a Physician recommends or approves certain treatment, service or supply does not mean that it is Medically Necessary. Cosmetic and Experimental and/or Investigational services and procedures are not Medically Necessary.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act (Parts A and/or B) as it is now amended and as it may be amended in the future.

Mental Health Practitioners: See the definition of Behavioral Health Practitioners.

Mental and Nervous Conditions: See the definitions of Behavioral Health Disorders and Alcohol and Substance Abuse.

Midwife or Nurse Midwife: A person legally licensed as a midwife or certified as a nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administering intravenous fluids and certain medications, providing emergency measures while awaiting aid, performing newborn evaluations, signing birth certificates, and billing and being paid in his or her own name.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, slings, hypodermic syringes, diapers, soap or cleansing solutions.

Nurse: A person legally licensed as a Registered Graduate Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or Licensed Midwife, Nurse Practitioner, Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the same or jurisdiction where the services are rendered.

Ophthalmologist: A Physician who specialized in the diagnosis and medical and surgical treatment of diseases and defects of the eye and related structures.

Optometrist: A person legally licensed and authorized under the laws of the state or jurisdiction where the services are rendered, to practice Optometry.

Optometry: The professional practice of primary eye and vision care for the diagnosis, treatment and prevention of associated disorders and for the improvement of vision by the prescription of lenses and by the use of other functional, optical, and pharmaceutical means.

Orthotic Appliance (or Device): A type of durable Corrective Appliance or device, either customized or available “over-the-counter”, designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does not include Dental Orthotics.

Outpatient Services: Services provided either outside of a Hospital or other Health Care Facility setting or at a Hospital or other Health Care Facility when room and board charges are not incurred.

Part: A numbered Part of this document (Part 1 through Part 15).

Participant: An Employee who is eligible for coverage under Part 1 or Part 6 of this document. This term does not include the Spouse or Dependent(s) of a Participant.

Pharmacy: A business or other organization that sells prescription drugs that is supervised by a Pharmacist in accordance with the laws of the state or other United States jurisdiction where the pharmacy is located and operates.

Pharmacist: A person legally licensed under the laws of the state or other United States jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist or Physiotherapist: A person legally licensed and authorized under the laws of the state or jurisdiction where the services are rendered, to practice Physical Therapy.

Physical Therapy or Physiotherapy: The evaluation and rehabilitation of patients disabled by pain, disease, illness or injury, with treatment using physical therapeutic measures as opposed to medical, surgical, or radiologic measures. For Physical Therapy expenses to be paid under the Benefit Plans, it must be ordered by a Physician.

Physician: A person legally licensed as a Medical Doctor (M.D.), a Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S., D.M.D.), and a Doctor of Podiatry (D.P.M.) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered.

Plan: The plan of benefits offered by the Fund whose terms/conditions are set forth in this document.

Podiatrist: A person legally licensed as a doctor of podiatric medicine (DPM) and authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

Pre-Admission Testing: Laboratory tests and x-rays and other Medically Necessary tests performed on an out-patient basis prior to a scheduled Hospital admission or out-patient Surgery.

Pre-certification: A Managed Care Program designed to ensure that Hospital and other Health Care Facility admissions and lengths of stay, Surgery and other health care services are Medically Necessary by having the Utilization Management Company determine the Medical Necessity before the services are provided.

Pre-Existing Condition: Any Illness or Injury for which a diagnosis has been made or medical care and/or treatment has been provided (including the prescription of drugs or medicines) during the months immediately preceding the date coverage begins. The Benefit Plans have no Pre-Existing Condition Exclusions.

Prosthetic Appliance (or Device): A type of durable Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, corrective lenses needed after cataract surgery. For the purposes of the Medical Plan, this definition does not include Dental Prostheses. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

Qualified Medical Child Support Order (QMCSO): A court order that complies with federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that Benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child.

Reasonable and Customary:

1. The Reasonable and Customary charge for Medically Necessary services or supplies will be determined by the Fund Administrator or its designee to be the lowest of:
 - * The Health Care Provider's actual charge; or
 - * No more than 90% of the "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same/similar health care supply, treatment/service.
2. The "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply shall be determined by the Claims Administrator who shall use HIAA or MDR data that is updated at least annually.
3. The Reasonable and Customary charge is the highest Allowable Expense that your Plan will accept for Medically Necessary services or supplies. If the Health Care Provider's actual charge is more than the Reasonable and Customary charge, you will have to pay the difference. A number of your Benefits are payable according to a percentage of charges. If the actual charge exceeds the Reasonable and Customary charge, the Fund will pay the Benefit based on a percentage of the Reasonable and Customary charge (not a percentage of the actual charge). Otherwise, the Fund will pay a percentage of the actual charge.

Reconstructive Surgery: A surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Therapy: Physical, speech or other types of therapy, that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of Illness, Injury or Surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the Injury, Illness or Surgery, and that is performed by a licensed Therapist acting within the scope of his or her license.

Reimbursement: The right of the Plan to be reimbursed by a Covered Individual or by a Health Care Provider who received payments from the Fund to which he/she/they are required to return to Fund under the terms of the Plan. This may include circumstances in which the Fund Administrator or Claims Administrator mistakenly made payments on the Covered Individual's behalf or when a Covered Individual receives payment from a liable third party for the Covered Individual's Injury or Illness. See Part 7 for an explanation of how the Plan is entitled to recover medical and/or other benefits paid if the Covered Individual recovers any amount from a third party either by way of settlement or judgment. See also Part 7 for an explanation of how the Plan is entitled to recover benefits paid which are contrary to the terms of the Plan or are otherwise excessive.

Relevant Documents: Documents, records and other information (i) relied upon in making the benefit determination; (ii) submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; (iii) demonstrating compliance with the administrative processes and safeguards required to ensure that benefit claim determinations are made in accordance with governing plan documents and that the plan provisions have been applied consistently with respect to similarly situated claimants; or (iv) constituting a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosed condition, without regard to whether such advice was relied upon in making the benefit determination.

Residential Treatment Facility: A public or private non-hospital facility, licensed and operated according to law, that provides a program in a residential setting for diagnosis, evaluation, and effective treatment of alcohol or substance abuse, and nervous, mental or emotional illnesses or disorders. See the definition of Behavioral Health Treatment Facility, in which one or more Physicians or Behavioral Health Practitioners provide treatment.

Single Coverage: See Part 1, Section 1.3.

Skilled Nursing Care: Services performed by a licensed Nurse.

Skilled Nursing Facility: A public or private facility, licensed and operating according to law, that is Certified as a Skilled Nursing Facility by the Joint Commission on Accreditation of Hospitals and Healthcare Organizations ("JCAHHO") and that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people.

Specialty Care Unit: A section, ward, or wing within a Hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapist or Speech Pathologist: A person legally licensed and authorized under the laws of the state or jurisdiction where the services are rendered, to practice Speech Therapy.

Speech Therapy: The use of special techniques for correction of speech and language disorders. For Speech Therapy expenses to be paid under the Benefit Plans, it must be ordered by a Physician and must be for the restoration of lost speech due to a diagnosed Illness or Injury.

Spouse: See Part 1, Section 1.12.

Substance Abuse: Alcohol or drug dependency as defined by the current ICD-9-CM manual.

Surgery: Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Fund Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits.

Temporomandibular Joint (TMJ) Syndrome: Jaw joint disorders, including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Therapist: See the definition of Health Care Practitioner.

Tort, Tortfeasor: A Tort is a civil wrong or injury, typically arising from a negligent or intentional act of an individual. The individual committing the tort is called a Tortfeasor.

Total Disability, Totally Disabled: To the extent not otherwise defined in the text of this document, the inability of a Covered Employee to perform the duties of his or her occupation with the Employer as a result of an Illness or Injury, or the inability of a Covered Dependent to perform the normal activities or duties of a person of the same age and sex as a result of an Illness or Injury. See also the definition of Handicap.

Urgent Care Facility: A public or private free-standing facility, not located on the premises of or operating in conjunction with a Hospital, that is licensed or legally operating, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Registered Nurses, and x-ray technicians are in attendance at all times the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Review Provider: The company selected by the Board of Trustees to manage the Plan's Utilization Review Program including review your care and evaluate requests for approval of coverage to assess the Medical Necessity for the services and supplies, review the appropriateness of the Hospital or other Health Care Facility requested and determine the approved length of confinement or course of treatment. In addition, the company may engage in other aspects of utilization management such as second surgical opinion and/or pre-admission testing requirements, concurrent review, discharge planning and Case Management. See Part 2, Sections 2.8 and 2.9.

Well Baby Care; Well Child Care: Health care services provided to a newborn or Child through age eighteen (18) that are determined by the Plan to be Medically Necessary even though they are not provided as a result of Illness, Injury or Congenital Abnormality. See Part 2, Section 2.3.

You, Your: When used in this document, these words refer to a Participant (an Employee who is eligible for coverage under the Plan).