

**LABORERS NATIONAL HEALTH & WELFARE FUND
NEW ELIGIBILITY RULES FOR PLAN 1 & PLAN 2
EFFECTIVE DECEMBER 1, 2005**

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 occurred while the Participant or Dependent is eligible for coverage.

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

This section 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.

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.

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

(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) is 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 third calendar month of participation. 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 270 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 third calendar month following participation. 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

If you have Family Coverage, but you are going to lose that coverage because contributions for less than 360 hours, but more than 319.5 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's 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 from time-to-time.]

- * 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;
- * birth or adoption of a Dependent Child;
- * Dependent Child attains age 19;
- * divorce;
- * 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 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. 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 for; 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, or nor any other 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

- (a) This section describes the reasons why your eligibility for coverage may terminate. This section also describes the reasons your Dependents' eligibility coverage may terminate.
- (b) 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 (Purchasing Family Coverage).

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

(c) **Insufficient Contributions (Monthly Rate Contributions)**

If your Employer contributes on a monthly rate basis, you will lose eligibility 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, your 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

Your spouse or 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 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 first day of the second 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 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 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 your eligibility for coverage so that claims incurred during the period of delinquency can be accepted.

(e) COBRA Continuation Coverage

See the COBRA section concerning the rules for continuing your and your Dependents' eligibility for coverage on a self-pay basis if you or a 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 FLMA leave by your Employer, your Employer may be 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 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 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 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 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 30 days after the due date set by the Fund Administrator;
- * the last day of the month after 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 reemployed 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.

1.12: Eligible Dependents

- (a) Your Dependents, for purposes of this Plan, are your (the Employee's) Dependent Spouse and your Dependent Child (or Children) who meet the qualifications described in this section 1.11.
- (b) Your Dependent 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. Common law marriages are not recognized by the Fund even if they are recognized under the laws of a State or country.
 - * 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.
 - * 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 coverage.
- (c) A Dependent Child is any of your unmarried children (natural child, stepchild, adopted child, prospective adoptive child placed in your home, or foster 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).

- * If such a 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.
 - * If such a child is an Incapacitated Child, he or she 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.