

LABORERS' NATIONAL HEALTH & WELFARE FUND

**SUMMARY PLAN DESCRIPTION
FOR BENEFIT PLAN 2**

January 2019

Si Usted necesita esta notificación traducida al lenguaje Español, por favor contacte a la Oficina LIUNA salud y bienestar al 1-800-235-5805 o a través de la página de web al <http://www.lnhwf.org>.

**LABORERS' NATIONAL HEALTH & WELFARE FUND
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Benefits Consultant: Segal Consulting
Legal Counsel: Law Offices of James S. Ray PLLC
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BENEFITS AT A GLANCE (Benefit Plan 2)

Medical Services

Coverage: all medically appropriate services, subject to Exclusions and Limitations

No annual or lifetime dollar limits

Annual Member General Deductible: \$200 (Individual In-Network), \$400 (Family In-Network)

Annual Member Out-Of-Pocket Maximum: \$5,350 (Individual In-Network), \$10,700 (Family In-Network)

Preventive Care: no charge, no Deductible, no Co-Payment (In-Network)

Primary Care Doctor Visit: \$10 Co-Payment (In-Network)

Specialist Visit: \$25 Co-Payment (In-Network)

Urgent Care Services: \$50 Co-Payment (In-Network and Out-of-Network)

Hospital Emergency Room Services: \$150 Co-Payment (In-Network and Out-of-Network)(waived if admitted to hospital)

Hospital: Plan pays 90% after \$200 Deductible (In-Network)

Lab Services: \$5 Co-Payment (In-Network)

X-Ray: \$5 Co-Payment (In-Network)

Advanced Radiology / Imaging (CT/PET/MRI scans): Plan pays 90% after \$200 Deductible (In-Network) (prior authorization required)

Telehealth: \$10 Co-Payment (phone or video access to doctor)

Nurse 24/7 service: no charge

Prescription Drugs

Retail-Generic: \$5 Co-Payment

Retail-Brand on Formulary: 20% Co-Payment (\$10 minimum, \$35 maximum)

Retail-Brand Non-Formulary: 30% Co-Payment (\$10 minimum, \$35 maximum)

Mail Order-Generic: \$10 Co-Payment (larger supply than retail)

Mail Order-Brand on Formulary: 20% Co-Payment (\$20 minimum, \$70 maximum)

Mail Order-Brand Non-Formulary: 30% Co-Payment (\$20 minimum, \$100 maximum)

Annual Member Out-Of-Pocket Maximum: \$2,000 (Individual In-Network), \$4,000 (Family In-Network)

Dental

Annual Maximum Benefit: \$2,500

Orthodontia Lifetime Maximum: \$1,000

Vision

Exam - Annual Maximum Benefit: \$60

Frames / Lenses / Contacts Annual Maximum Benefit: \$150

Life & Disability Insurance

Life: \$20,000 (Member), \$2,000 (Dependent)

Accidental Death & Disability: \$20,000 (Member), \$2,000 (Dependent)

Short Term Disability: \$125 per week for maximum of 26 weeks

Membership Assistance Benefits

Assistance for dealing with a wide range of personal or family matters: no cost

January 2019

TO ALL EMPLOYEES COVERED BY THE LABORERS' NATIONAL HEALTH & WELFARE FUND (PLAN 2):

Congratulations! LIUNA--your Union--and your Employers have entered into collective bargaining agreements requiring the Employers to contribute to the Laborers' National Health & Welfare Fund ("the Fund") so that you, your spouses and your children can earn eligibility for the wide range of valuable benefits provided by the Fund.

We are pleased to present to you this new Summary Plan Description ("SPD"). It provides a summary of the benefits provided by the Fund to eligible employees (called "participants") and eligible family members (sometimes called "dependents" or "beneficiaries") under Benefit Plan 2. These benefits include medical benefits, prescription drug benefits, dental benefits, vision benefits, short term disability insurance, life insurance, accidental death and dismemberment, and membership assistance benefits.

This SPD also summarizes the rules, terms and conditions under which these benefits are available to you and your family members, including eligibility (coverage) requirements.

For example, this SPD describes:

- > How you and your family members become eligible for benefit coverage, keep coverage, and lose coverage. How changes in your life may affect your or your family's coverage.
- > The benefits provided for covered participants and beneficiaries, 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) if you or a family member loses coverage under the Fund.
- > Your obligations and rights as a participant in the Fund.
- > Other valuable information about the operation of the Fund.

This SPD reflects the rules, terms and conditions of Benefit Plan 2 as adopted and amended through January 1, 2019, and it supersedes all earlier Benefit Plan 2 booklets, summaries of material modifications, and notices.

The Plan Description contains the official rules, terms and conditions of Benefit Plan 2 that are summarized in this SPD. The Plan Description, not this SPD, determines your eligibility, benefits, rights and obligations under the Plan. You can review the Plan Description at any time on the Fund's website (www.lnhwf.org). You can obtain a copy of the Plan Description by telephoning or writing the Fund Office. The Fund Office's telephone number and mailing address is on the first page of this SPD.

Note that the Board of Trustees reserves the right to change the rules, terms and conditions of Benefit Plan 2 at any time, with or without advance notice, or to terminate Benefit Plan 2. This includes the right to set, and to change from time-to-time, the contribution rates required for Benefit Plan 2 coverage and the amount of deductibles, co-payments and other cost-sharing charges.

We encourage you to check the Fund's website (www.Inhwf.org) for updates that could affect your and your family members' standing and coverage, including changes in Benefit Plan 2. We also encourage you to contact the Fund Office if you have any questions regarding the Fund or Benefit Plan 2.

A final comment. We continue to look for ways to improve the benefits offered by the Fund under Benefit Plan 2 and other plans so that the benefits and coverages meet your and your family's needs. We want to make it as easy as we can for you and your family members to obtain good health care, including preventive care and treatment when needed, so that you and they can enjoy healthy, happy and productive lives.

We are also mindful of the need to contain costs for the Fund and for you so that the coverage remains affordable, both in terms of collectively bargained employer contribution rates and cost-sharing by participants and beneficiaries. This means designing the benefit programs so the Fund's resources are used efficiently and in ways that promote good health behaviors and outcomes for you and your loved ones. As the costs of medical care and prescription drug costs in America continue to increase, the challenge of balancing benefits and costs is tougher than ever and requires adjusting the benefit programs from time-to-time.

We wish you and your family the best of health!

THE BOARD OF TRUSTEES

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OVERVIEW OF THE LABORERS' NATIONAL HEALTH & WELFARE FUND

The Laborers' National Health & Welfare Fund ("Fund") is a joint labor-management, non-profit, multiemployer trust fund established in 1988 by agreement between the Laborers' International Union of North America (LIUNA) and various employers for the benefit of employees represented by LIUNA and affiliated Local Unions, primarily in the service contract industry.

Governance & Administration

The Fund is governed by a Board of Trustees ("Board") composed of Union and Employer Trustees. The Board has overall authority and responsibility regarding the structure and operations of the Fund, including the design of the benefit programs offered by the Fund.

The day-to-day administration of the Fund has been assigned by the Board to an "in-house" administrative staff based in offices at 905 16th Street, N.W., Washington, D.C. ("the Fund Office"). The staff is headed by the Fund Administrator (Adam M. Downs) and the Assistant Fund Administrator (Michael J. Davis). Prior to January 1, 2017, the Fund was administered by a third-party administration company.

The Fund Office is assisted in its administrative functions by various service providers including Cigna Health and Life Insurance Company (Cigna, medical claims administration, vision benefits administration, and member assistance program administration), Express Scripts Inc. (prescription drug administration), Delta Dental (dental benefits administration), and Union Labor Life Insurance Company (short term disability and life insurance). The Fund Office is the "go to" place for questions and information regarding the Fund.

The Fund's main website (www.lnhwf.org) can be accessed at any time through the Internet. The website is interactive. Each covered employee, upon becoming eligible for benefits, will be able to set up a personal account on the website through which he or she will be able to obtain individualized information such as employer contributions received, eligibility status and, through hyperlinks to websites maintained by Cigna, Express Scripts, and Delta Dental, the status of benefit claims

In addition, the website gives eligible employees and contributing employers access to a wide range of information about the Fund.

Benefit Plans

The Fund currently offers two Benefit Plans (Plan 1 and Plan 2). Both Benefit Plans offer comprehensive benefits to eligible employees and their eligible spouses and children. These benefits include hospital care, doctor care, prescription drugs, dental care, vision care, short term disability, accidental death and disability insurance, life insurance, and member assistance benefits. The main difference between Plan 1 and Plan 2 is the amount of benefits that the Fund pays under each Plan. For example, Plan 2 generally pays a larger share of the cost of medical care, and the patient pays a lesser share.

Plan 1 was closed indefinitely to new groups in 2017, but continues for existing groups. The Board has full authority to amend, suspend, or terminate Benefit Plan 1, Benefit Plan 2 or any other Benefit Plan of the Fund at any time and for any reason. This includes the authority to limit participation in any Benefit Plan and to terminate or suspend the participation of any employer or employee group to protect the Fund. If the Benefit Plan is amended, a notice in the form of a Summary of Material Modifications will be sent to all participants by the Fund Office.

Both Benefit Plans encourage the use of the Fund's preferred provider networks of hospitals, doctors and dentists. The costs of medical and dental care for both the patient and the Fund are lower

when the care is received from an "in-network" provider. Use of an "out-of-network" medical or dental care provider is permitted, but the cost to you will be higher.

Funding & Contributions

All of the medical, prescription drug, and dental benefits are paid directly from the Fund's assets to the care provider or the patient. In other words, the Fund "self-funds" or "self-insures" these benefits, rather than an insurance company. However, the short term disability, accidental death and disability, and life insurance coverages are all insured, and the Fund pays group premiums to the insurance companies for all Fund participants.

The Fund obtains the money with which to pay benefits primarily from two sources: (a) employer contributions; and (b) investments of Fund assets. Collective bargaining agreements between the Union and employers require the employers to contribute to the Fund for each hour for which their covered employees earn wages, including days of paid leave. The contributions are pooled with the Fund's existing assets and invested for the Fund by professional investment managers selected by the Board to earn income and grow the Fund's reserves.

Each year the Board sets the rate of contributions that participating Employers must contribute to maintain coverage under the Fund for their employees for the year. The rates are different for Plan 1 and Plan 2. The Union and each employer negotiate a collective bargaining agreement that: (a) selects coverage under Benefit Plan 1 or Benefit Plan 2 for the employees as a whole; and (b) obligates the employer to contribute to the Fund at the required rate for the selected Benefit Plan and in accordance with the Fund's rules.

The employer contributions to the Fund are tax deductible for the employer and are not included in the employees' taxable income (under current law). Generally no employee contributions are required by the Fund, or accepted in lieu of employer contributions, although there are circumstances under which employee contributions are permitted to maintain or extend coverage.

There are no individual accounts under the Fund. All contributions and investments are pooled and held in trust for the sole purpose of paying promised benefits and reasonable administrative expenses (including premiums for insurance purchased by the Fund).

Benefit Eligibility, Enrollment and Identification Cards

Employees are not automatically entitled to benefits from the Fund merely because they are covered by a collective bargaining agreement requiring their Employer to contribute to the Fund. Each employee must earn eligibility for benefit coverage by working enough hours for which his or her employer contributes to the Fund. Similarly, an employee's spouse and children are not eligible for benefits unless the employee works enough hours for family coverage and the employer pays the required contributions.

The failure of an employer to pay the required contributions can cause the employees and their families to lose eligibility for benefits. The Fund's ability to pay benefits depends on employers paying the required contributions on time each month. If an employee or family member loses eligibility for benefits for any reason, he or she may be entitled to self-pay the required contributions to maintain eligibility under the "COBRA continuation coverage" provisions of the Benefit Plans. An employer must be accepted into Fund participation by the Fund Office. As noted above, entering into a collective bargaining agreement with the Union does not automatically entitle the employer and its employees to participation in the Fund. The Fund Office is required by the Board to perform a due diligence review to ensure that participation by the employer or group would not cause harm to the Fund and its existing participants.

The Fund Office must also obtain certain information about each of the employees, spouses and children that is needed for proper administration of the Fund (including name, gender, date of birth, mailing address, and Social Security Number). Enrollment is the process through which the Fund obtains this information. Each employee, spouse and child must be enrolled with the Fund to have coverage.

Once the employer is accepted into participation by the Fund Office and the employees' enrollment information is received, the Fund will send to each employee and each enrolled spouse and child Identification Cards (medical, prescription drug, and dental).

The Cards can be presented to care providers (e.g. hospitals, doctors, pharmacists, dentists) when the employee or family member is receiving services. The Cards contain important information about the Fund, conditions of coverage, instructions regarding benefit claims, and contact numbers.

Legal Status & Regulation of the Fund: Non-Grandfathered Plans

The Fund is regulated under several Federal laws, and it is designed and operated to comply with all of those laws. The Employee Retirement Income Security Act ("ERISA") regulates the Fund as an employee welfare benefit plan, a group health plan and a multiemployer plan. The Internal Revenue Code regulates the Fund as a tax-exempt trust and voluntary employee beneficiary association. The Fund is a joint labor-management trust fund structured to comply with the Labor Management Relations (Taft-Hartley) Act. And, the Fund is a *bona fide* fringe benefit program under the Service Contract Act.

The Fund, Benefit Plan 1 and Benefit Plan 2 are "non-grandfathered plans" under the Affordable Care Act (ACA). This is a change from earlier years. Both Benefit Plans comply with the ACA's requirements for non-grandfathered plans, including preventive care benefits without patient cost-sharing, a limit on patient out-of-pocket costs, and an opportunity for external review of claims.

USING THE FUND'S INTERACTIVE WEBSITE

Fund's Main Website

The Fund's main website can be accessed through the Internet at any time: www.lnhwf.org. On this website, you can do all of the following, and more:

- > Obtain information about the Fund, including copies of the Plan Books, news about improvements and other changes in Plan rules or benefits, and announcements.
- > Obtain contact information for all of the Fund's benefit administrators, including telephone numbers and hyperlinks to the websites of these companies, including Cigna, Express Scripts and Delta Dental.
- > Set up a personal account. Once you set up your personal account on the website you will be able to check your eligibility status, check on contributions received by the Fund from your employers, and obtain other information about your rights and obligations.

If you have any trouble using the Fund's website, call the Fund Office at 1-800-235-5805 or 1-800-540-0113

Cigna's Website

Cigna administers medical claims, vision claims, and the member assistance program for the Fund. It also maintains an interactive website: www.myCigna.com. Cigna's website can be accessed directly or through the hyperlink to Cigna on the Fund's main website. You will need to register on the website to have full use of its many features.

On Cigna's website you can do all of the following, and more:

- > Search for In-Network providers (e.g. hospitals, doctors) in your area.
- > Compare costs of medical procedures and treatments.
- > View and print your Identification Card.
- > Estimate costs for medical services.
- > Take an online Health Assessment that will help to identify existing or potential health problems. By identifying health issues, you can start immediately to obtain treatment or make lifestyle changes that will improve your health and well-being.
- > Receive tips on how to protect and improve your health as well as how to best use Plan benefits.

Cigna also has a myCigna mobile app available. You can download the app from the Fund's website, the App Store, or Cigna's website.

If you have any trouble using Cigna's website, call the Customer Service telephone number on your identification Card or 1-800-244-6224 (Group Number 3340262).

Delta Dental Website

The Fund's dental claims administrator, Delta Dental, also maintains an interactive website: www.deltadentalins.com. Delta Dental's website can be accessed directly or through the Fund's main website at any time. You will need to register on the website to have full use of its many features.

On Delta Dental's website, you can do all of the following and more:

- > Search for In-Network Dentists in your area.
- > Check on your eligibility for dental coverage.
- > Check on the status of your dental claims.
- > Obtain information about improving your dental health.

If you have any trouble using Delta Dental's website, call the telephone number on your Identification Card or 1-800-932-0783 (Group Number 19221).

Express Scripts Website

The Fund's prescription drug administrator, Express Scripts, also maintains an interactive website: www.express-scripts.com. This website can be accessed directly or through the Fund's main website at any time. You will need to register on the website to have full use of its many features.

On this website, you can do all of the following, and more:

- > Learn how to use the Mail Order Pharmacy.
- > Find an In-Network Pharmacy in your area.
- > Obtain a list of the formulary drugs.
- > Learn about restrictions on filling certain prescriptions.

If you have any trouble using Express Scripts' website, call the Customer Service telephone number on your identification Card or 1-800-692-5263 (Group Number YGQA).

LABORERS' NATIONAL HEALTH & WELFARE FUND

SUMMARY PLAN DESCRIPTION (SPD) FOR BENEFIT PLAN 2: SUMMARY OF THE PLAN'S TERMS AND CONDITIONS

INTRODUCTION

This part of the Plan Book contains only a summary of the terms, conditions and rules of Benefit Plan 2 ("Plan 2" or "Plan") and some basic information about the Plan. The actual terms, conditions and rules of Plan 2 are contained in the Plan Description.

Eligibility for coverage under the Plan, the benefits payable under the Plan, and all other questions relating to Plan 2 will be decided under the rules, terms, and conditions of the Plan Description, and not under this SPD.

The Plan Description should be consulted for the answer to questions about coverage, costs, rights, terms, conditions and rules under the Plan. In the event of a difference between this SPD and the Plan Description, the Plan Description will control.

The Plan Description contains the official rules, terms and conditions of Benefit Plan 2 that are summarized in this SPD. The Plan Description, not this SPD, determines your eligibility, benefits, rights and obligations under the Plan. You can review the Plan Description at any time on the Fund's website (www.lnhwf.org). You can obtain a copy of the Plan Description by telephoning or writing the Fund Office.

This summary 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 Fund covered by Plan 2.

ELIGIBILITY FOR PLAN COVERAGE & ENROLLMENT IN THE PLAN

The following is a summary of Section 1 of the Plan Description which contains other important details that you should read.

Eligibility

Benefits are payable under this Plan only for Participants, Spouses of Participants and Children 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, Spouse or Child is eligible for coverage. Individuals who are eligible and enrolled are entitled to the Plan's Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, Short Term Disability Benefits, Accidental Death & Disability Insurance, Life Insurance, and Member Assistance Program Benefits to the extent they meet the terms and conditions of those benefit programs.

Generally, you can become eligible and remain eligible for coverage only if your Employer is accepted into participation in the Fund and Plan by the Fund Office, and the Employer makes timely contributions to the Fund at the required contribution rate. Employer contributions must be made for each hour you work or are paid, or for each month you work or are paid, depending on the terms of the employer's collective bargaining agreement.

For Single Coverage (Employee Only) based on 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 three consecutive calendar months during which contributions are made to the Fund on your behalf for at least 210 hours. You must also enroll in the Fund and Plan to be eligible.
- (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 month period.

If the Fund does not receive this minimum amount of contributions, you may lose coverage.

- (c) **Banked Hours:** 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.
- (d) **Regaining Eligibility:** If you lose eligibility for Single Coverage due to insufficient contribution hours during any three consecutive calendar month period, you will regain eligibility if your Employer makes at least 210 hours of contributions during a subsequent three calendar month period. Once the Fund receives sufficient contributions, your eligibility for Single Coverage will be renewed as of the first day of the second month following the continuing eligibility base period (three consecutive calendar months). The Fund Administrator may require you to re-enroll in the Plan.

For Family Coverage based on 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 three consecutive calendar months during which contributions are made to the Fund on your behalf for at least 360 hours. You and your Spouse and each of your Children must also enroll in the Plan to be eligible.
- (b) Continuation of Eligibility: Once you earn initial eligibility, 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 month period.

If the Fund does not receive this minimum amount of contributions, you may lose coverage. If you lose Family Coverage, you may qualify for Single Coverage if the Fund has received the minimum contributions for Single Coverage.

- (c) Banked Hours: 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.
- (d) Self-Paying A Shortfall: If you are going to lose Family Coverage because Employer contributions for less than 360 hours were made for you during a three-month continuing eligibility period, you may self-pay up to 40 hours of contributions to the Fund during the eligibility period to purchase a continuation of your Family Coverage. You cannot self-pay for more than 40 hours in an eligibility period. In other words, if your Employer made at least 320 hours of contributions for you in the eligibility period, you can pay the difference to the Fund so that you have the 360 hours to keep your Family Coverage.
- (e) Regaining Eligibility: If you lose eligibility for Single Coverage due to insufficient contribution hours during any three consecutive calendar month period, you will regain eligibility if your Employer makes at least 360 hours of contributions during a subsequent three calendar month period. Once the Fund receives sufficient contributions, 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 to again enroll in the Plan.
- (f) Eligible Family Members: See the Plan Description for rules defining who is a Spouse and a Child for purposes of the Plan.

For Family Coverage based on monthly rate contributions:

- (a) Initial Eligibility: Generally, you will become eligible for Family Coverage after the Fund receives two consecutive months of contributions for you. Your coverage will be effective as of the first day of the next month (that is, the third month). You and your Spouse and each of your Children must also enroll in the Plan to be eligible.
- (b) Continuation of Eligibility: Once you earn initial eligibility, you will remain eligible for Family Coverage for each calendar month thereafter so long as the Fund continues

to receive the required monthly contributions from your Employer.

- (c) Regaining Eligibility: 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) Eligible Family Members: See the Plan Description for rules defining who is a Spouse and a Child for purposes of the Plan.

Enrollment

Enrollment in the Fund and Plan is a necessary condition of eligibility for coverage for you and, if you have Family Coverage, for your Spouse and each of your Children. To enroll in the Fund and Plan, you must complete and submit to the Fund Administrator an Enrollment Form 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 Child.
- > If your Spouse's or Child's name is different than yours, you must submit a copy of your most recent federal income tax return.
- > Such additional documentation as the Fund Administrator deems necessary to determine if a person claimed to be a Spouse or Child can qualify for coverage.

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, your Spouse's or Child's eligibility (for example, a newborn child will not be eligible until enrolled).

In particular, you must notify the Fund Administrator of:

- > changes in your mailing address, or the mailing address of your Spouse or a Child;
- > the birth or adoption of a Child;
- > a Child attaining age 26;
- > a divorce;
- > the death of a Spouse or Child.

If a State court or agency has issued an order requiring you to provide health plan coverage for your Child (a Qualified Medical Child Support Order), you should submit it to the Fund Office as soon as possible.

Identification Cards

Once you are enrolled, you will be sent three Identification Cards by Cigna, Express Scripts and Delta Dental. These Identification Cards contain information on how you or your health care provider (hospital, doctor, pharmacist, etc.) can contact Cigna, Express Scripts and Delta Dental for

questions about your medical, prescription drug, dental, vision and member assistance program benefits. The Identification Cards also contain information about the Fund and Plan that your health care provider needs. You should bring your Identification Cards whenever you visit a doctor, pharmacy, dentist, hospital, urgent care facility, or other health care provider. Cards will also be sent to you for your Spouse and each Child, if you have Family Coverage.

Loss Of Coverage

You and, if you have Family Coverage, your Spouse or Children may lose coverage under the Plan and Fund if any of the following events occurs:

- > Your Employer fails to make contributions for the minimum number of hours or months required for eligibility.
- > Your Employer's participation in the Fund terminates. This may happen if the Employer's collective bargaining agreement expires, the Employer goes out of business, the Employer is expelled from the Fund, or other reasons.
- > Your Spouse ceases to be your Spouse or your Child attains age 26.

If you, your Spouse or Child lose coverage under the Plan, you may be able to continue your or their coverage for a limited period on a self-paid basis under the "COBRA" provisions of the Plan. See the Plan Description.

If you take Family and Medical Leave Act leave from covered employment, your coverage under the Plan may continue. See the Plan Description. If you take military leave from covered employment, your coverage under the Plan may continue. See the Plan Description.

MEDICAL BENEFITS COVERAGE INCLUDING HOSPITAL & DOCTOR SERVICES

The following is a summary of Section 2 of the Plan Description which contains other important details that you should read.

24 Hour Health Information Line

The Plan provides you free telephone access, 24-hours a day, to a Health Information Line run by Cigna. If you have a medical or health concern or question, you can call the Health Information Line at any time and speak with a nurse. The nurse can answer the question or guide you to where to get the help you need.

The Health Information Line telephone number is 1-800-244-6224 (1-800-Cigna24).

Medical Telehealth

The Plan, through Cigna, offers 24-hour / 7 days-a-week access by telephone or video access to a Physician for minor conditions that do not require emergency or urgent care treatment. The Physician may be able to diagnose your condition and prescribe medications. This can save you a doctor's office visit for conditions like sore throats, fever, allergies, colds and flu.

After a Co-Payment of \$10, the Plan pays 100% of the cost of a Cigna Medical Telehealth call by you (or by your Spouse or Child, if you have Family Coverage) up to the Maximum Reimbursable Charge.

To use the Cigna Medical Telehealth benefit, you must pre-register by contacting either or both of the following providers (online or by telephone):

- > AmwellforCigna.com or 1-855-667-9722
- > MDLIVEforCigna.com or 1-888-726-3171

Covered Medical Expenses: Generally

"Covered Medical Expenses" means the cost charged for medical services, treatment, equipment or supplies that are covered by the Plan and are not excluded from coverage. Generally, the Plan covers a certain percentage of the Covered Medical Expenses that you or your Eligible Dependents (if you have Family Coverage) incur, 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 do not exceed the Maximum Reimbursable Charge;
- (c) you have satisfied the applicable Deductible(s);
- (d) you satisfy any other Plan conditions applicable to benefits for the particular Covered Medical Expense; and
- (e) you pay the required Co-payment, 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.

Note that the cost to you of medical care will normally be lower if you receive the services from an

"In-Network" provider. "In-Network" means a doctor, hospital or other care provider that participates in the Cigna Health and Life Insurance Company network of preferred providers. You do not need to register with any In-Network providers in advance of needing their services. If and when you need an In-Network provider's services, present your Plan Member Identification Card to the provider who will check with the Fund Administrator to confirm your eligibility for coverage.

Notice of Network Directory Availability

A list of network providers is available to you without charge by visiting Cigna's website (www.myCigna.com), or by calling the phone number on your Identification Card. This information may change frequently, so you should check the website for updates when you need to find a provider.

You can receive medical care services from a hospital, doctor or other medical care provider who is not in the Cigna network ("Out-Of-Network"), but the cost of those services to you are normally higher and you may have to submit a claim form to have the Fund pay its share of the cost. Your Deductibles and Co-Payments are higher for Out-Of-Network providers. Providers usually have claim forms available.

Your Share Of Medical Expenses: Deductibles

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. However, not all Medical Expenses are subject to a Deductible (for example, preventive care services are not subject to a Deductible). Only Covered Medical Expenses can be used to satisfy a Deductible requirement.

Under the Plan there are two types of Deductibles: Annual Deductibles and Special Deductibles.

Annual Deductibles: There are two Annual Deductibles: an Individual Deductible and a Family Deductible. The Annual Individual Deductible is the amount of Covered Medical Expenses that any one Covered Individual (you, your Spouse or Child) must pay during a calendar year before the Plan pays any portion of the Covered Medical Expenses for that Covered Individual. The Annual Individual Deductible is \$200 of In-Network Covered Medical Expenses, and \$400 of Out-of-Network Covered Medical Expenses.

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 \$400 of In-Network Covered Medical Expenses, and \$800 of Out-of-Network Covered Medical Expenses.

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.

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.

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.

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.

Your Share Of Medical Expenses: Co-Payments

In addition to a Deductible, if any, you are responsible for paying:

- (a) The portion of the cost of Covered Medical Expenses not payable under the Plan (called "Co-Payment"), including any additional Co-Payment required for failure to use the Plan's utilization management program when required to do so. Co-Payments are normally paid directly to an In-Network provider.
- (b) 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 the provider.
- (c) The full cost of medical expenses not covered by the Plan because they are excluded medical expenses ("Exclusions");
- (d) Charges for Covered Medical Expenses that exceed the Maximum Reimbursable Charge for such expenses (excess cost); and
- (e) Covered Medical Expenses that exceed any benefit-specific limitations on benefits in the Plan.

Medical Expenses (Out-Of-Pocket Maximum)

There is a maximum limit on how much you and your family will have to pay in any year for covered medical care and prescription drugs. This annual limit, called the Out-Of-Pocket Maximum, applies to the total amount of Deductibles and Co-Payments you are required to pay. After this limit is reached, the Fund will pay the remaining allowable costs of covered medical and hospital care for the rest of the calendar year. This annual limit is called the Out-Of-Pocket Maximum.

The annual In-Network, Out-Of-Pocket Maximum for covered medical expenses (not including prescription drug expenses) is \$5,900 per individual and \$11,800 per family.

The annual Out-Of-Network, Out-Of-Pocket Maximum for medical expenses is \$10,000 per individual and \$20,000 per family for covered medical expenses. Prescription drug costs do not count towards the Out-Of-Network, Out-Of-Pocket Maximum.

The Plan's Share Of Covered Medical Expenses

After you pay any Deductible and Co-Payment that is due, the Plan will pay a portion of the cost of the Covered Medical Expenses, unless excluded from coverage or limited by other Plan rules. The portion payable by the Plan is a percentage of the Maximum Reimbursable Charge for each Covered Medical Expense or, if Out-of-Network, the charge negotiated by Cigna with the provider. The portion payable by the Plan generally depends on whether the Covered Medical Expenses are for In-Network or Out-Of-Network services. An Out-of-Network health care provider may charge you the difference between its normal charges and the amount payable by the Plan. In-Network providers are not allowed to do so.

Expenses are considered Covered Medical Expenses only to the extent that they are recommended (or prescribed where required) by a Physician and are Medically Necessary for the care and treatment of an Injury or Sickness as determined by Cigna.

The following categories of Covered Medical Expenses are only a summary of the Plan Description. You should check the Plan Description for a more complete description of each Covered Medical Expense including limitations and conditions on coverage. You should also check the Exclusions section of this Summary Plan Description and of the Plan Description.

1. **Preventive Care Services**
Including immunizations, lab services, screenings, annual physical exam (for you)
In-Network: 100% (No Deductible)
Out-of-Network: 60%
2. **Doctors Office Visits (Primary Care)**
All services including lab services, radiology services, office surgical services, Medical Pharmaceuticals. No limit on number of visits.
In-Network: 100% after \$10 Co-Payment
Out-of-Network: 60%
3. **Doctors Office Visits (Specialist)**
All services including lab services, radiology services, office surgical services, Medical Pharmaceuticals. No limit on number of visits.
In-Network: 100% after \$25 Co-Payment
Out-of-Network: 60%
4. **Hospital Services (In-Patient)**
Semi-private room, special care unit care, hospital primary and specialty care physician services, lab services, radiology services, Medical Pharmaceuticals.
In-Network: 90%
Out-of-Network: 60%
5. **Hospital Services (Out-Patient, including Free-Standing Surgical Facility)**
All services including lab services, radiology services, Hospital primary and specialty care Physician services, Medical Pharmaceuticals.
In-Network: 90%
Out-of-Network: 60%
6. **Urgent Care Facility Services**
All services including X-rays, lab services, Medical Pharmaceuticals. Also includes advanced imaging with pre-approval from Cigna (which provider will obtain if In-Network).
In-Network: 100% after \$50 Co-Payment
Out-of-Network: 100% after \$50 Co-Payment
7. **Hospital Emergency Room Services**
All services including X-rays, labs, advanced imaging if billed by the Hospital as part of visit.
In-Network: 100% after \$150 Co-Payment (forgiven if the patient is admitted)
Out-of-Network: 100% after \$150 Co-Payment (forgiven if the patient is admitted)
8. **Ambulance Services**
Limited to licensed ambulance services to and from nearest Hospital where needed medical care can be provided.
In-Network: 90%
Out-of-Network: 90%

9. **Other Health Care Facilities (In-Patient)**
Includes Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility. All services. Limited to Calendar Year Maximum of 60 days.
In-Network: 90%
Out-of-Network: 60%
10. **Short Term Rehabilitative Therapy (Out-Patient)**
Includes Occupational Therapy, Physical Therapy, Cognitive Therapy, Pulmonary Rehabilitation Services. All services. Limited to Calendar Year Maximum of 28 visits.
In-Network: 100% after \$10 Co-Payment per visit.
Out-of-Network: 60%
11. **Cardiac Rehabilitation**
All services. Limited to Calendar Year Maximum of 36 visits.
In-Network: 100% after \$25 Co-Payment per visit.
Out-of-Network: 60%
12. **Chiropractic Services**
In-Network: 90% (\$10 Co-Payment)
Out-of-Network: 60%
Limit of 30 visits per year
13. **Home Health Care Services**
Includes private duty nursing if approved by Cigna as Medically Necessary, Medical Pharmaceuticals. Limited to Calendar Year Maximum of 40 days of care.
In-Network: 90%
Out-of-Network: 60%
14. **Hospice Services (In-Patient & Out-Patient)**
Includes Bereavement Counseling by a Mental Health Professional
In-Network: 90%
Out-of-Network: 90%
15. **Maternity Care Services**
For a global maternity fee by an OB/GYN including prenatal, delivery, and postnatal visits:
In-Network: 90%
Out-of-Network: 60%

For the Delivery Facility (Hospital or Birthing Center):
In-Network: 90%
Out-of-Network: 60%

Breast Feeding Equipment & Supplies (including rental of breast pump):
In-Network: 100%
Out-of-Network: Not covered
16. **Abortion Services**
In-Network: If performed in doctor's office, 100% after \$10 Co-Payment for Primary Care / \$25 for Specialist. Otherwise, 90%.
Out-of-Network: 60%

17. **Family Planning Services**
Includes prescribed female contraceptive devices, female and male sterilization surgeries (but not reversals).
In-Network: 100%
Out-of-Network: 60%
18. **Organ Transplants**
Lifesource Center: 100% + travel expenses of up to \$10,000
In-Network: 90%
Out-of-Network: Not covered
19. **Prosthetic Appliance & Devices (Internal & External)**
As needed for permanent or temporary alleviation or correction of an Injury, Sickness or congenital defect. Limited to most appropriate and cost effective alternative as determined by Cigna's Utilization Review Physician.
In-Network: 90% (Special Deductible of \$200)
Out-of-Network: 60% (Special Deductible of \$200)
20. **Hearing Aids**
Limited to two (2) hearing aids per individual within 36 months.
In-Network: 100%
Out-of-Network: Not covered
21. **Mental Health Services**
All In-Patient services, including Acute and Residential Treatment, and all Out-Patient services.
In-Network: 90%, except 100% after \$10 Co-Payment for office visits
Out-of-Network: 60%
22. **Substance Abuse**
All In-Patient services, including Acute and Residential Treatment, and Out-Patient services.
In-Network: 90%
Out-of-Network: 60%
23. **Clinical Trials**
See the special section about when the Plan will pay your routine costs if you are enrolled in a qualifying clinical trial.
24. **Genetic Testing**
See the Plan Description for a complete description of the Plan's coverage of genetic testing.
In-Network: 90%
Out-of-Network: 60%
25. **Any Other Medical Services Required By Law**
In-Network: 90%
Out-of-Network: 60%

Expenses Excluded From Medical Coverage: Plan Pays No Share

The Plan generally will not pay any portion of the costs you incur for certain types of situations, services, treatments, supplies and equipment. These are called Exclusions. They are all excluded from the Plan's medical benefits coverage, although they may be covered by other benefit

coverages offered by the Plan (e.g. Dental Benefits, Prescription Drug, Vision Benefits). The most commonly applicable Exclusions are list below.

For a full list of the Exclusions and General Limitations, and more complete explanation of each, see the Plan Description.

1. General Exclusions

Abdominoplasty / Panniculectomy

Acupressure

Applied Kinesiology

Artificial Aids (e.g., arch supports, corrective orthopedic shoes, wigs)

Artificial Insemination

Augmentative Communication Devices

Biopharoplasty

Cosmetic Surgery or Therapy

Cranial Therapy

Custodial Care

Dance Therapy

Dental Care / Dental Implants

Experimental / Investigational / Unproven Services, Treatments and Devices

Extracorporeal Shock Wave Lithotripsy

GIFT

In Vitro / ZIFT

Infertility: Drugs / Office Visit / Surgical Treatment

Self-Administered Injectibles

In-Patient Private Duty Nursing

Lasik Surgery

Macromastia / Gynecomastia Surgery

Massage Therapy

Personal or Comfort Items

Procedures for Sex Determination

Proiotherapy

Removal of Skin Tags

Reversals of Voluntary Sterilization

Rhinoplasty

Rolfing

Routine Foot Care

Third Party Requests for Health Exams

TMJ Treatments

Treatment of Obesity

Treatment of Sexual Dysfunction

Treatment of Varicose Veins

2. Exclusions Regarding Mental Health and Substance Use Disorder Services

Counseling for activities of an educational nature

Counseling for borderline intellectual functioning

Counseling for occupational problems

Counseling related to consciousness raising, and vocational, or religious counseling

Custodial care including geriatric day care

Developmental disorders

IQ testing

Occupational / recreational therapy programs

Psychological testing on children requested by school

Treatment of disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain

When Certification Of Prior Authorization Is Required Before You Obtain Certain Services

The Plan has Utilization Review Programs designed to minimize unnecessary costs for the Fund and you, while enabling you and your family to receive necessary and appropriate medical services, treatment, equipment and supplies. These Programs include requirements for Certification or Prior Authorization from the Fund Administrator's designee (Cigna) before Hospital admissions and receiving some other services. In-Network providers are responsible for obtaining prior approval when required. You are responsible for obtaining any required prior approval if you use an Out-Of-Network provider.

This prior approval process enables Cigna to confirm that the Hospital admission, length of stay, tests and other procedures are Medically Necessary and covered by the Plan. A summary of the Certification and Prior Authorization rules follows. A complete description of these rules can be found in the Plan Description.

You can obtain a Certification or Prior Authorization by contacting Cigna's Review Organization at the toll-free telephone number on the back of your Member Identification Card. You can also obtain the telephone number on the Fund's website.

If your request for a Certification or Prior Authorization is denied, in whole or in part, you can appeal the denial. See the "How To Claim Benefits & Appeal Denials Of Benefits", below.

(1) Out-Of-Network Hospital: Pre-Admission Certification Requirement

You must request a Pre-Admission Certification ("PAC") before any *non-emergency* treatment in an Out-of-Network Hospital for you (or your Spouse or Child, if you have Family Coverage):

- > as a registered bed patient (except for 48/96 hour maternity stays);
- > for a Partial Hospitalization for the treatment of a Mental Health or Substance Abuse Disorder; or
- > for Mental Health or Substance Abuse Disorder Residential Treatment Services.

In the case of an *emergency* admission to a Hospital, you must request an Admission Certification within 48 hours after admission to an Out-Of-Network Hospital.

In the case of an admission in an Out-Of-Network Hospital due to pregnancy, you should

contact Cigna by the end of the third month of pregnancy.

Failure to obtain a timely Certification may result in loss of some or all benefits for the Hospital admission. The Plan Description lists the benefits that you may lose, including non-coverage for the first \$750 of Hospital charges.

(2) Out-Of-Network Hospital: In-Patient Continued Stay Review Requirement

If you are admitted to an Out-Of-Network Hospital and certified for a specific length of stay there, but need to stay longer, you should request a Continued Stay Review before the end of the certified length of stay.

Failure to obtain a timely Continued Stay Review and authorization to extend the Hospital stay may result in loss of some or all benefits if you stay longer than authorized. The Plan Description lists the benefits that you may lose, including non-coverage of the Hospital charges for the unauthorized days.

(3) Out-Of-Network Out-Patient Procedures: Certification Requirement

Before you (or your Spouse or Child, if you have Family Coverage) obtain non-emergency Out-Patient diagnostic testing or an Out-Patient procedure at a Free-Standing Surgical Facility, Other Health Care Facility, or a Physician's office, you must contact Cigna's Review Organization and request a Certification of the testing or procedure. The request should be made at least four working days (Monday - Friday) in advance of the testing or procedure.

The testing and procedures covered by this requirement include, but are not limited to, Advanced Radiological Imaging (for example: CT scan, MRI, MRA, PET scan) and a Hysterectomy. Before undergoing any Out-Patient testing or procedure, you should contact Cigna's Review Organization (toll-free telephone number on the back of your Member Identification Card) and ask whether the testing or procedure requires Certification.

Failure to obtain a timely Certification may result in loss of some or all benefits for the testing or procedure. The Plan Description lists the benefits that you may lose, including non-coverage for the first \$750 of charges for the testing or procedure.

(4) In-Network Hospital Admission & Procedures: Prior Authorization Requirement

In-Network Hospitals, Physicians and other providers are required to obtain Prior Authorization from Cigna's Review Organization before providing some services for you (and your Spouse or Child if you have Family Coverage) to confirm coverage under the Plan. Obtaining the Prior Authorization for In-Network services is the responsibility of the In-Network Hospital, Physician or other provider.

The services requiring Prior Authorization include the following:

- > In-Patient Hospital services (except 48/96 hour maternity stays);
- > In-Patient services at any Other Health Care Facility;
- > Residential treatment;
- > Out-patient Facility Services;
- > Partial Hospitalization;
- > Advanced Radiological Imaging;
- > Non-Emergency ambulance;

- > certain Medical Pharmaceuticals; and
- > transplant services.

Emergency Hospitalization

You do not have to obtain prior authorization before seeking emergency services in a Hospital Emergency Room. The same Co-Payment for an Emergency Room visit applies to both In-Network and Out-Of-Network facilities (\$150). The Co-Payment is waived if the patient is admitted to the Hospital.

Emergency services for patients with an emergency medical condition include a medical screening examination and treatment to stabilize the patient. An "Emergency Medical Condition" is defined in the Plan Description (Definition Of Terms).

Designation of Primary Care Provider

Under the Plan, there is no requirement to designate a primary care provider. However, should you wish to choose a primary care provider, you have the right to designate any In-Network primary care provider who is available to accept you. This includes the right to designate a participating pediatrician as your child's primary care provider, and the right to designate a participating obstetrical or gynecological physician as your primary care provider.

Direct Access To Obstetrical and Gynecological Care

You do not need prior authorization from the Fund Office or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from an In-Network health care professional who specializes in such care. The health care professional, however, may be required to comply with certain procedures, including obtaining proper authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of the participating In-Network specialists in obstetrics and gynecology, contact Cigna by going on Cigna's website (myCigna.com) or by calling the Customer Service telephone number on the back of your Identification Card.

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 individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- > All stages of reconstruction of the breast on which the mastectomy was performed.
- > Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- > Prostheses.
- > Treatment of physical complications of the mastectomy, including lymphadema.

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

Newborns' and Mothers' Health Protection Act Notice

The Plan is designed to comply with the Federal Newborns' and Mothers' Health Protection Act. Under this Federal law, group health plans like the Plan generally may not 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).

Clinical Trial Costs

If you, your Spouse or your Child are eligible to participate in a qualified Clinical Trial with respect to medical treatment of cancer or another life-threatening disease or condition, the Fund will:

- > Not deny you participation in the trial;
- > not deny, limit or impose additional conditions on the Plan's coverage of routine patient costs for items, services or drugs otherwise covered by the Plan that are furnished in connection with participation in the trial; and
- > will not discriminate against you because of your participation in the trial.

The Plan will deem you eligible to participate in the trial if:

- > Your health care provider is an In-Network provider under the Plan and that provider has concluded that your participation in the trial would be medically appropriate; or
- > you provide medical and scientific information establishing that your participation in the trial would be medically appropriate for you.

See the Plan Description for a complete description of the Plan's rules regarding Clinical Trials.

Case Management

Cigna has a program under which a Case Manager can be assigned to assist you (or your Spouse or Child, if you have Family Coverage) if you become a patient to make sure that you are receiving appropriate care in the most effective setting possible (at home, as an Out-Patient, or as an In-Patient at a Hospital or other facility). Case Managers are Registered Nurses or other health care professionals with appropriate training for your particular condition. Your Physicians remain responsible for your care, but a Case Manager can assist you.

You (or, if you have Family Coverage, your Spouse or Child) or your Physician can request Case Manager services by calling the toll-free telephone number on the back of your Member Identification card. Also, Case Manager services can be requested as part of a Utilization Review Program or by Cigna.

More complete information about Case Manager services can be found in the Plan Description.

Care Management & Coordinated Care

Cigna has collaborative care arrangements with some In-Network providers. These arrangements are intended to encourage Physicians and other providers to be proactive in their care for you. The aim is to improve your health and well-being by keeping in contact with you and coordinating your medical care. Reimbursement by the Plan is 100% for services provided by an In-Network collaborative care provider.

Benefit Claims and Appeals

In-Network: If you or your eligible Dependent receives medical services from an In-Network hospital, doctor or other provider, the provider will submit an electronic claim for benefits to Cigna on your

behalf. The In-Network provider may also request pre-authorizations from Cigna and submit urgent claims, pre-service claims and concurrent care claims to Cigna. You pay the provider your Co-Payment, if one is owed for the services.

Out-of-Network: If you or your eligible Dependent receives medical services from a Hospital, Physician or other provider that is not In-Network, you or your provider will have to submit an approved claim form to Cigna. Your provider can submit the claim form to Cigna for you, if the provider is willing and able to do so. The form may also be submitted to Cigna by your Authorized Representative on your behalf. An approved medical claim form can be obtained on the Fund's website (<http://www.inhwhf.org>), on the Cigna website (<http://www.mycigna.com>), or by calling the Customer Service telephone number listed on your Identification Card. It is important that you or your provider include your Identification Number and Group Number on the claim form.

Time Limit For Claims: A claim is timely if submitted to Cigna within 180 days after the medical treatment, services, supplies or equipment to which the claim relates were received by the patient. A claim received after that 180-day period may be denied as untimely and no benefits paid.

Processing Claim: Upon receipt of a benefit claim, Cigna will check with the Fund Administrator to confirm the patient's eligibility for benefits. Cigna will then process the claim to determine what amount, if any, is payable by the Fund under the terms and conditions of the Plan. Cigna will pay directly to the provider the amount of benefits due under the Plan if you have assigned your benefits to the provider. If you have not assigned your benefits under the Plan to the provider, Cigna will pay directly to you the benefits payable under the Plan and you will be responsible for paying the provider. A Cigna or other Fund representative may contact you or your provider for additional information needed to properly process your claim. The provider may bill you directly for payment of the cost of the services to the extent not payable under the Plan.

A written or electronic Explanation of Benefits ("EOB") will be sent by Cigna to the provider and to you regarding the claim. The EOB will show the amount of the provider's charges, the amount payable by the Fund, the amount payable by you, and other information. If the claim is denied in whole or in part, the EOB will also include a reason for the denial and explain that you have a right to appeal the denial.

If you have a question regarding an EOB, you can contact a Cigna Customer Service Representative by calling the toll-free telephone number on your Member Identification Card or the EOB. Cigna will review or investigate your question as soon as possible, but in any case within 30 days. If you are not satisfied with Cigna's response, you can start the appeals procedure, described below.

Appealing A Denial Of Benefits: If your claim for medical benefits is denied, in whole or in part, by Cigna, you have a right to appeal. See "How To Claim Benefits & Appeal Denials Of Benefits", later in this book.

PRESCRIPTION DRUG COVERAGE

The following is a summary of Section 3 of the Plan Description which contains other important details that you should read.

Prescription Drug Benefits Covered

The Plan pays benefits for Covered Prescription Drug Expenses incurred by you and, if you have Family Coverage, your Eligible Dependents, except to the extent excluded. The Plan pays no benefits for drug expenses that are not Covered Prescription Drug Expenses or that are excluded from coverage under this Plan.

Covered Prescription Drug Expenses are all Federal Legend Drugs, State Restricted Drugs, and injectable insulin that are obtainable only with a Physician's prescription and dispensed by a licensed Pharmacist. 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 uses a "formulary", which is 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 Plan's formulary is called a formulary drug. A drug that is not listed in the formulary is called a non-formulary drug. You may be required to pay a higher Co-Payment, or even the full cost, for drugs that are not on the formulary. The formulary may be obtained by contacting the Pharmacy Benefits Manager (Express Scripts, Inc. or "ESI") through its website (www.express-scripts.com) or calling the number on your Identification Card.

Exclusions: Drugs & Items For Which The Plan Pays No Benefits

No prescription drug benefits are payable under the Plan for the following exclusions, although coverage may be provided for some items under another Plan benefit program (e.g. Medical Benefits):

Any charge for the administration or injection of a drug or insulin (which may be covered under the Medical Benefits provisions of the Plan).

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.

Any charge where the Reasonable and Customary Charge is less than the Covered Individual's Co-Payment.

Any charge above the Reasonable and Customary Charge or the advertised or posted price, whichever is less.

Bee sting kits

Blood or plasma

Diagnostic drugs

Drugs which are lawfully obtainable without a prescription, except injectable insulin

Drugs used to treat obesity and anorexia or assist weight reduction

Drugs used for cosmetic purposes

Drugs received without charge under governmental programs or workers' compensation

Drugs which are not Medically Necessary

Fertility drugs (injectables or oral)

Growth hormones

Immunization agents (except to the extent required by the Affordable Care Act)

Injectables, except injectable insulin

Investigational or Experimental drugs, even though a charge is made to the individual.

Levonorgestrel (Norplant)

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.

Minoxidel, Rhogaine, Rhogam and similar drugs

Non-Federal Legend drugs and non-state restricted drugs, other than injectable insulin

Serums

Sexual dysfunction drugs, including Yohimbine and similar drugs

Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, elastic stockings and other non-medical items regardless of their intended use.

Tretinoin and Retin-A for persons age 25 or older

Vitamins, whether Federal Legend or not, except prenatal vitamins.

Limitations on Supplies of and Access to Drugs

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

- > Retail Pharmacy: 30-day supply or 100 units, whichever is less.
- > Mail Service Pharmacy: 90-day supply

A prescription can be filled only two (2) times at a Retail Pharmacy. Additional fills must be done through the Mail Service Pharmacy.

Coverage of certain drugs may be limited, conditioned or excluded under utilization and cost containment programs adopted by the Board and administered by Express Scripts to save you and the Fund unnecessary drug costs. See "Cost Containment and Utilization Management Programs" later in this book.

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 will usually 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 Fund.

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.

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 (up to a 90-day supply compared to a 30-day supply at a Retail Pharmacy), 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.

Participating Retail Pharmacies

The Fund, through Express Scripts, has a network of Participating Retail Pharmacies that will accept the Plan'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. Note that a prescription fill or re-fill at a Retail Pharmacy is limited to up to a 30-day supply. In contrast, a prescription may be filled or re-filled through the Mail Service Pharmacy for up to a 90-day supply. You can obtain a list of the Participating Retail Pharmacies on the Express Scripts website (www.express-scripts.com), directly or indirectly through the hyperlink on the Fund’s website (www.lnhwf.org), or by calling the Express Scripts customer service telephone number on your Identification Card.

Your Share Of The Cost: Co-Payments

A Co-Payment, for purposes of the Prescription Drug Program, 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 Plan pays for the rest of the drug’s cost. 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 Pharmacy
20% of cost..... (\$10 min., \$35 max.)	Brand, Formulary / Retail Pharmacy
30% of cost..... (\$10 min., \$50 max.)	Brand, Non-Formulary / Retail Pharmacy
\$10.....	Generic / Mail Service Pharmacy
20% of cost..... (\$20 min., \$70 max.)	Brand, Formulary / Mail Service Pharmacy
30% of cost..... (\$20 min., \$100 max.)	Brand, Non-Formulary / Mail Service Pharmacy

Maximum Limit On Your Annual Costs (Out-Of-Pocket Maximum)

There is a maximum limit on how much you and your Family (if you have Family Coverage) will have to pay in any year for Covered Prescription Drug Expenses. This annual limit, called the Out-Of-Pocket Maximum, applies to the total amount of Deductibles and Co-Payments you are required to pay. After this limit is reached, the Fund will pay your remaining allowable Covered Prescription Drug Expenses for the rest of the calendar year. The annual In-Network, Out-Of-Pocket Maximum for covered medical expenses and prescription drug expenses is \$2,000 per individual and \$4,000 per family. Prescription drug costs do not count towards the Out-Of-Network, Out-Of-Pocket Maximum.

Any manufacturer-funded Co-Payment assistance will not apply to the Out-Of-Pocket limits.

Filing Claims for Drug Benefits & Appeals

If you or your Eligible Dependent use 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 Express Scripts for reimbursement of that part of the cost payable by the Plan. You can obtain a claim form through Express Script's website directly or through the hyperlink to Express Scripts on the Fund's website (<http://www.Inhwf.org>).

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See "How To Claim Benefits & Appeal Denials Of Benefits" later in this book.

Cost Containment and Utilization Management Programs

The Plan's prescription drug benefits are subject to cost containment and utilization management programs administered by the Pharmacy Benefit Manager (Express Scripts) and adopted by the Fund's Board of Trustees from time-to-time. Such programs may condition, limit or exclude coverage of certain drugs, or result in you having to pay a greater share or all of the cost of a drug. These programs are intended to reduce the risk that you will be exposed to an unsafe or inappropriate drug, to control costs for the Fund and you, and to foster the proper usage of a drug. See the Plan Description for a description of these programs, including: Compound Drugs Cost Management Program; Cholesterol Drug Management Program (PCSK9 Inhibitors); the Cholesterol Drug Management Program for Non-PCSK9 Inhibitor Drugs; the Market Events Protection Program; the Opioid Drug management Program; and a program that coordinates Co-Payments with cost-sharing programs offered by drug manufacturers. The Board of Trustees may amend or terminate these programs, and may adopt additional cost containment and utilization management programs, from time-to-time. Any such changes will be announced on the Fund's website (www.Inhwf.org).

DENTAL CARE COVERAGE

The following is a summary of Section 4 of the Plan Description which contains other important details that you should read.

Dental Benefits Coverage Generally

The Plan provides Dental Benefits Coverage through a dental “preferred provider organization” (“PPO”) administered by Delta Dental of Pennsylvania (“Delta Dental”). The PPO is a network of Dentists, including Specialists, located throughout the United States. These “In-Network” Dentists have contracts with Delta Dental requiring them to provide covered dental services at discounted prices and to meet quality of care standards. In-Network Dentists also submit claims for benefits directly to Delta Dental.

You can obtain a list of In-Network Dentists, including Specialists, through Delta Dental's website (www.deltadentalins.com) directly or indirectly through the hyperlink on the Fund’s website (www.Inhwhf.org). Or, you can call Delta Dental’s customer service telephone number on your Identification Card or 1-800-932-0783 (Group ID 19221).

You can use a Dentist who is not In-Network with Delta Dental. However, the Plan provides lower benefits for covered dental services that you or your Eligible Dependents (if you have Family Coverage) receive from a Dentist who is not a member of Delta Dental's Network (“Out-of-Network” Dentist). This means that you will pay more if you use an Out-of-Network Dentist. Also, you will have to submit a claim form for benefits to Delta Dental.

Dental Benefits: In-Network

The Plan will pay a certain percentage of the In-Network dentist’s discounted charges for treatments and services covered by the Plan (“In-Network”), up to the Annual Maximum Limit (if applicable). The rest of the charges will be the patient’s responsibility, in addition to any applicable Deductible. The percentage of the In-Network Dentist’s charges that the Plan will pay, and any applicable Deductible, is set in the following chart.

Note that the percentages are based on the PPO Allowed Amount, which is the lesser of the Dentist’s submitted fee or the PPO Maximum Plan Allowance. In-Network Dentists have agreed to accept the PPO Maximum Plan Allowance as full payment for each service.

Diagnostic Services.....100% paid by the Plan (Maximum waived)

Includes periodic exams (2x per calendar year)
bitewing x-rays (no frequency limit)
full-mouth x-ray (once per 3 year period)
Additional benefits during pregnancy

Preventive Services100% paid by the Plan (Maximum waived)

Prophylaxis / Cleaning (2x per calendar year)
Fluoride treatments (2x per calendar year to age 19)
Sealants (to age 14)
Space maintainers (to age 14)
Additional benefits during pregnancy

Basic Restorative100% paid by the Plan

Filings (amalgam “silver” and composite “white” non-molar)

Major Restorative60% paid by the Plan

Single crowns, inlays, onlays

Oral Surgery.....100% paid by the Plan
Extraction and other oral surgery procedures including pre- and post-operative care.
Includes extraction of wisdom teeth.

Endodontics.....100% paid by the Plan
Root canal, pulpal therapy

Surgical Periodontics.....100% paid by the Plan
Surgical treatment of the gums and supporting structures of the teeth.

Non-Surgical Periodontics.....100% paid by the Plan
Non-surgical treatment of the gums and supporting structures of the teeth.
Additional benefits during pregnancy.

Prosthodontics.....60% paid by the Plan

Orthodontics.....50% paid by the Plan
To age 19. \$50 Deductible (lifetime).

General Anesthesia and IV Sedation.....100% paid by the Plan
Covered when used in conjunction with covered oral surgical procedures and
other selected endodontic and periodontic procedures.

Dental Benefits: Out-of-Network

The Plan will pay a certain percentage of the Out-of-Network dentist's charges for treatments and services covered by the Plan, up to the Annual Maximum Limit, after payment by the patient of an annual Deductible (\$50 per individual, \$100 per family). The percentage of the dentist's charges that the Plan will pay is set in the following chart. You will owe the remaining part of the Dentist's charges.

Note that the percentages are based on the PPO Allowed Amount, which is the lesser of the Dentist's submitted fee or the PPO Maximum Plan Allowance. Out-of-Network Dentists have not agreed to accept the PPO Maximum Plan Allowance as full payment for each service, and so their charges for each service will normally be higher than In-Network Dentists. Some ("Premier Dentists") have agreements with Delta Dental to accept a higher discounted fee level as full payment.

Diagnostic Services.....100% paid by the Plan (maximum and Deductible waived)
Includes periodic exams (2x per calendar year)
bitewing x-rays (no frequency limit)
full-mouth x-ray (once per 3 year period)
Additional benefits during pregnancy

Preventive Services100% paid by the Plan (maximum and Deductible waived)
Prophylaxis / Cleaning (2x per calendar year)
Fluoride treatments (2x per calendar year to age 19)
Sealants (to age 14)
Space maintainers (to age 14)
Additional benefits during pregnancy

Basic Restorative100% paid by the Plan
Fillings (amalgam "silver" and composite "white" non-molar)

Major Restorative60% paid by the Plan
Single crowns, inlays, onlays

Oral Surgery.....100% paid by the Plan
Extraction and other oral surgery procedures including pre- and post-operative care. Includes extraction of wisdom teeth

Endodontics.....100% paid by the Plan
Root canal, pulpal therapy

Surgical Periodontics.....100% paid by the Plan
Surgical treatment of the gums and supporting structures of the teeth.

Non-Surgical Periodontics.....100% paid by the Plan
Non-surgical treatment of the gums and supporting structures of the teeth. Additional benefits during pregnancy.

Prosthodontics.....60% paid by the Plan

Orthodontics.....50% paid by the Plan
To age 19. \$50 Deductible (lifetime).

General Anesthesia and IV Sedation.....100% paid by the Plan
Covered when used in conjunction with covered oral surgical procedures and other selected endodontic and periodontic procedures.

Annual Maximum Limits On Benefits

The Plan will pay no more than \$2,500 per patient (for you and for each of your Eligible Dependents, if you have Family Coverage) in a Calendar Year for covered dental benefits. Orthodontic benefits are not included in this annual maximum limit.

Orthodontic benefits are separately limited to lifetime limit of \$1,500 per patient.

Additional Benefits During Pregnancy

If the patient is pregnant, the Plan will pay for additional services: one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written proof of pregnancy may be required.

Exclusions: Dental Expenses For Which No Benefits Are Payable By The Plan

The following services and items are excluded from coverage as Dental Benefits, and no benefits are payable as Dental Benefits of the Plan (although coverage might be available under other provisions of the Plan, such as Medical Benefits):

- (a) Treatment or materials that are benefits to the patient under Medicare or Medicaid, unless this exclusion is prohibited by law.
- (b) Treatment or materials to correct congenital or developmental malformations (including treatment of enamel hypoplasia); except for newborn children for whom coverage will include cleft lip or cleft palate, subject to other limitations in the Plan.
- (c) Treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition, erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury.
- (d) Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis and porcelain, or other veneers not for restorative purposes, except as part of treatment dentally necessary due to accident or injury. If services are not excluded as to

particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected teeth are excluded.

- (e) Treatment or materials for which you or the patient has no legal obligation to pay.
- (f) Services provided and materials furnished while you or the patient were not eligible for coverage, unless the treatment was a year in duration and completed after you and the patient became eligible if no other limitations apply.
- (g) Periodontal splitting, equilibration, gnathological recordings and associated treatment and extra-oral grafts.
- (h) Preventive plaque control programs, including oral hygiene instruction programs.
- (i) Myofunctional therapy, unless saved from exclusion under (b), above.
- (j) Temporomandibular joint dysfunction (TMJ), unless saved from exclusion under (b), above.
- (k) Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.
- (l) Experimental procedures that have not been accepted by the American Dental Association.
- (m) Services provided or material furnished after the termination of your, or the patient's, coverage eligibility, except that this exclusion shall not apply to services commenced while coverage eligibility was in effect.
- (n) Charges for hospitalization or any surgical treatment facility, including hospital visits.
- (o) Dental proactive administrative services including but not limited to preparation of claims, any on-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (p) Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.
- (q) Any tax imposed (or incurred) by a government, state or other entity in connection with any fees charged for benefits provided under the Plan. Such taxes will be the responsibility of the patient or provider, and not of the Plan.

Limitations on Benefits

The following limitations apply to covered benefits:

- (a) **Optional Treatment Plans**: The Plan will pay benefits only for the least costly course of treatment, if there are optional plans of treatment, provided that such treatment will restore the oral condition in a professionally accepted manner. Procedures that are not customarily performed alone in a generally accepted dental practice cannot be unbundled.
- (b) **Major Restorative Benefits**: If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the Dentist and patient decide on another type of restoration, the Plan will pay benefits only for the least costly restorative procedure.

Replacement of crowns, jackets, inlays and onlays will be covered no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period is measured from the date on which any prior restoration was last supplied, whether paid for by the Plan or

otherwise.

- (c) **Prosthodontic Benefits:** Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services, including denture repair and relining, which are necessary to make such appliances fit will be covered benefits. Prosthodontic appliances and abutment crowns will be replaced only after five years has elapsed following any prior provision of such appliances and abutment crowns.
- (d) **Orthodontic Benefits:** Benefits are limited to devices and procedures for the correction of misposed teeth of patients up to age 19, through the completion of the procedure, or the termination of coverage, whichever occurs first. No benefits are provided for the repair or replacement of appliances.
- (e) **Oral Surgery Benefits:** If oral surgery procedures (including reduction of fractures, removal of tumors and removal of impacted teeth) are covered by the Medical Benefits of this Plan, the Dental Benefits will be limited to the amounts not paid under the Medical Benefits provisions, subject to the provisions of the Dental Benefits.
- (f) **Periodontal Surgery Benefits:** Benefits for surgery in the same quadrant is limited to once in any five-year period. The five-year period is measured from the date on which any prior surgery was last performed, whether paid for by the Plan or otherwise.
- (g) **Sealants:** Benefits are limited to applications to eight posterior teeth. Applications to deciduous teeth or teeth with caries are not covered. Benefits are payable for sealant replacement only after three years have elapsed following any prior provision of such materials.
- (h) **Occlusal Restorations:** Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve (12) months, and two or three surface restorations within six (6) months, which include occlusal surfaces on which sealants have been placed are not covered services. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six (12-36) months after a sealant has been applied to that tooth, Benefits will be payable only for the fee appropriate to the restoration in excess of the fee paid for application of the sealant.

Pre-Treatment Estimate of Cost

If you or your Dentist is unsure whether a specific course of treatment will be covered by the Plan, or if the costs are expected to exceed \$300, you should ask Delta Dental for a pre-treatment estimate of the costs for you and the Plan. A Dentist can obtain an estimate by submitting a claim form to Delta Dental before beginning the treatment. The estimate will show whether the treatment is covered, the share of the cost that the Plan would pay, and the share of the costs that would be your responsibility.

Claims For Dental Benefits & Appeals

If you receive dental services from an In-Network Dentist or a Premier Dentist, you will not be required to submit a claim form. The Dentist will automatically submit a claim for payment to Delta Dental. You will be required to pay to the Dentist only the Co-Payment, if any is required for the service you receive. Delta Dental will submit payment of the Plan's share directly to the Dentist. If you receive dental services from an Out-Of-Network Dentist, you or the Dentist will have to submit a dental benefits claim form to Delta Dental to receive payment of the Plan's share of the charges.

You can print a dental claim form off of Delta Dental's website (www.deltadentalins.com). The claim form should be sent to Delta Dental, P.O. Box 2105, Mechanicsburg, PA 17055-6999.

Payment of the Plan's share of the cost will be sent directly to the In-Network Dentist or Premier Dentist who submitted the claim. If you used an Out-of-Network Dentist, the Plan's share will be sent to you and you will be responsible for paying the Dentist.

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See "How To Claim Benefits & Appeal Denials Of Benefits", below.

VISION CARE COVERAGE

The following is a summary of Section 5 of the Plan Description which contains other important details that you should read.

The Plan pays benefits for vision-related services and materials received by you and, if you have Family Coverage, your Dependent(s). In general, the Plan pays up to a certain amount for covered services and materials. In addition, if you or your Dependent obtain covered vision-related services and materials from a participating In-Network vision provider, you will receive money-saving discounts from the provider.

The PPO Network of vision providers is maintained by Cigna Health and Life Insurance Company for the Fund. Participating providers are considered In-Network.

Covered Vision Benefits

The vision benefits payable under the Plan are as follows:

- (a) **Eye Exam Benefit:** The Plan will pay the actual cost of a vision and eye health evaluation, including dilation, refraction, and prescription for eyeglasses or contact lenses, up to a maximum of \$60.00. This benefit can be used by an individual (you, and if you have Family Coverage, your Spouse and each Child) once in any 12-month period. This benefit is payable regardless of whether the vision care provider is In-Network or Out-of-Network.
- (b) **Eyeglasses & Contact Lenses Benefit:** The Plan will pay the actual cost of prescription eyeglass lenses, frames and /or contact lenses up to \$150. This benefit can be used by an individual (you, and if you have Family Coverage, your Spouse and each Child) once in any 12-month period. This benefit is payable regardless of whether the materials provider is In-Network or Out-of-Network.
- (c) **Patient's Share of Cost:** There is no Deductible for Covered Vision Benefits. However, the patient (you, your Spouse or your Child) is responsible for any costs of vision care services or materials in excess of the benefit payable.
- (d) **Declining Balance:** The Eye Exam Benefit and the Eyeglasses & Contact Lenses Benefit can be used by you, your Spouse or your Child multiple times in a calendar year. However, the maximum benefits stated in paragraphs (a) and (b) above limit the amount that the Plan will pay for the individual in any calendar year.

In-Network Discounts On Materials And Services

- (a) If an eye exam, eye glasses and/or contact lenses are obtained by you or your Dependent (if you have Family Coverage) from a participating In-Network provider, the following discounts are generally available: (1) 20% discount on glasses frames, lenses and lens options; and (2) up to a 15% discount on contact lens professional services (including fitting and evaluation). Note this discount does not include the contact lenses themselves.

Note: Some vision care providers in the Network may not offer discounts or the same level of discounts. You should ask your provider if there are discounts available.

- (b) The Eye Exam Benefit and Glasses and Contact Lens Benefits can be applied to the discounted services. For example, if you obtain eyeglasses from an In-Network provider at a price that is discounted by 20%, you can still receive up to \$150 towards the discounted cost of the eyeglasses.
- (c) To use your benefits In-Network, visit an In-Network vision care provider and present your Fund Member Identification Card. The provider will verify your eligibility with the Fund and

take care of submitting a claim for benefits to Cigna for you. You can find an In-Network provider on the Cigna website (www.myCigna.com). You may also go through the hyperlink to Cigna on the Fund's website (www.Inhwf.org).

Out-Of-Network Materials And Services

To use your benefits Out-Of-Network, obtain your eye examination, eyeglasses or contact lenses from a vision care provider who is not in the Cigna Network. You can submit a claim for your benefits by obtaining, completing and submitting a Cigna Vision claim form (including any required receipts or other documentation) to Cigna. You can obtain a Cigna Vision claim form by going to Cigna's website (www.myCigna.com) and selecting Forms, then Vision Forms. You may also go through the hyperlink to Cigna on the Fund's website (www.Inhwf.org).

The completed Cigna Vision claim form should be mailed to: Cigna Vision, Claims Department, P.O. Box 385018, Birmingham, Alabama 35238-5018. Cigna will mail you a check for your benefits, usually within 10 business days after the claim is received.

Exclusions: No Vision Benefits Payable

The following treatments, conditions and situations are excluded from coverage by the vision program, and no benefit is payable for them under the Plan:

- (a) Orthoptic or vision training, and any associated supplemental testing.
- (b) Medical and surgical treatment of the eyes. (Such treatment may be covered by the Plan's medical benefits coverage.)
- (c) Any eye examination, or corrective eyewear, required by an employer as a condition of employment.
- (d) Any injury or illness when paid or payable by Workers Compensation or similar law, or which is work related.
- (e) Charges in excess of reasonable and customary charges for examinations, other services, eyeglass frames and lenses, and contact lenses.
- (f) Charges incurred after eligibility for benefits under the Plan or Fund ends.
- (g) Experimental or non-conventional treatment or device.
- (h) Magnification or low vision aids.
- (i) Eyeglasses or contact lenses for video display terminal (VDT) / computer viewing.
- (j) Services or materials for which a claim is not submitted within twelve (12) months from the date of incurrence.

Appeal Of Benefit Denial

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See "How To Claim Benefits & Appeal Denials Of Benefits", below.

SHORT TERM DISABILITY BENEFITS

The following is a summary of Section 6 of the Plan Description which contains other important details that you should read.

Benefits

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 Section.

Definitions

- (a) "Disabled" and "Disability" means:
- (1) you are unable to perform the essential duties of your regular occupation or a reasonable employment option offered to you by the Fund,
 - (2) because of a change in your functional capacity to work due to sickness or accidental injury,
 - (3) and, as a result, you are unable to earn more than 80% of your basic weekly earnings,
 - (4) and, you are receiving regular and appropriate care.
- (b) "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.
- (c) "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.
- (d) "Sickness" means any physical illness, mental disorder, normal pregnancy or complication of pregnancy.
- (e) "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.
- (f) "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.
- (g) "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.
- (1) 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.
 - (2) 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.

Exclusions: No Disability Benefits Payable

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.
- (i) 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.
- (j) No additional benefit is payable if the Disability is caused by multiple sicknesses and/or accidental injuries.

Benefit Claims

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

Upon receipt of the notice, the Fund Office will send to you a claim form. You will have to complete the claim form and return it to the Fund Office 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 office.

The Fund Office 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.

The procedural requirements and protections of 29 CFR Section 2560.503-1, as amended, will be followed by the Fund's Short Term Disability insurer to the extent applicable.

Appeal Of Benefit Denial

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See "How To Claim Benefits & Appeal Denials Of Benefits", below.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

The following is a summary of Section 7 of the Plan Description which contains other important details that you should read.

Life Insurance Benefit

If you (an Eligible Participant) die from any cause while eligible under the Plan, a life insurance benefit of Twenty Thousand Dollars (\$20,000.00) will be paid to your Beneficiary or Beneficiaries by an insurance company from which the Fund has purchased and maintains a group insurance policy for this purpose. The life insurance benefit is payable in the event of your death in addition to any Accidental Death & Disability death benefit that may be payable under the Plan.

If your Eligible Dependent dies from any cause while eligible under the Plan, a life insurance benefit of Two Thousand Dollars (\$2,000.00) will be paid to you unless you have died before the Eligible Dependent.

The benefits will be paid in a single lump sum unless other arrangements are made with the insurance company by the Beneficiary or Beneficiaries.

Accidental Death & Dismemberment Benefit (AD&D)

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 and maintains a group insurance policy for this purpose. 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>
(a) life	\$20,000
(b) two hands	\$20,000
(c) two feet	\$20,000
(d) sight of two eyes	\$20,000
(e) one hand and one foot	\$20,000
(f) one hand and sight of one eye	\$20,000
(g) one foot and sight of one eye	\$20,000
(h) one foot or one hand	\$10,000
(i) sight of one eye	\$10,000

No AD&D benefit is payable unless the loss occurred within ninety (90) calendar days after the date of the accident. 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.

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:

- (a) bodily or mental illness or disease of any kind;
- (b) ptomaines or bacterial infections, except infections caused by a pyogenic organism that occurs with and through an accidental cut or wound;

- (c) hernia;
- (d) suicide or self-inflicted injury while sane or insane;
- (e) participation in the commission of a felony;
- (f) war or act of war, or service in the Armed Forces of any country when that country is engaged in war; or
- (g) police duty as a member of any military, naval or air organization.

Beneficiary Rules

To be eligible under the Plan, you must fill out and submit to the Fund Administrator an Enrollment Form. On the Enrollment Form you can 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 Office. The change will not be effective until the new Enrollment Form is received by the Fund Office.

If your Beneficiary dies before you, the Beneficiary's interest automatically terminates. If you name more than one Beneficiary, the total amount of benefits due will be divided equally among the surviving Beneficiaries. 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: your Spouse; your Children in equal shares; your parents in equal shares; your siblings in equal shares; or the executors or administrators of your estate. 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 Office.

Claims For Benefits & Appeals Of Denied Claims

Life insurance and AD&D benefits must be claimed by you or your Beneficiary or Beneficiaries by contacting the Fund Administrator for a claim form and instructions on submitting the claim and supporting documentation (including proof of death or other loss) that is satisfactory to the Fund and to the insurer. All life insurance and AD&D benefit claims must be submitted to the Fund Office.

The procedural requirements and protections of 29 CFR Section 2560.503-1, as amended, will be followed by the Fund's Disability insurer to the extent applicable

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See "How To Claim Benefits & Appeal Denials Of Benefits" later in this book.

Extension Of Life Insurance If You Become Totally Disabled

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 terms and conditions described in Section 7 of the Plan Description.

Conversion Of Life Insurance Benefit To Individual Policy

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.

Important terms and conditions of this conversion benefit, including certain timing requirements, are described in Section 7 of the Plan Description.

MEMBERSHIP ASSISTANCE PLAN (MAP) BENEFITS

The following is a summary of Section 8 of the Plan Description which contains other important details that you should read.

Overview

Most American families are affected, at some point in their lives, by personal problems such as marital stress, alcoholism, drug addiction, grief and loss, financial trouble, legal problems, and child and elder care needs. Many people do not know where to turn for help. Unfortunately, their problems often go unaddressed and get worse.

The Member Assistance Program (MAP) of the Plan is intended to give you and your family a place to turn for help and guidance in these situations, especially in times of crisis. Through MAP, problems can be identified and arrangements made for you to obtain the type of assistance needed to deal with your problems. This assistance may include referrals to professionals who specialize in handling your type of problem.

You, as well as your Eligible Dependents (if you have Family Coverage), are eligible for MAP benefits if you have eligibility under the Plan.

Accessing MAP Benefits

You can access MAP benefits at any time by calling Cigna Behavior Health's telephone number: 1-888-325-3978, and speaking with a MAP counselor. You can also obtain information through the special website maintained by Cigna Behavior Health: www.cignabehavioral.com.

Benefits: Confidential Counseling

You can contact a MAP counselor for help over the telephone as often as you need. Your conversation will be confidential. You will not be charged for the call or the counseling.

If an in-person meeting with a MAP counselor is necessary or appropriate for dealing with your problem, you can have up to 3 meetings per issue with a counselor in the Cigna Behavioral Health network of providers. A list of the network counselors can be obtained from Cigna Behavioral Health's website: www.cignabehavioral.com.

Benefits: Access To Work / Life Resources

Through the Cigna Behavioral Health website (www.cignabehavioral.com) you can obtain information and resources regarding emotional well-being, handling life events, family and care giving, educational programs, disability programs, adoption programs, health and wellness, career assistance, daily living needs, pet care, and professional services. Discounts and referrals for various health services and products are also available through the Cigna Healthy Rewards program described on the website.

Benefits: Legal Services

MAP offers legal consultation of up to 30 minutes without charge and a 25% discount on legal fees normally charged by lawyers to which MAP refers you. You will be responsible for any additional fees and costs.

Cost

The benefits described in this Section are provided without cost to you. However, if you receive professional services for mental or behavioral health, substance abuse or other health issues, you will be responsible for the cost of those services except to the extent that they are covered by other

benefits offered by the Plan (e.g. Medical Benefits).

Appeals

If your claim for benefits is denied, in whole or in part, you have a right to appeal to the Fund's Board of Trustees. See "How To Claim Benefits & Appeal Denials Of Benefits", below.

HOW TO CLAIM BENEFITS & APPEAL DENIALS OF BENEFITS

The following is a summary of Section 9 of the Plan Description which contains other important terms and conditions including timing requirements. Note that benefits under the Plan are payable to or for you and your Dependents only if the Fund receives a timely claim from you or for you. You should review Section 9 for a complete description of your rights and obligations regarding benefit claims, claims determinations, appeals of denials of claims, and making other complaints.

Claims For Medical Benefits

In-Network: If you or your eligible Dependent receives medical services from an In-Network hospital, doctor or other provider, the provider will submit an electronic claim for benefits to Cigna on your behalf. The In-Network provider may also request pre-authorizations from Cigna and submit urgent claims, pre-service claims and concurrent care claims to Cigna. You pay the provider your Co-Payment, if one is owed for the services.

Out-of-Network: If you or your eligible Dependent receives medical services from a hospital, doctor or other provider that is not In-Network, you will have to submit an approved claim form to Cigna. Your provider can submit the claim form to Cigna for you, if the provider is willing and able to do so. The form may also be submitted to Cigna by your Authorized Representative on your behalf. An approved medical claim form can be obtained on the Cigna website listed on your Member Identification Card, by calling the toll-free telephone number on your Member Identification Card, or through the Fund's website (www.lnhwf.org). It is important that you or your provider include your Member Identification Number and Group Number on the claim form.

Time Limit For Claims: A claim is timely if submitted to Cigna within 180 days after the medical treatment, services, supplies or equipment to which the claim relates were received by the patient. A claim received after that 180-day period may be denied as untimely and no benefits paid.

Processing Claim: Upon receipt of a benefit claim, Cigna will check with the Fund Office to confirm the patient's eligibility for benefits. Cigna will then process the claim to determine what amount, if any, is payable by the Fund under the terms and conditions of the Plan. Cigna will pay directly to the provider the amount of benefits due under the Plan if you have assigned your benefits to the provider. If you have not assigned your benefits under the Plan to the provider, Cigna will pay directly to you the benefits payable under the Plan and you will be responsible for paying the provider. A Cigna or other Fund representative may contact you or your provider for additional information needed to properly process your claim.

Provider Billing: The provider may bill you directly for payment of the cost of the services to the extent not payable under the Plan.

Notice of Decision: A written or electronic Explanation of Benefits ("EOB") will be sent by Cigna to the provider and to you regarding the claim. The EOB will show the amount of the provider's charges, the amount payable by the Fund, the amount payable by you, and other important information. If the claim is denied in whole or in part, the EOB will also include the reason for the denial, explain that you have a right to appeal the denial, and include other important information required by law.

If you have a question regarding an EOB, you can contact a Cigna Customer Service Representative by calling the toll-free telephone number on your Member Identification Card or the EOB. Cigna will review or investigate your question as soon as possible, but in any case within 30 days. If you are not satisfied with Cigna's response, you can start the appeals procedure, described

below.

First Level Of Appeal: Internal Appeal To Cigna: To appeal the denial, in whole or in part, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone at the toll-free number on your Member Identification Card, EOB or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

Cigna will respond in writing with a decision within 30 calendar days after it receives an appeal for a required pre-service or concurrent care coverage determination or a post-service Medical Necessity determination.

Cigna will respond within 60 calendar days after it receives an appeal for any other post-service coverage determination.

If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, this information will be provided automatically to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

Expedited Appeals: You may request that the appeal process be expedited if, (1) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality, or in the opinion of your health care provider, would cause you severe pain which cannot be managed without the requested services; or (2) your appeal involves non-authorization of an admission or continuing in-patient Hospital stay. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

If you request that your appeal be expedited, you may also ask for an expedited External Review at the same time, if the time to complete an expedited review would be detrimental to your medical condition.

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information described in Section 9 of the Plan Description.

Second Level Of Appeal: Internal Appeal To Fund's Board Of Trustees: If your First Level appeal to Cigna is denied, in whole or in part, you can appeal to the Fund's Board of Trustees for review of Cigna's actions in denying your claim. You can appeal to the Board of Trustees by sending a letter by mail, fax or email to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

Your appeal must be received by the Fund Administrator within 120 days following the date of Cigna's notice to you that your First Level appeal has been denied in whole or in part. Your appeal should state clearly the reason(s) for your appeal, and be accompanied by any documents or other proof that you have to support your appeal.

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. If additional information is needed, the Fund Administrator will contact you.

In the event any new or additional information (evidence) is considered, relied upon or generated by the Board or Committee in connection with the appeal, this information will be provided automatically to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Board or Committee, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include the information described in Section 9 of the Plan Description.

The Board or Committee may decide to refer your appeal to Independent External Appeal without deciding the appeal itself.

Third Level Of Appeal: Independent External Review: Certain types of medical claims may be appealed to an Independent Review Organizations (IRO) composed of persons who are not employed by the Fund, by Cigna, or by any Cigna affiliate to conduct External Reviews of qualifying claims to the extent required by the Affordable Care Act.

An External Review of medical claims will be conducted under any of the following circumstances:

- (a) You request an expedited appeal of a claims denial by Cigna for permitted reasons and request an External Review as part of that expedited appeal. In this circumstance, Cigna will conduct an expedited First Level review and, if that review upholds the denial, Cigna will refer the claim to External Review if a decision on the claim requires medical judgment. Alternatively, Cigna may decide to refer the claim immediately to External Review without making a First Level appeal decision.
- (b) If you file a Second Level appeal with the Fund's Board of Trustees and the Board denies your appeal, you can request that the Board refer your claim to External Review if a decision on the claim involves medical judgment. The Board's notice of decision to you will explain the procedure for requesting an External Review. Your request for an External Review must be received by the Fund Administrator within 130 days following the date of the notice to you of the Board's decision on your Second Level appeal.

You are not required to pay any fee or other charge to initiate an External Review.

The IRO will conduct the External Review and render a decision within 45 days after receiving the claim file. Cigna and the Fund will abide by the IRO's decision. You will be promptly notified in writing by Cigna or the Fund Administrator of the IRO's decision.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the External Review shall be completed within 72 hours.

Claims For Prescription Drug Benefits

In-Network: If you or your Eligible Dependent use 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.

Out-Of-Network: 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 Express Scripts, the Fund's Pharmacy Benefit Manager, for reimbursement of the share of the cost payable by the Plan. You can obtain a claim form through the Express Scripts website (www.express-scripts.com).

Problem Solving: If you encounter any difficulty in having a prescription fill or re-filled by a Retail Pharmacy or the Mail Service Pharmacy, you (or your Pharmacist) should first contact Express Scripts by calling the telephone number on your Identification Card to discuss the problem.

To Appeal A Denial Of Prescription Drug Benefits: If your claim for prescription drug benefits from the Plan is denied, in whole or in part, you can appeal to the Fund's Board of Trustees for review of the denial. You can appeal to the Board of Trustees by sending a letter by mail, fax or email to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include the information described in Section 9 of the Plan Description.

Claims For Dental Benefits

In-Network: If you receive dental services from an In-Network Dentist, you will not be required to submit a claim form. The Dentist will automatically submit a claim for payment to Delta Dental. You will be required to pay to the Dentist only the Co-Payment, if any is required for the service you receive.

Out-Of-Network: If you receive dental services from an Out-Of-Network Dentist, you or the Dentist will have to submit a dental benefits claim form to Delta Dental to receive payment of the Plan's share of the charges. You can print a dental claim form off of Delta Dental's website (www.deltadentalins.com).

Problem Solving: If you encounter any difficulty in receiving covered dental benefits, you should first contact Delta Dental by calling the telephone number on your Member Identification Card to discuss the problem.

To Appeal A Denial Of Dental Benefits: If your contact with Delta Dental is unsatisfactory and your claim for dental benefits from the Plan is denied, in whole or in part, you can appeal to the Fund's Board of Trustees for review of the denial. You can appeal to the Board of Trustees by sending a letter by mail, fax or email to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include the information described in Section 9 of the Plan Description.

Claims For Vision Benefits

In-Network: To use your benefits In-Network, visit an In-Network vision care provider and present your Fund Member Identification Card. The provider will verify your eligibility with the Fund and take care of submitting a claim for benefits to Cigna for you. You can find an In-Network provider on the Cigna website, which can be accessed directly (<http://www.myCigna.com>) or through the Fund's website (<http://www.lnhwhf.org>).

Out-Of-Network: To use your benefits Out-Of-Network, obtain your eye examination, eyeglasses or contact lenses from a vision care provider who is not in the Cigna Network. You can submit a claim for your benefits by obtaining, completing and submitting a Cigna Vision claim form (including any required receipts or other documentation) to Cigna. You can obtain a Cigna Vision claim form by going to Cigna's website (www.myCigna.com) and selecting Forms, then Vision Forms.

The completed Cigna Vision claim form should be mailed to: Cigna Vision, Claims Department, P.O. Box 385018, Birmingham, Alabama 35238-5018. Cigna will mail you a check for your benefits, usually within 10 business days after the claim is received.

Problem Solving: If you encounter any difficulty in obtaining covered vision benefits, you can contact a Cigna Customer Service Representative by calling the toll-free telephone number on your Member Identification Card or the EOB. Cigna will review or investigate your question as soon as possible, but in any case within 30 days. If you are not satisfied with Cigna's response, you can start the appeals procedure, described below.

To Appeal A Denial Of Vision Benefits: If your contact with Cigna is unsatisfactory and your claim for vision benefits from the Plan is denied, in whole or in part, you can appeal to the Fund's Board of Trustees for review of the denial. You can appeal to the Board of Trustees by sending a letter by mail, fax or email to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include the information described in Section 9 of the Plan Description.

Claims For Short Term Disability Benefits

Claim: To make a claim for Short Term Disability (STD) 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. 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.

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.

Once a decision is made by the Fund's STD insurer on your claim, you will be sent a notice of the decision. The notice will contain the information required under Section 9 of the Plan Description.

To Appeal A Denial Of STD Benefits: If your claim for benefits is denied in whole or in part by the Fund Administrator or the Fund's STD insurer, you may appeal to the Fund's Board of Trustees by sending a letter to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

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.

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals

Committee, ordinarily at the first meeting after the appeal is received. In the event any new or additional information (evidence) is considered, relied upon or generated by the Board or Committee in connection with the appeal, this information will be provided automatically to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Board or Committee, the Board or Committee will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include the information described in Section 9 of the Plan Description and will comply with 29 CFR Section 2560.503-1, as amended, to the extent applicable.

Claims For Life Insurance Or Accidental Death & Dismemberment Benefits

Claims: To claim Life Insurance or AD&D benefits, you or your Beneficiary must contact the Fund Administrator for a claim form and instructions on submitting the claim and supporting documentation (including proof of death or other loss) that is satisfactory to the Fund and to the insurance company. All Life Insurance or AD&D benefit claims must be submitted to the Fund Administrator within sixty (60) days after death or other covered loss.

To Appeal A Denial Of Life Insurance Or AD&D Benefits: If your claim for Life Insurance or AD&D benefits is denied in whole or in part by the Fund Administrator or the Fund's insurer, you may appeal to the Fund's Board of Trustees by sending a letter to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

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.

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include the information described in Section 9 of the Plan Description and will comply with 29 CFR Section 2560.503-1, as amended, to the extent applicable.

Claims For Member Assistance Benefits

Claims: To access MAP benefits at any time, call Cigna Behavior Health's telephone number 1-888-325-3978, and speak with a MAP counselor. Some benefits are available through the special Cigna Behavior Health website (www.cignabehavioral.com).

To Appeal A Denial Of MAP Benefits: If your claim for benefits is denied in whole or in part by Cigna Behavioral Health, you may appeal to the Fund's Board of Trustees by sending a letter to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

Your appeal will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after the appeal is received. Once the Board of Trustees makes a decision on the appeal, a written notice and explanation of that decision will be sent to you. If the decision is to deny the appeal in whole or in part, the notice and explanation will include the information described in Section 9 of the Plan Description.

COBRA Coverage & All Other Matters / Complaints

If your claim for COBRA continuation coverage is denied in whole or in part by the Fund Administrator, you may appeal to the Fund's Board of Trustees by sending a letter to:

Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Fax Number: 202-318-0654
E-Mail Address: info@lnhwhf.org

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.

If you have any complaint regarding the Plan or Fund, including a denial of benefits, not covered by any other provision above, you may appeal to the Fund's Board of Trustees by sending a letter to the Fund Administrator at the address given above. Your letter should state clearly the reason(s) for your complaint and you should enclose any documents that relate to your complaint.

Your appeal or complaint will be reviewed and decided by the Board of Trustees or by the Board's Appeals Committee, ordinarily at the first meeting after it is received. Once the Board of Trustees makes a decision on the appeal or complaint, a written notice and explanation of that decision will be sent to you.

Lawsuits & Limitations

The Board of Trustees' intention is to comply in all respects with ERISA's claims and appeals procedure requirements and with the ACA's requirements relating to external review. The claims and appeals procedure will be interpreted and applied accordingly. ERISA Section 502(a) provides a cause of action to enforce the terms of the Plan and your benefit rights under the Plan. However, before filing a lawsuit regarding the denial of a benefit claim, you must have exhausted the Appeals Procedure for the type of claim you are making. This exhaustion requirement is intended to ensure that your claim is fully and fairly reviewed before a lawsuit is commenced. No lawsuit will be timely unless it is brought within 3 years after a claim is submitted to the Fund.

**LOSS OF COVERAGE UNDER THE PLAN:
COBRA TEMPORARY CONTINUATION OF COVERAGE
ON A SELF-PAY BASIS**

The following is a summary of Section 10 of the Plan Description. You should read that section for a complete description of the COBRA rules, including definitions of key terms used in this summary. 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 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".

You and, if you have Family Coverage, your Eligible Dependents can 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. COBRA continuation coverage is not automatic. You must take action to choose the coverage, and have to pay the monthly cost of the coverage to the Fund.

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

Adam M. Downs, Fund Administrator
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
Telephone: 202-737-1898 or 1-800-540-0113

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.

Eligibility for COBRA Continuation Coverage

You 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:

- > 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);
- > insufficient hours of contributions are made on your behalf (e.g. your hours of Covered Employment are reduced);
- > the end of a period of Family and Medical Leave.

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:

- > you die;
- > 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);

- > insufficient hours of contributions are made on your behalf (e.g. your hours of Covered Employment are reduced);
- > you become entitled to Medicare benefits (under Medicare Part A, Part B, or both) (see Note below); or
- > you become divorced or legally separated from your Spouse.

If you have Family Coverage, your Eligible 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:

- > you die;
- > 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);
- > insufficient hours of contributions are made on your behalf (e.g. your hours of Covered Employment are reduced);
- > you become entitled to Medicare benefits (under Medicare Part A, Part B, or both)(see Note below);
- > you become divorced or legally separated from your Eligible Spouse; or
- > the Dependent ceases to qualify as your Eligible Dependent Child under the Plan (for example: he / she loses eligibility due to age).

Note: You will not become ineligible for coverage under the Plan merely because you become eligible for Medicare coverage. If you meet the eligibility rules under the Plan, you can continue coverage under the Plan even if you become eligible for Medicare.

Required Notice to the Fund of a Qualifying Event

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. If the Fund Administrator does not receive timely notice, you and / or your Eligible Dependent(s) might lose any right to choose COBRA continuation coverage. The Fund Administrator will normally send you a COBRA notice if your contribution hours fall below the levels required for eligibility for Single or Family Coverage.

For some Qualifying Events, you are required to give notice to the Fund Administrator within 60 days. For other Qualifying Events, your Employer is required by law to give notice within 30 days.

Even though your Employer is required to notify the Fund Administrator of these Qualifying Events, you or your Eligible 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.

Choosing COBRA Continuation Coverage

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 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, an election form and an explanation of the

cost that you would have to pay to the Fund for the coverage.

If the Fund Administrator determines that you and / or your Eligible Dependents are not eligible for COBRA continuation coverage, the Fund Administrator will send to you and / or your Eligible Dependents a written explanation. If you disagree with the decision, you can appeal to the Fund's Board of Trustees under the Section 9 of the Plan Description.

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 60 days after you receive the notice of rights and election form from the Fund Administrator (or, if coverage will not be lost until later, 60 days after the actual loss of coverage).

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

You and each of your Eligible Dependents has an individual right to elect COBRA continuation coverage. You or your Eligible Spouse may elect COBRA continuation for you and all Eligible Dependents.

Types Of Coverage

The COBRA continuation coverage will keep you and / or your Eligible Dependents 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.

However, you can choose COBRA continuation coverage only for "core" benefits (medical and prescription drug) or for core benefits and "non-core" benefits (dental and vision). COBRA does not apply to "welfare benefits" such as life insurance, short term disability, accidental death and disability, and membership assistance.

Cost Of COBRA Coverage

You and / or your Eligible Dependents must pay for COBRA continuation coverage on a monthly basis. The monthly amount that you and / or your Eligible Dependents have to pay for this coverage is called the "COBRA Premium".

The Fund Administrator will notify you as to the amount of the monthly COBRA Premium (for both "core only" and "core plus non-core" coverage). In general, the COBRA Premium will be 102% of the cost of the coverage as determined by the Fund. The Board of Trustees sets COBRA Premium rates yearly, and they may increase while you have COBRA continuation coverage. COBRA Premium payments are usually due on the first day of each month. The materials sent to you by the Fund Administrator will include information on when and how to make a payment. Failure to pay the COBRA Premiums when due will result in a termination of the coverage unless payment is made during a "grace period".

Maximum Period Of COBRA Continuation Coverage

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 Dependents' eligibility. 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 under certain circumstances, including non-payment of the COBRA Premium.

Generally, the Maximum Periods are as follows:

- > If the Qualifying Event is the termination of your Covered Employment or insufficient hours of contributions, the Maximum Period is 18 months.
 - > If the Qualifying Event is your death, the Maximum Period is 36 months.
 - > If the Qualifying Event is your divorce or separation from your spouse, the Maximum Period is 36 months.
 - > If the Qualifying Event is your eligibility for Medicare, the Maximum Period is 36 months.
 - > If the Qualifying Event is your Dependent loses status as a Dependent Child, the Maximum Period is 36 months.
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DUPLICATE COVERAGE OF COVERED EXPENSES AND BENEFITS (Coordination Of Coverage & Subrogation)

Coverage Under Multiple Health Plans: Coordination Of Benefits Rules

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. Certain Coordination of Benefits ("COB") rules apply if you and/or your Eligible Dependents are covered under this Plan and another Health Plan.

The generally applicable COB rules are described in detail in the Plan Description.

Medicare

If you, your Spouse and/or your Dependent Child are covered by this Plan and by Medicare, this Plan generally pays its maximum benefit on a claim first and Medicare pays second. There may be circumstances under which the law does not require the Plan to pay first. In those circumstances, Medicare will be responsible for paying its maximum before the Plan has any responsibility to pay benefits.

The rules governing coordination with Medicare are described in detail in the Plan Description.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan pays its maximum benefits on a claim first and Medicaid pays second.

TRICARE

If you are covered by both this Plan and TRICARE, this Plan pays its maximum benefits on a claim first and TRICARE pays second.

Services Received At A Veterans Affairs Facility

No benefits are payable under the Plan for any services, treatment, supplies or equipment you receive at or from a U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury.

If you receive services, treatment, supplies or equipment at or from a U.S. Department of Veterans Affairs hospital or facility on account of any condition that is not military service-related illness or injury, benefits are payable by the Plan under the same terms and conditions that apply under the Plan.

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 must pay its maximum benefits before benefits become payable under the Plan.

Workers' Compensation Benefits

No benefits are payable under the Plan if the medical, prescription drug, dental or vision expenses are covered by workers' compensation or occupational disease laws or programs.

If your employer contests the application of workers' compensation for the illness or injury for which

expenses are incurred, the Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under workers' compensation. However, before such payment will be made, you (or your Spouse or Child, if they are the patient) must execute an agreement to reimburse the Fund that is acceptable to the Fund Administrator or its designee. Cigna will send a notice to you.

Motor Vehicle No-Fault Coverage

If you are covered by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle coverage must pay its maximum benefits before benefits become payable under the Plan.

Third Party Causes Your Injury Or Illness (Subrogation)

If your (or your Spouse or Child, if you have Family Coverage) illness or injury is caused by another person ("third party"), the Plan imposes conditions on payment of any benefits for services, treatment, supplies or equipment related to the illness or injury. In general, if the Plan pays benefits for you relating to an illness or injury caused by a third party, you are automatically deemed to agree that the Plan is entitled: (a) to reimbursement of all the benefits related to the injury or illness it paid from you if you recover money from the third party; and (b) to be subrogated to your claims and rights to recover from the third party.

These conditions are intended to protect the rights of the Fund to reimbursement for the benefits it pays in case you recover money from the third party. By protecting its rights to reimbursement if and when you recover money from the third party, the Plan is able to pay benefits for you up front when you need coverage to obtain services, treatment, supplies or equipment. Without this right to reimbursement, the Fund would exclude from coverage illness and injury caused by third parties. These conditions on benefits apply to medical, prescription drug, dental, and vision benefits as well as accidental death and dismemberment benefits and short term disability benefits.

You (or your Spouse or Child, if you have Family Coverage and he or she is the patient) may be required by the Fund Administrator or his designee to sign a written agreement with the Fund acknowledging its reimbursement and subrogation rights. If you do not sign an agreement when presented to you by the Fund Administrator or his designee, your benefits under the Plan may be suspended or withheld. The Fund's reimbursement and subrogation rights under the Plan Description apply and are enforceable even if you do not sign an agreement.

The Plan Description (Section 2) describes the Fund's reimbursement and subrogation rights, the procedures for protecting these rights, and your and your lawyer's obligations to the Fund. You and your attorney should carefully review Section 2 if you believe that your illness or injury was caused by a third party to understand the full extent of your and your lawyer's responsibilities regarding the Fund.

IMPORTANT PLAN INFORMATION AND ERISA RIGHTS

The following information about the Fund is provided in accordance with regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA):

Names, Address and Telephone Number of the Fund:

Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006
1-800-235-5805 or 1-800-540-0113

Plan Identification Number / Employer Identification Number: 52-1601994

Plan Number: 002

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 Benefit Plan 2, the following types of benefits are provided: medical, prescription drug, dental, vision, life insurance, accidental death and dismemberment, short term disability benefits, and member assistance plan benefits.

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 Fund is self-administered. The Board of Trustees has delegated responsibility for the Fund's day-to-day operations to an administrative office (the "Fund Office") that is headed by a Fund Administrator and Assistant 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, 2019:

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
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006

NOEL C. BORCK
Laborers' National Health & Welfare Fund
905 16th Street, N.W.
Washington, D.C. 20006

ROCCO DAVIS
Vice President & Regional Manager
Laborers' International Union of North America
3775 N. Freeway Blvd, Suite 110
Sacramento, CA 95834

JAMES F. GROSSO, Esq.
1661 Worcester Road, Suite 403
Framingham, Massachusetts 01701

DENNIS L. MARTIRE
Vice President & Regional Manager
Laborers' International Union of North America
11951 Freedom Drive, 13th Floor
Reston, VA 20190

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

ANTONIO RANGEL
425 Soledad, 8th Floor
San Antonio, TX 78205

Agent for Service of Process:

The Board of Trustees has designated the Fund Administrator, Adam M. Downs, as the Fund's agent for receipt of process. He is located at the Fund Office. Service of process may be made on

the Fund Administrator at the Fund Office which is located at 905 16th Street, N.W., Washington, D.C. 20006.

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.

Medical, prescription drugs, dental and vision 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 Union Labor Life Insurance Company, 1625 Eye Street, N.W., Washington, D.C. 20006, (202) 682-0900. The group policy number is C-8214.

Investments and Other Assets:

The Fund's assets are prudently invested in diversified portfolios of marketable securities managed by JPMorgan Asset Management Inc. and Vanguard. The investment managers are selected by the Board of Trustees on the recommendation of the Fund's professional investment consultant, Segal Marco Advisors. The Fund's assets are custodied by the Bank of New York Mellon.

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.

A complete list of employers that contribute under the Plan, and of unions whose members are covered by the Plan, may be obtained by participants and beneficiaries upon written request to the Fund Administrator.

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 (up to 25 cents per page or the legal maximum if less).

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.

Fiscal/Plan Year: The Fund's fiscal year and plan year is the calendar year ending on December 31st.

Obtaining Information and Answers:

Information concerning the Fund, including copies of the Summary Plan Description, 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.

In addition, the Fund maintains an Internet website at www.Inhwf.org.

Your Rights Under The Employee Retirement Income Security Act (ERISA):

As a participant in the Laborers' National Health & Welfare 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.

Continuation Group Health 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 COBRA 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.

