LABORERS' DISTRICT COUNCIL

HEAVY AND HIGHWAY CONSTRUCTION

HEALTH & WELFARE FUND

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Effective January 1, 2017

LABORERS' DISTRICT COUNCIL
HEAVY AND HIGHWAY CONSTRUCTION
HEALTH & WELFARE FUND

FUND OFFICE

665 N. Broad Street
Philadelphia, PA 19123
(215) 236-6700

BOARD OF TRUSTEES

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SECTION I

INTRODUCTION

Dear Covered Member: January 2017

This booklet contains a description of the benefits available under the Laborers' District Council Heavy and Highway Construction Health & Welfare Fund (the "Plan"). Please read the material in this booklet and keep it in a safe place for future reference. Every effort has been made to describe your benefits in easy to understand language. However, if you have any questions regarding your benefits, please call the Fund Office at (215) 236-6700, at any time during regular business hours (8 a.m. to 4 p.m.), Monday through Friday.

This booklet contains the latest changes and clarifications approved by your Board of Trustees. From time to time, when benefit changes are made, you will receive a notice of such change, to be inserted into this booklet in its proper location.

This Plan has been established on as much of a comprehensive basis as possible, consistent with sound financial policy. In most situations, your Contributing Employer is paying the cost of the coverage through negotiated contributions made to the Fund.

Sincerely,

THE BOARD OF TRUSTEES

LABORERS' DISTRICT COUNCIL
HEAVY AND HIGHWAY CONSTRUCTION
HEALTH AND WELFARE FUND

IMPORTANT NOTICE TO MEMBERS

Eligibility for benefits provided under the Plan is based on hours worked for which a Contributing Employer is required to report and pay contributions to the Fund in accordance with the Collective Bargaining Agreements. Failure on the part of a Contributing Employer to correctly report all hours worked and pay contributions can result in loss of coverage. Similarly, benefit eligibility may be adversely affected if you work for an Employer who has not signed the Collective Bargaining Agreement, even though such Employer may have reported work hours and made payment of contributions.

Remember that the benefits are provided for you and your Eligible Dependents. You are urged to take the following steps to protect your benefits:

1. Keep a personal record of the correct name and address of each Employer for whom you may work, the job name and site location.
2. Know when your pay period begins and ends. Keep a record of hours actually worked on a day by day basis. Total your hours at the end of each payroll period.
3. Keep pay check stubs, envelopes and other wage statements that may be provided to you by your Employer.
4. Periodically check with the Fund Office to determine work hours reported for you.
5. Make sure that each Employer for whom you may work has signed the Collective Bargaining Agreement. This information may be obtained from the business manager or field representatives of your local Union.

NOTICE REGARDING RETROACTIVE CANCELLATION OF COVERAGE

The Fund Administrator, in his discretion, may retroactively cancel coverage for a Member and his or her Dependents for the following reasons:

- Fraud or intentional misrepresentation of a material fact;
- Failure to timely pay premiums or required contributions; or
- Untimely notification of a divorce.

For this purpose, enrolling an ineligible individual or otherwise knowingly failing to comply with the Plan's eligibility requirements will constitute an intentional misrepresentation of fact and may trigger a retroactive termination of coverage.

If the retroactive cancellation is due to fraud or an intentional misrepresentation of a material fact, the plan will provide advance notice at least 30 days before a retroactive termination of coverage and you may appeal the termination. If coverage is retroactively terminated, the Member and/or his Dependents may be liable for any benefits paid by the Plan.

SECTION II

DEFINITIONS

DEFINITIONS

"Board of Trustees" means the board of trustees of the Laborers' District Council Heavy and Highway Construction Health and Welfare Fund.

"Bronze Benefits Package" means the medical benefits described on pages 10 and 21.

"Child/Children" means your biological or adopted child, child placed for adoption with you, stepchild or foster child through the end of the month that he or she turns 26, regardless of the child's marital, financial or student status. Children also means any child older than 25, if such child is incapable of self-sustaining employment by reason of mental or physical disability provided he or she was diagnosed prior to his or her 26th birthday; written evidence of such continued eligibility will be required and may be required to be updated on a periodic basis as determined by the Board of Trustees. Children also means any alternate recipients under a qualified medical child support order. Child does not mean grandchild, unless such child is placed for adoption or legally adopted by you.

"Collective Bargaining Agreement" means (i) the most recent agreement between the Contractors Association of Eastern Pennsylvania and the Laborers' District Council of the Metropolitan Area of Philadelphia & Vicinity, or (ii) the most recent agreement between the Greater Philadelphia Utility Contractors Association, and the Laborers' District Council of the Metropolitan Area of Philadelphia & Vicinity, Laborers' International Union of North America.

"Contributing Employer" means an Employer which is obligated by the Collective Bargaining Agreement or a related participation agreement to make contributions to the Laborers' District Council Heavy and Highway Construction Health & Welfare Fund.

"Covered Member" means a Member that meets the eligibility requirements in Section III and that has elected to participate in the Plan. All references to "you," "your" and "you're" refer to a Covered Member.

"Dependent" means your Spouse and Children.

"Eligible Dependent" means those Dependents eligible for coverage under the Plan as described on page 13 that you have elected to cover under the Plan.

"Eligibility Period" means the periods described on page 10.

"Employer" means a Member's employer.

"Fund" means the Laborers' District Council Heavy and Highway Construction Health & Welfare Fund.

"Fund Office" means the Laborers' District Council Heavy and Highway Construction Health & Welfare Fund's office, 665 N. Broad Street, Philadelphia, PA 19123, (215) 236-6700.

"Gold Benefits Package" means the medical benefits described on pages 10 and 21.

"Hours Bank" means the system established to account for hours worked, as described on pages 10-12.

"Member" means an individual whose employment is covered by one of the Collective Bargaining Agreements.

"Pension Plan" means the Laborers' District Council Construction Industry Pension Plan.

"Plan" means the plan of benefits set forth in this document.

"Fund Administrator" means Alan Parham, 665 N. Broad Street, Philadelphia, PA 19122, (215) 236-6700.

"Plan Sponsor" means the Board of Trustees.

"Retired Covered Member" means a former Covered Member that is eligible for benefits under the Plan according to Section XII.

"Silver Benefits Package" means the medical benefits described on page 11 and 21.

"Spouse" means an individual to whom you are legally married under the laws of a state or foreign jurisdiction.

"Trust Agreement" means the trust agreement between the Contractors Association of Eastern Pennsylvania and the Laborers' District Council of the Metropolitan Area of Philadelphia & Vicinity regarding the establishment and administration of the Fund.

"Union" means the Laborers' District Council of the Metropolitan Area of Philadelphia & Vicinity, Laborers' International Union of North America.

"Work Period" means the periods described on page 10.

SECTION III

ELIGIBILITY, ENROLLMENT, AND COVERAGE

WHO IS ELIGIBLE?

You are eligible for the benefits described in this booklet if your employment is covered by a Collective Bargaining Agreement, your Employer makes the required monthly contribution, and you meet the hours requirements described below.

GENERAL ELIGIBILITY REQUIREMENTS

Your eligibility for benefits generally depends on the hours that you work during the applicable Work Period. After you satisfy the applicable hourly work requirements for benefit coverage, you will be eligible to receive the applicable coverage during the following Eligibility Period. If you work more than the minimum number of required hours in a Work Period, you may accumulate excess hours in an Hours Bank for use towards future eligibility.

Work Periods	Eligibility Periods
March 1 to August 31	**November 1 to April 30**
September 1 to February 28	**May 1 to October 31**

ELIGIBILITY REQUIREMENTS FOR MEDICAL BENEFITS

The Plan provides three separate medical benefit packages (i.e., Gold, Bronze and Silver, as described below). The benefit package that applies during an Eligibility Period generally depends on the number of hours that you work during the applicable Work Period, as described below.

Gold Benefits Package

To be eligible for the Gold Benefits Package, you must complete at least 450 hours of work during the applicable Work Period. If you complete more than 300 hours, but less than 450 hours during the applicable Work Period, you will only be eligible for the Bronze Benefits Package (described below) unless you utilize hours, if any, that you deposited in your Hours Bank for Gold or Bronze Benefits, as discussed below.

Once you become eligible for the Gold Benefits Package, you will remain eligible for that benefits package until you fail to complete at least 450 hours of work during the applicable Work Period, subject to the Hours Bank for Gold or Bronze Benefits rules discussed below.

Bronze Benefits Package

To be eligible for the Bronze Benefits Package, you must complete at least 300 hours of work during the applicable Work Period. If you work less than 300 hours during the applicable Work Period you will not be eligible for the Bronze Benefits Package unless you utilize hours, if any, that you have deposited in your Hours Bank for Gold or Bronze Benefits, as discussed below. Your eligibility commences for Bronze benefits the first day of the month following accumulation of 300 or more hours within a Work Period.

Once you become eligible for the Bronze Benefits Package, you will remain eligible for such benefits package until you fail to complete at least 300 hours of work during the applicable Work Period, subject to the Hours Bank for Gold or Bronze Benefits rules discussed below.

Hours Bank Rules for Gold and Bronze Benefits

The following rules apply to the hours that are contributed to your Hours Bank after December 31, 2010. Hours that were contributed to your Hours Bank on or before December 31, 2010 are grandfathered (i.e., they will not be affected by the following rules).

1. Your Hours Bank account balance may not exceed 450 hours. For example, if your grandfathered Hours Bank account has a balance of 425 hours, you may not add more than 25 hours to your Hours Bank account after December 31, 2010. Similarly, if your grandfathered Hours Bank account has a balance of 500 hours, you may not add any additional hours to your Hours Bank account until your account falls below 450 hours.

2. You may not add hours to your Hours Bank account unless you have worked more than 450 hours during the applicable Work Period. This means that if you are eligible for the Bronze Benefits Package — because you worked more than 300 hours but less than 450 hours — you cannot add any hours to your Hours Bank account, even though you earned more than the 300 hours necessary to become eligible for the Bronze Benefits Package.

3. Hours in your Hours Bank account may be used for eligibility for either the Bronze or the Gold Benefits Package.

4. Hours in your Hours Bank account will be used to attain the highest level of eligibility.

5. You may also purchase up to 50 hours of contributions that may be used toward eligibility for either the Bronze or the Gold Benefits Package. The cost of each purchased hour will be determined by the Plan Administrator. You must purchase any such hours within forty-five days of the beginning of the Eligibility Period or the date of the notice, whichever is later.

Silver Benefits Package

To be eligible for the Silver Benefits Package, you must work under a Collective Bargaining Agreement with any of the following Contributing Employers:

- Roosevelt Memorial Park;
- Forest Hills Cemetery; or
- Any other Employer required to contribute to the Fund on behalf of a Member pursuant to a Collective Bargaining Agreement that does not cover work to be performed at the site of construction and specifying that each employee's hours of service shall be credited toward Silver Benefits only.

Hours of work for these Contributing Employers are taken into account only for purposes of the Silver Benefits Package. Such hours of work cannot be used to establish eligibility toward the Gold or Bronze Benefits Package and cannot otherwise be combined with hours of work credited toward Gold or Bronze Benefits. This means that, if your Contributing Employer contributes towards Silver Benefits on your behalf, your hours of work for such Contributing Employer are credited solely and exclusively towards Silver Benefits.

There are two tiers of Silver Benefits:

Silver Benefits — Tier 1

To be eligible for Tier 1 of the Silver Benefits Package, you must complete at least 600 hours of work during the applicable Work Period. If you complete more than 450 hours, but less than 600 hours during the applicable Work Period, you will only be eligible for Tier 2 of the Silver Benefits Package (described below), unless you utilize hours, if any, that you deposited in your Hours Bank for Silver I Benefits, as discussed below.

Once you become eligible for Tier 1 of the Silver Benefits Package, you will remain eligible for that benefits package until you fail to complete at least 600 hours of work during the applicable Work Period.

Silver Benefits — Tier 2

To be eligible for Tier 2 of the Silver Benefits Package, you must complete at least 450 hours of work during the applicable Work Period. If you work less than 450 hours during the applicable Work Period, you will not be eligible for the Tier 2 of the Silver Benefits Package.

Once you become eligible for Tier 2 of the Silver Benefits Package you will remain eligible for that benefits package until you fail to complete at least 450 hours of work during the applicable Work Period.

You may also purchase up to 50 hours of contributions, if necessary, that may be used to satisfy the 450 hours requirement. The cost of each purchased hour will be determined by the Plan Administrator. You must purchase any such hours within forty-five days of the beginning of the Eligibility Period or the date of the notice, whichever is later.

Hours Bank for Silver Benefits — Tier 1

If you are covered under Tier 1 of the Silver Benefits Package, you may accrue hours in a special Hours Bank that is available for your use due to a seasonal layoff. Such layoff must be confirmed in writing by the contributing employer.

Your Hours Bank will be credited with hours worked during a Work Period that are in excess of 600 hours, up to a maximum of 200 hours per Work Period. You may accrue up to a maximum of 450 hours in your Hours Bank. You may only use the hours in this Hours Bank for Silver I benefit eligibility in the event of a seasonal layoff. If you fail to earn at least 100 hours in two consecutive six-month Work Periods, your Hours Bank will be cancelled and may not be used for future eligibility.

You may also purchase up to 50 hours of contributions, in addition to your Hours Bank for Silver I Benefits, if necessary, that may be used to satisfy the 600 hours requirement. The cost of each purchased hour will be determined by the Plan Administrator. You must purchase any such hours within forty-five days of the beginning of the Eligibility Period or the date of the notice, whichever is later.

ELIGIBILITY REQUIREMENTS FOR OTHER BENEFITS

During any Eligibility Period for which you are eligible for any of the medical benefit packages described above, you will also be eligible for the following benefits:

Mental Health Benefits
Prescription Benefits
Dental Benefits
Vision Benefits
Short Term Disability Insurance
Life and AD&D Insurance
Custom Orthotic Benefit

All Members are eligible for mental health and substance abuse benefits regardless of eligibility for medical benefits. There are separate eligibility requirements for postretirement benefits set forth in Section XII.

SPECIAL CREDIT HOURS FOR PERIODS OF DISABILITY

A special credit of 30 hours per week up to a maximum of 30 weeks (900 maximum) is given to a Member who is otherwise eligible for benefits and who is disabled as a result of an on-the-job

injury or illness and is receiving workers' compensation benefits or who is disabled as a result of a non-occupational injury or illness and is receiving short term disability benefits through the Fund Office. The special credit applies to each week during which workers' compensation or short term disability benefits are paid. This special credit may accumulate over more than one Work Period. The special credit hours cease when either workers' compensation or short term disability benefits cease but in no case will the special credit exceed 30 weeks (900 hours) for any one injury or illness.

Documentation from the Workers' Compensation Bureau, the insurance company paying your benefit, or a letter from your Employer must be sent to the Plan stating the date of injury or illness and the length of time you were receiving workers' compensation.

You, too, are responsible to notify the Fund Office that you are receiving workers' compensation benefits, the date they begin and any date you return to work.

EXCEPTIONS TO THE RULE

Under certain conditions, or because of particular circumstances, you may remain eligible for benefits if you and/or your Contributing Employer provide proper documentation to the Plan. If you are absent from your job for one of the following reasons, the Plan will continue your eligibility: vacation, military reserve duty, jury duty or disability. The maximum amount of time allowed for each incident is 90 days. However, in those situations where incidents overlap, only one 90 day period will apply.

DEPENDENT COVERAGE

Your Eligible Dependents become eligible for medical, mental health, substance abuse, dental, vision, and prescription coverage when you first become eligible for coverage. Unless otherwise provided in "Special Enrollment Rights" below, a person who first becomes a Dependent after the Covered Member's initial eligibility will become eligible for coverage on the first day of the month following the date such individual becomes a Dependent (e.g., first day of the month following the date of marriage).

The following Dependents are eligible for medical, dental, vision, and prescription coverage under this Plan, and are otherwise referred to as Eligible Dependents:

- Your Spouse to whom you are legally married;
- Your Children up to age 26;
- Your Child age 26 and older if such Child is incapable of self-sustaining employment by reason of mental or physical disability provided he or she was diagnosed prior to his or her 26th birthday.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan may be required by law to recognize court imposed medical child support orders. The Board must honor a "qualified medical child support order" (QMCSO) which is defined as a decree or order issued by a court that obligates the Plan to continue to provide coverage and benefits to the child during the term of the order. The Fund Administrator shall determine the validity of any medical child support order they receive. Because the procedures governing QMCSOs change periodically, if you receive such an order contact the Fund Office immediately and we will provide you with a written explanation of the Plan's procedure which sets forth your rights and obligations.

ENROLLMENT

Once you become eligible under the Plan, you must enroll yourself and any Eligible Dependents in the Plan in order to be covered and receive benefits under the Plan. To enroll in the Plan you must complete an enrollment form. Enrollment forms may be obtained in person at 665 N. Broad Street, 2nd Floor, Philadelphia, PA 19123. You may also download the enrollment forms from our website: www.ldc-phila-vic.org. Go to Member Benefits, then to Benefit Forms and Downloads. You may also call the Plan at: 215-236-6700 and request that an enrollment form be mailed to you.

Your coverage will be effective as soon as administratively practicable after your enrollment materials are received by the Plan.

When you are eligible to participate in the Plan, you may enroll yourself and any Eligible Dependents at any time.

CHANGE IN YOUR ADDRESS OR FAMILY STATUS

It is important that you notify the Fund Office promptly of any change in your address or your family status — including marriage, divorce, birth or legal adoption of a child, and death of spouse or child. Enrollment and change forms should be sent directly to the Fund Office.

TERMINATION OF COVERAGE

Coverage with respect to a Covered Member shall cease automatically on the earliest of the following dates:

1. Termination of the Plan;
2. The date the Member ceases to be included in the classes of individuals eligible for coverage hereunder; and
3. The date the Member ceases to maintain eligibility as described above.

Except as set forth in Section XII regarding post-retirement benefits, upon retirement, a Member and any Eligible Dependents will remain covered under the Plan through the end of the Eligibility Period during which the retirement occurred. After this date, if a Member has enough hours in his or her Hours Bank to qualify for coverage during an additional Eligibility Period, such hours may be used and coverage for the Member and any Eligible Dependents will not terminate until the end of such additional Eligibility Period.

Coverage for Eligible Dependents will cease automatically on the date that they fail to qualify as an Eligible Dependent as described herein. Dependents shall not be eligible for benefits provided by this Plan if or when the person on whom they are dependent fails or ceases to qualify as a Covered Member. However, if the Covered Member dies, his or her otherwise Eligible Dependents will continue to be eligible until the end of the Eligibility Period in which the death occurs. After this date, if the deceased Member has enough hours in his or her Hours Bank to qualify for coverage during an additional Eligibility Period, such hours may be used and coverage for the Eligible Dependents will not terminate until the end of such additional Eligibility Period.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. COBRA only applies to those portions of the Plan that qualify as group health plan benefits (the medical, dental, vision, and prescription benefits) and not to any other benefits offered under the Plan. The Plan provides no greater COBRA rights than what COBRA requires — nothing in this booklet is intended to expand your rights beyond COBRA's requirements.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and your Eligible Dependents when group health coverage would otherwise end.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your Eligible Dependents could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're a Covered Member, you'll become a qualified beneficiary if you lose your group health coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the Spouse of a Covered Member, you'll become a qualified beneficiary if you lose your group health coverage under the Plan because of the following qualifying events:

- Your spouse-Covered Member dies;
- Your spouse-Covered Member's hours of employment are reduced;
- Your spouse-Covered Member's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse-Covered Member. Also, if your spouse-Covered Member reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then you may become a qualified beneficiary even though your coverage was reduced or eliminated before the divorce or separation.

Your Children will become qualified beneficiaries if they lose group health coverage under the Plan because of the following qualifying events:

- The parent-Covered Member dies;
- The parent-Covered Member's hours of employment are reduced;
- The parent-Covered Member's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- Your Child stops being eligible for coverage under the Plan as a Child (e.g., becomes older than 25).

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. The Employer must notify the Fund Office of the following qualifying events:

- The end of employment or reduction of hours of employment; or
- Death of the Covered Member.

You must give notice of certain qualifying events

For the other qualifying events (divorce or legal separation of the Covered Member and Spouse, or a Child losing eligibility for coverage as a Child), a COBRA election will be available to you only if you notify the Fund Office in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

No COBRA election will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the Fund Office during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Information Required for Qualifying Event Notices

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Plan that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Plan that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

How is COBRA continuation coverage provided?

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary is eligible for the level of coverage (e.g., Gold, Silver, or Bronze) that such qualified beneficiary maintained in the Plan immediately prior to the qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Members may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Fund Office within the time period described in your COBRA election notice, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of the Covered Member's termination of employment or reduction in hours. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences certain others qualifying events during the 18 months of COBRA continuation coverage, the Spouse and Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Fund Office is properly notified about the second qualifying event. This extension may be available to the Spouse and any Children getting COBRA continuation coverage if the Member or former Member dies; gets divorced or legally separated; or if the Child stops being eligible under the Plan as a Child. This extension is only available if the second qualifying event would have caused the Spouse or Child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Administrator, who can be contacted at 665 N. Broad Street, Philadelphia, PA 19123 and can also be reached by telephone at (215) 236-6700, ext. 1101. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Fund Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Administrator.

COBRA Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written

Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. Notices must be in writing.

How, When, and Where to Send Notices

You must send your notice to:

Laborers District Council Benefits Fund
Lockbox #7616
Philadelphia, PA 19178-7616

Information Required for All Notices

In addition to any specific information listed above, any notice you provide must include (1) the name of the Plan (Laborers' District Council Heavy and Highway Construction Health and Welfare Fund); (2) the name and address of the Member who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Who May Provide Notices

The Member or former Member who is or was covered under the Plan, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Effective January 1, 1998, group health plans may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not generally prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). The Plan is governed by this federal law.

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 ("USERRA")

USERRA protects the benefits for anyone who leaves an employee position to perform training or service in the armed forces on or after December 12, 1994. For the first 31 days of absence, the Member must be treated like any other Covered Member. After 31 days, such Member may continue coverage for a period up to 24 months by paying 102% of the full premium under the Plan. Upon reemployment after military service, USERRA requires that coverage will be reinstated upon reemployment without having to satisfy any waiting period.

GENETIC INFORMATION NONDISCRIMINATION ACT ("GINA")

Effective January 1, 2010, GINA prohibits the Plan from improperly discriminating on the basis of genetic information. Genetic information includes the results from genetic testing of a Covered Member or family members, or information regarding the manifestation of a disease or disorder in Covered Members or members of their families (family history). Genetic information cannot be used as a basis for raising premiums or co-pays.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998 (the "WHCR Act"). Under the WHCR Act, group health plans that provide coverage for mastectomies must also cover reconstructive surgery and prostheses for mastectomy patients. The WHCR Act requires that a member receiving benefits for a medically necessary mastectomy may also be eligible to receive benefits for:

- Surgical reconstruction of the breast on which the mastectomy has been performed;
- Surgical reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications, including lymphedemas, associated with all stages of the mastectomy procedure.

The coverage will be provided in consultation with the attending physician and the patient, and is subject to the same annual deductibles and coinsurances provisions that apply to the mastectomy itself.

HIPAA SPECIAL ENROLLMENT

Because the Plan provides that an eligible Member may enroll himself and any Eligible Dependents at any time, if you decline enrollment for yourself or your Eligible Dependents because of other health insurance coverage, you may enroll yourself or your Eligible Dependents in this Plan if that coverage is lost. In addition, if you have a new Eligible Dependent as a result of marriage, birth adoption or placement for adoption, you may enroll yourself and your Eligible dependents at any time and coverage will be effective as soon as practicable after the enrollment materials are received by the Plan. However, if you have a new Eligible Dependent as a result of birth, adoption or placement for adoption, and you request enrollment of that new Eligible Dependent within 30 days of the birth, adoption or placement for adoption, that Eligible Dependent's coverage will be retroactive to the date of the birth, adoption or placement for adoption.

SECTION IV
MEDICAL BENEFITS

MEDICAL BENEFITS

This Section IV provides a summary of the medical benefits offered under the Plan. For more detailed information regarding the specific medical benefits that you are eligible for or enrolled in (including important exclusions), please contact the Fund Administrator.

If the terms of the Independence Blue Cross booklet conflict with the terms of this Plan document, the terms of the Independence Blue Cross booklet will control.

MEDICAL BENEFITS SUMMARY
Independence Blue Cross
Personal Choice/Keystone
1901 Market Street
Philadelphia, PA 19103-1480
Personal Choice/Keystone: 1-800-ASK-BLUE
Keystone 65 Customer Service: 1-800-645-3965

Schedule of Benefits — Benefit Period January 1 through December 31

(Deductibles, Coinsurance and Out-of-Pocket Maximums are based on the Benefit Period)

POS AND HMO PLANS — You Must Select a PCP and Obtain Referrals for Certain Services

Covered Benefits and Services	Gold		Silver		Bronze and Silver II
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible					
Individual	$0	$500	$0	$500	$0
Family	$0	$1,500	$0	$1,500	$0
Out-of-Pocket Maximum*					
Individual	$2,000	$3,000	$2,000	$3,000	$2,000
Family	$4,000	$9,000	$4,000	$9,000	$4,000
Lifetime Maximum	None	None	None	None	None
Doctor's Office					
Primary Care Services	$10 copay	70%, after deductible	$15 copay	70%, after deductible	$15 copay
Specialist Services	$20 copay	70%, after deductible	$30 copay	70%, after deductible	$30 copay
Preventive Care for Adults & Children	100%	70%, NO deductible	100%	70%, NO deductible	100%

Covered Benefits and Services	Gold		Silver		Bronze and Silver II
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pediatric Immunizations	100%	70%, NO deductible	100%	70%, NO deductible	100%
Routine GYN Exam/ PAP (1 per year)	100%	70%, NO deductible	100%	70%, NO deductible	100%
Mammogram	100%	70%, NO deductible	100%	70%, NO deductible	100%
Nutrition Counseling for Weight Management (6 visits per year)	100%	70%, after deductible	100%	70%, after deductible	100%
Outpatient Laboratory/ Pathology	100%	70%, after deductible	100%	70%, after deductible	100%
Maternity					
First OB Visit	$10 copay	70%, after deductible	$15 copay	70%, after deductible	$15 copay
Hospital	$150/ day; max 5 copays/ admission	70%, after deductible	$150/ day; max 5 copays/ admission	70%, after deductible	$150/ day; max 5 copays/ admission
Inpatient Hospital Services					
Facility	$150/ day; max 5 copays/ admission	70%, after deductible	$150/ day; max 5 copays/ admission	70%, after deductible	$150/ day; max 5 copays/ admission
Physician/ Surgeon	100%	70%, after deductible	100%	70%, after deductible	100%
Inpatient Hospital Days	Unlimited	70	Unlimited	70	Unlimited
Outpatient Surgery					
Facility	$50 copay	70%, after deductible	$50 copay	70%, after deductible	90%
Physician/ Surgeon	100%	70%, after deductible	100%	70%, after deductible	100%

Covered Benefits and Services	Gold		Silver		Bronze and Silver II
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Emergency Room (copay NOT waived if admitted)	$125 copay	$125 copay, no deductible	$125 copay	$125 copay, no deductible	$125 copay
Urgent Care Center	$50 copay	70%, after deductible	$50 copay	70%, after deductible	$50 copay
Ambulance Services					
Emergency	100%	100%, no deductible	100%	100%, no deductible	100%
Non-emergency	100%	70%, after deductible	100%	70%, after deductible	100%
Outpatient X-ray/ Radiology					
Routine Radiology/ Diagnostic	$20 copay	70%, after deductible	$30 copay	70%, after deductible	$50 copay
MRI/MRA, CT/ CTA Scan, PET Scan	$40 copay	70%, after deductible	$60 copay	70%, after deductible	$100 copay
Allergy Injections	100%	70%, after deductible	100%	70%, after deductible	100%
Therapy Services					
Physical and Occupational Therapy (30 visits per year)	$20 copay	70%, after deductible	$30 copay	70%, after deductible	$40 copay
Cardiac Rehab (36 visits per year)	$20 copay	70%, after deductible	$30 copay	70%, after deductible	$40 copay
Pulmonary Rehab (36 visits per year)	$20 copay	70%, after deductible	$30 copay	70%, after deductible	$40 copay
Speech (20 visits per year)	$20 copay	70%, after deductible	$30 copay	70%, after deductible	$40 copay
Orthoptic/Pleoptic (8 sessions/lifetime max)	$20 copay	70%, after deductible	$30 copay	70%, after deductible	$40 copay
Spinal Manipulations (20 visits per year)	$20 copay	70%, after deductible	$30 copay	70%, after deductible	$40 copay

Covered Benefits and Services	Gold		Silver		Bronze and Silver II
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Injectable Medications					
Standard	100%	70%, after deductible	100%	70%, after deductible	100%
Biotech/Specialty	$50 copay	70%, after deductible	$75 copay	70%, after deductible	$75 copay
Chemo/Radiation/ Dialysis	100%	70%, after deductible	100%	70%, after deductible	90%
Outpatient Private Duty Nursing (360 hrs per year)	85%	70%, after deductible	85%	70%, after deductible	85%
Skilled Nursing Facility (120 days per year)	$75/day; max 5 copays/ admission	70%, after deductible	$75/day; max 5 copays/ admission	70%, after deductible	$75/day; max 5 copays/ admission
Hospice and Home Health Care	100%	70%, after deductible	100%	70%, after deductible	100%
Durable Medical Equipment	50%	50%, after deductible	50%	50%, after deductible	90%
Prosthetics	50%	50%, after deductible	50%	50%, after deductible	90%

* The out-of-pocket maximum includes payments toward deductibles, coinsurance, and copayments for in-network covered **medical services and mental health/substance abuse services,** but it does not include any payments above the allowed amount for a specific provider, the amount for any services not covered, or payments towards other types of benefits under the Plan (e.g., dental, prescription, visions, etc.). **The Prescription Benefits have a separate out of pocket maximum.** Please see below for an example of how the family out-of-pocket maximum works:

A family of four has family coverage. For all services that are obtained in-network, each member of the family is subject to the $2,000 individual out-of-pocket maximum, until the out-of-pocket expenses incurred by all covered family members reaches the $4,000 family out-of-pocket maximum.

One family member becomes ill. Through payment of coinsurance and copayments, that family member pays $2,000 for in-network expenses in a benefit period. That family member has met his individual in-network out-of-pocket maximum and any additional in-network coverage for that individual for the remainder of the benefit period will be paid at 100%.

During the same benefit period, another family member requires expensive durable medical equipment. That family member pays $1,500 for in-network coinsurance for that equipment.

A third family requires medical benefits. Once the third family member pays $500 in in-network copayments and coinsurance, the remainder of any in-network coverage for that family will be paid at 100% with no copayments because the 3 family members have together reached the family's in-network out-of-pocket maximum for the year ($2,000 + $1,500 + $500).

In addition, if the fourth family member receives any in-network medical benefits during the same benefit period, those benefits will be covered at 100%.

In summary, $2,000 is the most that an individual family member will need to pay for in-network coverage during a benefit period, and $4,000 is the most that the entire family will need to pay for in-network coverage during a benefit period.

Please keep in mind that there is also an out-of-pocket maximum for out-of-network coverage that accrues separately.

For additional coverage information, regarding the specific medical benefits that you are eligible for or enrolled in (including important exclusions), please contact the Fund Administrator.

SECTION V

PRESCRIPTION BENEFITS

PRESCRIPTION BENEFITS

Express Scripts, Inc. (ESI)
One Express Way
829 Academy Place
St. Louis, MO 63121
(800) 467-2006
https://starthomedelivery.com or Download ESI's mobile app

Schedule of Benefits — Benefit Period January 1 through December 31

Covered Benefits	Gold		Silver I		Bronze and Silver II	
	Retail	Home Delivery*	Retail	Home Delivery*	Retail	Home Delivery*
GENERIC	$5.00	$10.00	$10.00	$20.00	$25.00	$50.00
FORMULARY BRAND	$15.00	$30.00	$25.00	$50.00	—	—
NON-FORMULARY BRAND	$30.00	$60.00	$50.00	$100.00	—	—
BRAND					$40.00	$80.00
Annual Maximum Out-of-Pocket**						
Individual	$2,000		$2,000		$2,000	
Family	$4,000		$4,000		$4,000	

The above copayments will apply to any prescription benefits up to $5,000 annually per family. Once the Plan has paid $5,000 in prescription benefits for a family, additional prescription benefits are subject to 50% coinsurance, up to that individual's or that family's out-of-pocket maximum listed above. See below for an example.

* Unless otherwise specified, home delivery of maintenance medications through the Express Scripts EHD program will be filled with a three-month supply. Instead of three co-pay amounts for a three-month supply, a Covered Member will pay two co-pay amounts for a three-month supply.

** The prescription out-of-pocket maximum is separate from the medical/mental health/substance abuse out-of-pocket maximum. Please see the summary of the medical benefits for an example of how an out-of-pocket maximum works with family coverage.

HOW THE PRESCRIPTION PLAN WORKS

All Covered Members receive an Express Scripts (ESI) prescription card. Two cards per family are issued; however, an additional card may be ordered. At the time the prescription is to be filled, you must present your card to your pharmacist. Remember, the card may be used only by Covered Members or Eligible Dependents. Unauthorized or fraudulent use of your card to obtain prescription drugs results in immediate cancellation of your coverage under the Plan and may result in retroactive cancellation of coverage. The pharmacist will complete the prescription and the Covered Member will be required to pay whatever co-pay applies to the prescription and sign the appropriate form.

The copayments listed above will apply to any prescription drug benefits up to $5,000 annually per individual or per family, whichever is applicable. Once the Plan has paid $5,000 in prescription benefits for an individual or for a family, additional prescription benefits are subject to 50% coinsurance, up to that individual's or that family's out-of-pocket maximum. The following is an example of the prescription drug cost-sharing:

A Covered Member has Gold individual coverage. That Covered Member is prescribed a non-formulary drug that costs $1,030 a month. Over the course of a year, the payment for the drug will break down as follows:

January: Plan pays $1,000, Covered Member pays $30.

February: Plan pays $1,000, Covered Member pays $30.

March: Plan pays $1,000, Covered Member pays $30.

April: Plan pays $1,000, Covered Member pays $30.

May: Plan pays $1,000, Covered Member pays $30.

June: Plan has paid $5,000 in benefits, so a 50% coinsurance will apply. Plan pays $515, Covered Member pays $515.

July: Plan pays $515, Covered Member pays $515.

August: Plan pays $515, Covered Member pays $515.

September: Covered member only pays $305 because he has hit his out-of-pocket maximum of $2,000 for the year. Plan pays the remaining $725.

October: Plan pays $1,030.

November: Plan pays $1,030.

December: Plan pays $1,030.

COVERED PRESCRIPTION DRUG EXPENSES

Benefits are payable for any F.D.A. approved generic drug or, in the absence of a generic equivalent, you may obtain a brand name drug. However, you will be responsible for the additional cost. Insulin and oral anti-diabetic agents are covered. Needles, syringes, test strips, lancets, and glaucomatous are also covered.

The following are covered items due to the Affordable Care Act, also known as Health Care Reform:

(a) **Contraceptives —** Generic Rx and Generic OTC.

(b) **Aspirin —** Generic OTC. Males age 45-79; Females age 55-79.

(c) **Fluoride —** Generic Rx and Generic OTC (when available). Children 6 months through age of 5 years.

(d) **Folic Acid —** Generic Rx and Generic OTC (when available). Females through age 50.

(e) **Iron Supplements —** Generic Rx and Generic OTC Only. Children 6 months through age of 12 months.

(f) **Smoking Cessation Products —** Generic Rx and Generic OTC only, plus brand Chantix. Adults to 18 years old.

(g) **Bowel Preparation Agents —** Generic Rx and Generic OTC. Adults 50-75.

(h) **Vitamin D —** Generic Rx and Generic OTC. To age 65.

PRESCRIPTION DRUG EXPENSES NOT COVERED

The following items are not covered:

(a) Vitamins (except as listed above), minerals, dietary supplements;

(b) Any medications (except as listed above) which can be legally purchased over-the-counter without a prescription, even if prescribed by a physician; and

(c) Appliances, injectables, and immunological (vaccines) agents.

To obtain a full formulary, please contact:

Express Scripts
3684 Marshall Lane
Bensalem, PA 19020
800-467-2006

EXCLUSIVE HOME DELIVERY AND MAINTENANCE MEDICATION

A maintenance medication is a prescribed drug that treats an ongoing condition, such as diabetes or high blood pressure. Under the Home Delivery program, you may receive two refills of up to a 30-day supply of a maintenance medication from a local, participating pharmacy. After that, you will need to order these prescriptions through the Exclusive Home Delivery program from the Express Scripts Pharmacy or pay the FULL cost of the prescription if you choose to have it filled at your local, participating pharmacy.

How this Helps You

By using the Express Scripts Pharmacy, you'll save money on your copayments. Plus, you'll receive:

- Free home delivery of your medication.
- Up to a 90-day supply of medication with each order.
- 24-hour access to an Express Scripts pharmacist.

Short-term prescriptions, such as antibiotics, can still be filled at your local, participating pharmacy.

Three Easy Ways to Get Started

By Mail — Complete a Home Delivery order form and select your payment option. Mail the form, along with your prescription, to Express Scripts.

By Internet — Access **https://www.starthomedelivery.com**. Complete the requested information and Express Scripts will contact your doctor for a new prescription for Home Delivery.

By Phone — Call 1.866.841.5482 and speak with an Express Scripts patient care advocate who will help you get started with Home Delivery.

The first time you fill a prescription through the Express Scripts pharmacy, you should expect delivery of your order within two weeks from the time Express Scripts receives the prescription from your doctor. **It is recommended that you have a 30-day supply of your medication on hand at the time of your order. Refills typically take three to five days to process and ship.**

GENERICS PREFERRED

Generic drugs are copies of brand-name drugs whose patents have expired. A generic drug contains the same active ingredients and is available in the same strengths as the original brand-name drug. They are chemically equivalent to their non-generic drug counterpart. Any prescribed generic drug has been approved by the U.S. Food and Drug Administration (FDA) and meets strict requirements for quality and purity.

How this Helps You

Generic drugs cost about half the cost of brand-name drugs to product. The savings are passed on to you, in the form of a lower co-payment.

How Does the Generics Preferred Program Work?

When you have a prescription filled, the pharmacy will check to see if a generic is available.

- If a generic is available, you will pay the standard co-payment for a generic drug. This cost will be less than for a brand-name drug.
- If, instead, you choose the brand-name medication, you will pay your co-payment plus the difference in cost between the generic and the brand-name drug.

When a generic drug is available, the pharmacy will be required to fill a prescription with the generic drug, unless otherwise determined by the member's doctor.

STEP THERAPY

The Step Therapy Process

Step 1 medications are the first recommended to you. They are usually generics and you will pay the lowest co-payment for these drugs.

Step 2 medications are brand-name and are recommended if a Step 1 medication does not work for you. Step 2 drugs will almost always be more expensive.

Step 3 medications are the most expensive brand-name drugs. If the Step or Step 2 medications do not work for you, you may then be prescribed the higher cost Step 3 drug.

When your doctor prescribes a new medication, always ask if you can first try a Step 1 medication. If the Step 1 drug does not work for you, or if your doctor decides a Step 2 or Step 3 medication would be better, the member should contact Express Scripts to inquire about prior authorization.

How this Helps You

The Step Therapy program is about value. For people who have certain medication needs — arthritis, high blood pressure, and high cholesterol, for example. Step Therapy means receiving a medication that is proven safe and effective, at the lowest possible cost.

SECTION VI

VISION BENEFITS

VISION BENEFITS

National Vision Administrators, LLC (NVA)
P.O. Box 2187, Clifton, NJ 07015
(800) 672-7723 or www.e-nva.com

Schedule of Benefits — Benefit Period Rolling 12 or 24 Months

Covered Benefits	Gold		Silver I		Bronze and Silver II	
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
EXAMINATION Under 19 Once Every 12 Months; 19 & Over Once Every 24 Months	Covered 100%	Reimbursed Amount Up to $30	Covered 100%	Reimbursed Amount Up to $30	Covered 100%	Reimbursed Amount Up to $30
LENSES Under 19 Once Every 12 Months; 19 & Over Once Every 24 Months	Standard Glass or Plastic	Reimbursed Amount	Standard Glass or Plastic	Reimbursed Amount	Standard Glass or Plastic	Reimbursed Amount
Single Vision	Covered 100%	Up to $20	Covered 100%	Up to $20	Covered 100%	Up to $20
Bifocal	Covered 100%	Up to $30		Up to $30		Up to $30
Trifocal	Covered 100%	Up to $40		Up to $40		Up to $40
Lenticular	Covered 100%	Up to $80		Up to $80		Up to $80
Standard Scratch Coating	Covered 100%	Up to $12		Up to $12		Up to $12
LENS OPTIONS	Purchased from an NVA Par Provider, see fixed pricing on NVA Summary of Benefits	N/A	Purchased from an NVA Par Provider, see fixed pricing on NVA Summary of Benefits	N/A	Purchased from an NVA Par Provider, see fixed pricing on NVA Summary of Benefits	N/A
FRAME Under 19 Once Every 12 Months; 19 & Over Once Every 24 Month	Wholesale allowance up to $50	Reimbursed Amount Up to $50	Wholesale allowance up to $50	Reimbursed Amount Up to $50	Wholesale allowance up to $50	Reimbursed Amount Up to $50

Covered Benefits	Gold		Silver I		Bronze and Silver II	
	In-Network (Participating Providers)	**Out-of-Network (Non-Participating Providers)**	**In-Network (Participating Providers)**	**Out-of-Network (Non-Participating Providers)**	**In-Network (Participating Providers)**	**Out-of-Network (Non-Participating Providers)**
CONTACT LENSES Under 19 Once Every 12 Months; 19 & Over Once Every 24 Months	In Lieu of lenses and frame					
Elective	Up to $60 Retail allowance including exam	Up to $60	Up to $60 Retail allowance including exam	Up to $60	Up to $60 Retail allowance including exam	Up to $60
Medically Necessary*	Up to $150 including exam	Up to $150	Up to $150 including exam	Up to $150	Up to $150 including exam	Up to $150
LOW VISION AIDS* Under 19 Once Every 12 Months; 19 & Over Once Every 24 Months	Covered 100%	Up to $150	Covered 100%	Up to $150	Covered 100%	Up to $150

* Pre-approval from NVA required.

HOW THE VISION PLAN WORKS

This vision plan covers the benefits described above (examination, professional services, lenses and an allowance towards the wholesale cost of a frame). Benefits are provided on a rolling 12 or 24 month period, depending on the benefit. Any additional care, services and/or materials not covered by this Plan may be arranged between you and the doctor.

Medically necessary contact lenses are fully covered when the participating provider secures prior approval. An allowance of up to $60.00 is made towards the cost of contacts if they are not medically required (i.e., the covered individual would like contacts instead of glasses), including the vision exam, in lieu of all other benefits for the benefit period. The benefit is limited to contact lenses or frames and lenses once in a 24 month period.

Your vision plan includes the services of ophthalmologists, optometrists and opticians. Contact the Fund Office for a list of the participating providers in your area or go to the NVA website — https://www.e-nva.com. You may then choose one of the following three options to obtain vision care:

IN-NETWORK PROVIDER

Select a doctor from the list of plan approved participating providers and notify them that your coverage is administered by NVA and provided by the Plan. When you make an appointment, the provider will verify your vision care eligibility.

When you see the provider, present your NVA identification card. No claim forms are required.

Payment for all covered services rendered will be made directly from NVA.

OUT-OF-NETWORK PROVIDER

If you choose to see an optometrist, ophthalmologist or dispensing optician who is not a participating provider, you will be responsible for one hundred percent (100%) of the cost at the time of service.

Make an appointment and receive the necessary services from the provider. Pay the provider his/her full fee and obtain an itemized dated receipt which must contain the following information: patient's name, Covered Member's name, and social security number, or the patient's name and a photocopy of the Covered Member's ID. Mail this to NVA at the following address:

National Vision Administration
A Division of National Prescription Administrators
P.O. Box 2187
Clifton, NJ 07015

You will then be reimbursed directly according to the Schedule of Benefits, provided in this section, for the covered services and materials you received.

OUT-OF-NETWORK EXAM/IN-NETWORK FRAMES & LENSES

After receiving an examination from the non-participating provider, you will be responsible for one hundred percent (100%) of the cost at the time of service.

Call one of the participating providers who is willing to fill another doctor's prescription and make an appointment to have your prescription filled.

Present your NVA card, your prescription and receipt for your examination to the participating provider on your first visit.

The participating provider will fit you with your new glasses/contacts and take care of any further paperwork for payment.

You will be reimbursed directly according to the non-participating provider reimbursement Schedule for your exam and the participating provider will be paid for dispensing your glasses/contacts by NVA.

SECTION VII

DENTAL BENEFITS

DENTAL BENEFITS

Fidelio Insurance Company
2826 Mount Carmel Avenue, Glenside, PA 19038
(215) 885-2443, (800) 262-4949 outside of (215) area between 08:30 and 5:00 PM (M-F)
www.fideliodental.com for a list of In-Network Providers

Schedule of Benefits — Benefit Year January 1 through December 31

Covered Benefits	Gold		Silver I		Bronze and Silver II
	In-Network (Participating Dentists)	Out-of-Network (Non-Participating Dentists)	In-Network (Participating Dentists)	Out-of-Network (Non-Participating Dentists)	In-Network (Participating Dentists) No Benefits if Dentist is Out-of-Network
DEDUCTIBLE — Annual	N/A	N/A	$50 Individual/ $150 Family	$50 Individual/ $150 Family	N/A
COINSURANCE — Pediatric dental services above $1,000*	20%	20%	20%	20%	N/A
ANNUAL BENEFIT MAXIMUM*	$1,000 Individual $3,000 Family	$1,000 Individual $3,000 Family	$1,000 Individual $3,000 Family	$1,000 Individual $3,000 Family	1 Exam of any type and one cleaning per person (up to plan allowance) per 6 month period within the benefit year (Jan-Jun and Jul-Dec)
DIAGNOSTIC SERVICES	100%	100%	100%	100%	
PREVENTIVE SERVICES	100%	100%	100%	100%	
BASIC RESTORATIVE SERVICES	100%	100%	100%	100%	N/A
ORAL SURGERY	100%	100%	100%	100%	N/A
PROSTHODONTICS (BRIDGES, DENTURES)	100% 5 Yr Limit	100% 5 Yr Limit	80% 5 Yr Limit	80% 5 Yr Limit	N/A
RESTORATIONS (CAPS AND CROWNS)	100% 5 Yr Limit	100% 5 Yr Limit	80% 5 Yr Limit	80% 5 Yr Limit	N/A
PERIODONTICS	100%	100%	100%	100%	N/A
ENDODONTICS	100%	100%	100%	100%	N/A
ORTHODONTICS**	100%	100%	100%	100%	N/A

* Annual maximum unlimited for pediatric dental benefits that must be covered under the Affordable Care Act. There will be a 20% coinsurance required by Eligible Dependents for amounts in excess of $1,000 for the allowable pediatric dental costs per plan year. Otherwise, the current annual individual maximum of $1,000 per individual and $3,000 per family remain unchanged. Any pediatric dental benefits required to be covered under the Affordable Care Act will not count towards the annual family maximum.

** Eligible dependents under the age of 19, have a lifetime orthodontic benefit of $3,200 In-Network and $2,500 for Out-of-Network. Benefits above these amounts are ONLY available if medically necessary; however, benefits paid exceeding $1,000 have a coinsurance of 20% that must be paid by the patient. All orthodontic benefits for adolescents under the age of 19 are not applied to the yearly family maximum. For individuals 19 or over, there is a maximum lifetime orthodontics benefit of $2,400 for both in or out-of-network Providers. Invisalign is not a covered benefit.

GENERAL INFORMATION

Your dental plan provides excellent benefits. A participating dentist will generally accept the amount that is paid by the Plan as payment in full up to the annual benefit maximums, except that Silver I Covered Members and Eligible Dependents will have a 20% coinsurance portion for Prosthodontics (Bridges & Dentures) and Restorations (Crowns and Caps), and there is a 20% coinsurance for pediatric dental over a certain limit. A non-participating dentist may charge an additional fee.

You are entitled to payment up to the maximum allowed by the Plan for all covered services you receive from a dentist provided that the services are considered dentally necessary.

HOW TO USE YOUR DENTAL PLAN

The dental benefits are administered by Fidelio Insurance Company, 2826 Mount Carmel Avenue, Glenside, PA 19038. To maximize your benefit, select an in-network dentist. You can find an in-network dentist by calling Fidelio Insurance Company between the hours of 9:00 a.m. to 5:00 p.m. For local area codes (215) and (610) call (215) 885-2443. For all other callers, call (800) 262-4949. You may also visit the Fidelio website at **www.fideliodental.com** or call their automated 24 hour hotline at (215) 885-2453 or outside the (215) and (610) area code call (800) 929-0340. You may choose an "Out-of-Network" dentist; however, you may be subject to additional charges or balance billing.

DENTAL PLAN LIMITATIONS/EXCLUSIONS

Anesthesia is limited to dental services only when medically necessary and administered in conjunction with oral surgery and if the anesthesia agent produces a state of unconsciousness.

Services not covered are those that do not have uniform professional endorsement as identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature.

DENTAL PLAN TERMINOLOGY

Diagnostic	Procedures necessary to evaluate existing conditions and required dental care including visits, exams, diagnosis and x-rays.
Preventive	Prophylaxis (cleaning), fluoride treatments (to age 19) and space maintainers.
Restorative	Basic Restorative — amalgam and composite fillings.
	Major Restorative — inlays, onlays, crowns are a benefit where above materials are not adequate.
Oral Surgery	Extraction and oral surgery procedures, including pre- and post-operative care. General anesthesia is covered when used in conjunction with covered oral surgical procedures (see plan limitations).
Endodontics	Procedures for pulpal therapy and root canal filling.
Periodontics	Treatment to the gums and supporting structure of the teeth.
Prosthodontics	Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures. Denture repair and relining under prosthodontics are available as separate benefits if required.

Orthodontics Procedures for straightening teeth. See above for limitations for Covered Members and Eligible Dependents based on age.

FIDELIO FEE SCHEDULE

Fidelio pays all claims from in-network and out-of-network providers on the basis of Fidelio's UCR (Usual, Customary, and Reasonable) fee schedule. In-network providers accept Fidelio's UCR as payment in full for services provided. Out-of-network providers may balance bill the member for the difference between their regular fees and Fidelio's UCR. Fidelio mails to ALL members a copy of the Explanation of Benefits (EOB) which clearly shows the dentists' regular charge, Fidelio's UCR, benefits being paid by the Plan, and any patient balance (if any).

SECTION VIII

EMPLOYEE ASSISTANCE PROGRAM, MENTAL HEALTH AND SUBSTANCE ABUSE

EMPLOYEE ASSISTANCE PROGRAM, MENTAL HEALTH AND SUBSTANCE ABUSE

ALLIED TRADE ASSISTANCE PROGRAM (ATAP)
2791 Southampton Road, Suite 100
Philadelphia, PA 19154
(800) 258-6376 OR (215) 677-8820

Schedule of Benefits — Benefit Period January 1 through December 31

Covered Benefits	Gold		Silver I		Bronze and Silver II
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)	In-Network (Participating Providers)
DEDUCTIBLE — Combined with Medical/Surgical	$0	$500/ Individual $1,500/ Family	$0	$500/ Individual $1,500/ Family	$0
LIFETIME MAXIMUM	None	None	None	None	None
Annual Out-of-Pocket Maximum — Combined with Medical/Surgical (includes deductible, copays and coinsurance) **Individual** **Family**	 $2,000 $4,000	 $3,000 $9,000	 $2,000 $4,000	 $3,000 $9,000	 $2,000 $4,000
COINSURANCE	None	70% of allowance, after deductible	None	70% of allowance, after deductible	None
COPAYS — OFFICE VISITS	$20 Copay	70% of allowance, after deductible	$30 Copay	70% of allowance, after deductible	$30 Copay
INPATIENT HOSPITAL (Waived for 1st admission but applied to subsequent admission in a 12 month period)	$150 copay/ day up to five copays	70% of allowance, after deductible	$150 copay/ day up to five copays	70% of allowance, after deductible	$150 copay/ day up to five copays

Covered Benefits	Gold		Silver I		Bronze and Silver II
	In-Network (Participating Providers)	**Out-of-Network (Non-Participating Providers)**	**In-Network (Participating Providers)**	**Out-of-Network (Non-Participating Providers)**	**In-Network (Participating Providers)**
INPATIENT HOSPITAL DAYS	Unlimited	70 days combined for all out-of-network in-patient medical, maternity, mental health, substance abuse and detox services.	Unlimited	70 days combined for all out-of-network in-patient medical, maternity, mental health, substance abuse and detox services.	Unlimited
PSYCHIATRIC — PARTIAL DAY FACILITY CHARGES If a member is step down from an in-patient unit as a part of a continuum of care plan into a partial hospitalization program with no initial hospital admission, then the copay will be applied.	$50 copay If a member is step down from an in-patient unit as a part of a continuum of care plan into a partial hospitalization program with no initial hospital admission, then the copay will be applied.	70% of allowance, after deductible If a member is step down from an in-patient unit as a part of a continuum of care plan into a partial hospitalization program with no initial hospital admission, then the copay will be applied.	$50 copay If a member is step down from an in-patient unit as a part of a continuum of care plan into a partial hospitalization program with no initial hospital admission, then the copay will be applied.	70% of allowance, after deductible If a member is step down from an in-patient unit as a part of a continuum of care plan into a partial hospitalization program with no initial hospital admission, then the copay will be applied.	$50 copay If a member is step down from an in-patient unit as a part of a continuum of care plan into a partial hospitalization program, then the copay will be waived. If the member goes into a partial program without the initial hospitalization admission, then the copay will be applied.

Covered Benefits	Gold		Silver I		Bronze and Silver II
	In-Network (Participating Providers) w/ATAP Approval	**Out-of-Network (Non-Participating Providers)**	**In-Network (Participating Providers) w/ATAP Approval**	**Out-of-Network (Non-Participating Providers)**	**In-Network (Participating Providers) w/ATAP Approval**
PSYCHIATRIC ROOM AND BOARD FACILITY CHARGES	$150 copay/ day, max five copays	70% of allowance, after deductible	$150 copay/ day, max five copays	70% of allowance, after deductible	$150 copay/ day, max five copays (waived for the 1st admission but applied to subsequent admission within 12 month period)
PSYCHIATRIC FACILITY — MISC FACILITY CHARGES	Included in Room and Board Facility Charges	70% of allowance, after deductible	Included in Room and Board Facility Charges	70% of allowance, after deductible	Included in Room and Board Facility Charges
PSYCHIATRIC FACILITY — OUTPATIENT	$50 copay	70% of allowance, after deductible	$50 copay	70% of allowance, after deductible	$50 copay
PSYCHIATRIC TESTING — PROFESSIONAL CHARGES	Outpatient $20 Inpatient included in Room and Board Facility Charges	70% of allowance, after deductible	Outpatient $30 Inpatient included in Room and Board Facility Charges	70% of allowance, after deductible	Outpatient $30 Inpatient included in Room and Board Facility Charges
PSYCHOTHERAPY Inpatient Professional Charges **Outpatient Professional Charges**	Included in Room and Board Facility Charges $20 copay	70% of allowance, after deductible	Included in Room and Board Facility Charges $30 copay	70% of allowance, after deductible	Included in Room and Board Facility Charges $30 copay
SUBSTANCE ROOM AND BOARD FACILITY CHARGES	$150 copay/ day Max five copays	70% of allowance, after deductible	$150 copay/ day Max five copays	70% of allowance, after deductible	$150 copay/day Max five copays (waived for the 1st admission but applied to subsequent admission within 12 month period)

Covered Benefits	Gold		Silver I		Bronze and Silver II
	In-Network (Participating Providers) w/ATAP Approval	Out-of-Network (Non-Participating Providers)	In-Network (Participating Providers) w/ATAP Approval	Out-of-Network (Non-Participating Providers)	In-Network (Participating Providers) w/ATAP Approval
SUBSTANCE ABUSE — Inpatient Physician Visit	Included in Room and Board Facility Charges	70% of allowance, after deductible	Included in Room and Board Facility Charges	70% of allowance, after deductible	Included in Room and Board Facility Charges
SUBSTANCE ABUSE — Outpatient Physician Visit	$20 copay	70% of allowance, after deductible	$30 copay	70% of allowance, after deductible	$30 copay (Therapist or Certified Addiction Counselor Visits Only)
SUBSTANCE ABUSE — Partial Day Facility Charges	$50 copay	70% of allowance, after deductible	$50 copay	70% of allowance, after deductible	$30 copay If a member is step down from an in-patient unit as a part of a continuum of care plan into a partial hospitalization program, then the copay will be waived. If the member goes into a partial program without the initial hospitalization admission, then the copay will be applied
SUBSTANCE DETOX — Inpatient Facility Charges	$150 copay/ day Max five copays	70% of allowance, after deductible	$150 copay/ day Max five copays	70% of allowance, after deductible	$150 copay/ day Max five copays (waived for the 1st admission but applied to subsequent admission within 12 month period)

Covered Benefits	Gold		Silver I		Bronze and Silver II
	In-Network (Participating Providers) w/ATAP Approval	Out-of-Network (Non-Participating Providers)	In-Network (Participating Providers) w/ATAP Approval	Out-of-Network (Non-Participating Providers)	In-Network (Participating Providers) w/ATAP Approval
SUBSTANCE ABUSE HOSPITAL MISC FACILITY CHARGES	Included in Room and Board Facility Charges	70% of allowance, after deductible	Included in Room and Board Facility Charges	70% of allowance, after deductible	Included in Room and Board Facility Charges
SUBSTANCE ABUSE — Outpatient Facility Charges	$50 copay	70% of allowance, after deductible	$50 copay	70% of allowance, after deductible	$30 copay
PHARMACOLOGICAL MANAGEMENT — Inpatient Physician Charges	Included in Room and Board Facility Charges	70% of allowance, after deductible	Included in Room and Board Facility Charges	70% of allowance, after deductible	Included in Room and Board Facility Charges

GENERAL INFORMATION

The employee assistance program (EAP) is a counseling, information, and referral service that helps you address personal problems on a confidential basis. Benefits are provided through the Allied Trades Assistance Program (ATAP).

As a Member of a subscribing Organization, both you and your eligible dependents may use these services at any time. If you are eligible for welfare benefits, coverage for the EAP is automatic; there is no need to enroll.

HOW THE PLAN WORKS

ATAP provides toll-free access to information, intervention and triage 24 hours a day with a trained counselor. When you call a trained counselor, they will take as much time as you need and work with you to assess the situation. If appropriate, they will schedule a face to face session with a professional counselor.

In addition to your EAP, inpatient and outpatient mental health and substance abuse services are also available through ATAP. If you've contacted the EAP, and further treatment is clinically appropriate, an ATAP counselor will help assist you to locate an in-network provider that best meets your clinical needs.

COVERED BENEFITS

- Inpatient psychiatric hospital services, except when provided in a state mental health hospital
- Inpatient drug and alcohol detoxification
- Psychiatric partial hospitalization services
- Inpatient drug and alcohol rehabilitation
- Non-hospital residential detoxification and rehabilitation for drug and alcohol abuse or dependence

- Psychiatric outpatient clinic, licensed psychologist and psychiatrist services
- Mental health residential treatment services for children and adolescents (accredited and non-accredited)
- Outpatient drug and alcohol services, including partial and intensive outpatient services
- Crisis intervention services (telephone and mobile with in-home capability)
- Family-based mental health services for children and adolescents
- Targeted mental health case management (intensive care management, resource coordination, blended case management)
- Certified peer support services
- Functional Family Therapy
- Drug and Alcohol Intensive Case Management
- Crisis Residential Services
- Adult Residential Treatment
- Stress Management
- Work-life Issues
- Aftercare Programs
- Family Codependency Programs

The following are excluded from coverage as mental health and substance abuse benefits provided through ATAP, however, they may be covered under other plan benefits, such as medical or prescription drug. Please see those sections for more information.

Exclusions:

- Psychological testing
- ADD/ADHD testing
- Neuropsychological testing
- Neuropsychological treatment of any kind
- Outpatient methadone or suboxone maintenance programs/medication dispersion
- Ambulatory services
- Drug testing
- Prescription coverage
- Autism screening
- Autism treatment including most commonly used treatment codes:
    - H0032: mental health service plan development (15 minutes)
    - H2014: skills training and development (15 minutes)
    - H2019: therapeutic behavioral services (15 minutes)

SECTION IX

SUMMARY OF LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT, AND SHORT TERM DISABILITY BENEFITS

SUMMARY OF LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT, AND SHORT TERM DISABILITY BENEFITS

This Section IX provides a summary of the life insurance, accidental death and dismemberment and the short term disability benefits offered under the Plan. For more detailed information regarding the benefits that you are eligible for or enrolled in (including important exclusions), please see Appendix B — Union Labor Life Insurance Company contract, which is incorporated by reference.

If the terms of the insurance contract conflict with the terms of this Plan document, the terms of the insurance contract will control.

UNION LABOR LIFE INSURANCE COMPANY
8403 Colesville Road
Silver Spring, MD 20910
For Life Insurance and A&D, call 1-215-236-6700
For Short Term Disability, call 1-800-431-5425

Schedule of Benefits

Covered Benefits COVERED MEMBERS ONLY	Gold	Silver I	Bronze and Silver II
LIFE INSURANCE	$25,000	$25,000	$25,000
ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE	$25,000	$25,000	$25,000
ACCIDENT AND ILLNESS (Short Term Disability)	$500	$500	$500
Maximum Weekly Benefit Waiting Period			
Due to Injury	None	None	None
Due to Illness	7 Days	7 Days	7 Days
Maximum Benefit Period (Per Disability)	30 weeks	30 weeks	30 weeks

BENEFICIARY

The beneficiary shall be the person or persons designated by you, the Covered Member, on the census enrollment card, which is furnished by the Fund Office. A Covered Member may change his beneficiary, at any time, without the beneficiary's consent by contacting the Fund Office and completing a Change of Beneficiary Form. The change will become effective as of the date a signed request and/or Change of Beneficiary Form is received at the Fund Office.

LIFE INSURANCE

MEMBER DEATH BENEFIT

Life Insurance benefits are payable as a result of the death of a Covered Member from any cause. The death benefit, in the amount shown in the Schedule of Benefits, will be paid to the Beneficiary last designated by the Covered Member.

DEPENDENT DEATH BENEFIT

Upon receipt of the necessary proof of death of a Covered Dependent and the completion of the required claim form, furnished by the Fund Office, a death benefit will be payable to the Covered Person. The amount of this death benefit will be equal to the amount shown in the Schedule of Benefits.

SCHEDULE OF BENEFITS	Gold	Silver I	Bronze and Silver II
COVERAGE	**BENEFIT**		
Spouse	$6,000	$6,000	$6,000
Children			
14 days but less than 1 year	$1,200	$1,200	$1,200
1 year but less than 5 years	$2,400	$2,400	$2,400
5 years but less than 26 years	$3,600	$3,600	$3,600

CONVERSION PRIVILEGE

If a Covered Member's life insurance benefits, or any portion thereof, is terminated due to any of the events listed below, he or she is entitled to convert all or a portion of the amount of insurance which has been terminated. This conversion will be to an individual policy of life insurance ("Conversion Policy"). The individual will not be required to submit evidence of insurability to convert.

(1) Loss of eligibility.

(2) Termination of employment.

(3) Termination of policy.

(4) Amendment of the policy which terminates the life insurance on any class of insureds.

This notice of the right to convert is in satisfaction of any and all statutory requirements. Nevertheless, the Plan shall attempt to notify an individual of his or her right to convert. Generally, under state law, if notice is not given by the 16th day of the 31-day conversion period ("Conversion Period"), the individual will have an additional period in which to convert. The additional period will expire 15 days from the date he or she is notified, but in no event will the right to convert be extended more than 90 days beyond the date the individual's insurance terminated under this Policy. Written notice presented to the individual, or mailed to his or her last known address, shall constitute notice for purpose of this provision.

In no event are the individual's life insurance benefits extended beyond the end of the 31-day Conversion Period, whether or not notice is given.

To qualify for a Conversion Policy, an individual must submit a written application to The Union Labor Life Insurance Co. (contact information listed above) and pay the first premium due within 31 days from the date his or her life insurance benefit terminates under this policy or the end of any additional period, but such period shall not extend, under any circumstances, beyond the 91 day period described above.

The premium rates for the Conversion Policy will be The Union Labor Life Insurance Co. premium rates in effect for the amount and type of policy elected and based on the individual's call of risk and attained age (age nearest birthday at the date of issue of the Conversion Policy) on the effective date of the Conversion Policy.

The individual life insurance Conversion Policy will take effect at the end of the thirty-one day period provided the premium has been paid before the end of such period.

ACCIDENTAL DEATH AND DISMEMBERMENT

HOW BENEFITS BECOME PAYABLE

Upon receipt of due proof of loss, accidental death and dismemberment benefits will be paid if:

1. A Covered Member, while insured under this benefit, suffers an accidental injury; and
2. As the direct result of the accident, and independent of all other causes, the Covered Member:
   a. suffers a Covered Loss (defined below) other than death, within 90 days after the accident; or
   b. dies at any time after the accident.

A **"Covered Loss"** means permanent loss of:

a. Life;

b. A hand, by complete severance at or above the wrist joint;

c. A foot, by complete severance at or above the ankle joint; or

d. An eye, involving irrecoverable and complete loss of sight in the eye;

except as excluded under the provision titled Exclusions under this section, and subject to all the terms and conditions of the insurance contract. The amount of benefit to be paid for a Covered Loss is determined as follows:

SCHEDULE OF LOSSES

FOR LOSS OF:	**THE BENEFIT IS:**	
• Life	The Principal Sum	Listed in Schedule above
• Two Hands	The Principal Sum	Listed in Schedule above
• Two Feet	The Principal Sum	Listed in Schedule above
• Sight of Two Eyes	The Principal Sum	Listed in Schedule above
• One Hand and One Foot	The Principal Sum	Listed in Schedule above
• One Hand and Sight of One Eye	The Principal Sum	Listed in Schedule above
• One Foot and Sight of One Eye	The Principal Sum	Listed in Schedule above
• One Hand or One Foot	One-Half the Principal Sum	Listed in Schedule above
• Sight of One Eye	One-Half the Principal Sum	Listed in Schedule above

If the Covered Member suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

EXCLUSIONS

No benefits will be paid for any loss that is caused directly or indirectly, or in whole or in part by any of the following:

(1) bodily or mental illness or disease of any kind;

(2) Ptomaines, or bacterial infections (except infection caused by pyogenic organisms which occur with and through an accidental cut or wound);

(3) suicide or attempted suicide;

(4) intentional self-inflicted injury;

(5) participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion;

(6) war or act of war, declared or undeclared; or any act related to war, or insurrection;

(7) service in the armed forces of any country while such country is engaged in war; or

(8) police duty as a member of any military, navel or air organization.

SHORT TERM DISABILITY INCOME (LOSS OF TIME) BENEFITS

For claims, call 1-888-855-4261

SCHEDULE OF BENEFITS

Weekly Benefit	**Maximum $500 per week**
Waiting Period for Disability Benefits:	
Due to Injury	**None**
Due to Illness	**7 Days**
Maximum Benefit Period (Per Disability)	**30 Weeks**

A short term disability benefit will be paid upon receipt of proof that a Covered Member becomes Totally and Continually Disabled (as defined below) as a result of an accidental injury or an illness.

DEFINITIONS

"Totally and Continually Disabled" means the person, as a result of a covered injury or illness, is prevented from performing all of the material and substantial duties of his or her employment. The person must be under the regular care of a physician acting within the scope of his or her license.

"Elimination Period" means the period of time from the onset of a disability, due to an accident and/or sickness, to the time that benefit payments commence. If the disability is the result of an accident, there is no elimination period, the benefits will commence immediately. If the disability is the result of an illness, the elimination period is 7 days from the onset of disability.

CONCURRENT DISABILITIES

Weekly benefits will be payable for an injury or for an illness, but not for both, nor for more than one injury or illness at any one time.

RECURRENT DISABILITIES

Separate periods of disability due to the same cause or causes are considered as the same period of disability. A new period of disability begins:

(1) after the Covered Member has returned to active work for a period of at least two continuous weeks if the disability is due to the same cause or causes as the previous disability; or

(2) after the Covered Member has returned to active work on a full-time basis for one full day and the new disability is due to a cause or causes entirely unrelated to any previous disability.

LIMITATIONS

No disability income benefits will be payable for any period of disability during which a Covered Member is not under the direct care of a physician. No disability will be considered as beginning more than three days prior to the first visit made to or by a physician.

NOTE

Social Security and Federal Income Tax Withholding

The first six months of disability income benefit payments are subject to withholding of social security and Federal Income Tax. The amount withheld will be credited to your social security and income tax account by the Federal government. At the end of the year, you will be supplied with the necessary government forms to be used with your tax records.

SECTION X

CUSTOM ORTHOTIC BENEFITS

CUSTOM ORTHOTIC BENEFITS

Pro Support Systems, Inc. (PSS)
327 Montgomery Avenue
Bala Cynwyd, PA 19004
www.prosupportsystems.com (click LDC logo) or call
PSS Customer Service at (610) 664-0848 or (800) 262-FEET (3338)

Schedule of Benefits — Benefit Period Rolling 24-months
Must use a PPS In-Network Podiatrist

Covered Benefits	Gold		Silver I		Bronze and Silver II	
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
• Initial Examination • Prescription for Orthotics (if medically necessary) • Casting for Orthotics • Custom Foot Orthotics	$40 co-pay	N/A	$40 co-pay	N/A	$40 co-pay	N/A

* This co-pay does not apply to your annual out-of-pocket maximum for any other benefit. There is no deductible under this benefit.

This custom orthotic benefit is available once every 24 months and covers the benefits described above (examination, professional services, and custom foot orthotics) for Covered Members only (not their Eligible Dependents), as long as the services are rendered by a PPS Preferred Provider Network (PPN).

WHAT IS A CUSTOM ORTHOTIC?

Custom orthotics are insert liners for the boot or shoe. They are provided by foot specialists, podiatrists. A casted fitting of an individual foot molding by the specialist, along with an examination, allows for the custom orthotic laboratory to fabricate a personalized pair of devices for each patient. They are designed to balance and control foot and lower extremity function and reduce progressive deformity. When left untreated, this could result in painful injury or require corrective surgery.

HOW THE CUSTOM ORTHOTIC BENEFIT PLAN WORKS

Each Covered Member will be entitled to an examination by a PSS podiatrist and upon an examination, if medically necessary, a prescription for and manufacture of one pair of custom molded orthotics shall be provided once each period of twenty-four (24) months.

To obtain your custom molded orthotics, go to the PSS website www.Prosupportsystems.com and click on the LDC Logo or call Pro Support Systems office (610) 664-0848 or (800) 262-FEET (3338) for help in finding a participating provider.

If you need to see a podiatrist other than for custom orthotic benefits, please see your medical benefits.

SECTION XI

MEDICAL BENEFIT COVERAGE FOR ACTIVE COVERED PERSONS AND COVERED SPOUSES AGE 65 AND OLDER

MEDICAL BENEFIT COVERAGE FOR ACTIVE COVERED PERSONS AND COVERED SPOUSES AGE 65 AND OLDER

The Plan must provide the same coverage to active Covered Members and their Spouses age 65 and older as it does to Covered Members under age 65. In other words, the Plan is "Primary" (pays first) for your covered health care bills and Medicare is "Secondary." This means that the Plan, rather than Medicare, will be paying the majority of your health care bills until you lose eligibility for benefits provided by this Plan.

As long as you are covered by this Plan as an active employee, regardless of your age, and you have hospitalization expenses, Medicare will only pay for the portion of the basic hospital bill that you would otherwise have to pay directly. Because of the limits on what Medicare pays, it may not always reimburse you in full for those out-of-pocket expenses.

If you are enrolled in Medicare Part B (premium payment is required), Medicare will generally pay the deductible that you otherwise have to meet for doctors' services, as well as that part of the doctor bill that this Plan does not pay, because its coverage is limited to a specific dollar amount of the doctor's reasonable charge. Neither this Plan nor Medicare will pay for charges above what this Plan considers to be reasonable. If you drop your Part B Medicare coverage, Medicare will not pick up any portion of the Part B expense that this Plan does not pay.

If an item is covered by both this Plan and Medicare, this Plan will pay first and Medicare may fill in any remaining charge as long as you remain eligible under both this Plan and Medicare. It is likely that there are some items covered by this Plan that Medicare does not insure, and that Medicare covers some services that this Plan does not.

If you have any questions regarding this matter or if you require assistance, please contact the Fund Office.

SECTION XII

POSTRETIREMENT BENEFITS

POSTRETIREMENT BENEFITS

Effective May 1, 2015

ELIGIBILITY REQUIREMENTS FOR POSTRETIREMENT BENEFITS

You will be eligible for Pensioner (Postretirement) benefits, as described in this booklet, if you retire from active employment at or after age 65 and are receiving a pension under the Laborers' District Council Heavy and Highway Pension Plan.

Pensioner

An active participant (Covered Person) enrolled in the Laborers' District Council Heavy and Highway Welfare Plan who has terminated Covered Employment on or after attaining age 65 and who retires and is receiving a retirement benefit under the Laborers' District Council Heavy and Highway Pension Fund is eligible for Postretirement Benefits. Such Pensioner must also have been approved by the appropriate Governmental agency for Medicare benefits (see **"Important Notice"** below).

Upon receipt of due proof at the Fund Office that a Covered Person has fulfilled all of the foregoing requirements, he shall then qualify as a Covered Pensioner and be eligible to receive the Pre-65 Postretirement Benefits described in this section.

Effective Date of Coverage

You will become covered for Postretirement Benefits as of the first day of the month following the month that proof of eligibility for such benefits has been received at the Fund Office.

Dependent Spouse of Pensioner

In order for the Dependent Spouse of a Pensioner to become covered by the Plan's Postretirement Group Medicare Advantage Program, such Spouse must be Medicare Eligible, either at age 65 or Medicare Eligible due to Social Security Disability. The Spouse must also be a resident of the United States and also approved by the appropriate Governmental agency as eligible to receive Medicare benefits (see **"Important Notice"** below).

Dependent Spouse, as used herein, shall mean "an Individual who is lawfully married to the Pensioner and who resides with such Pensioner."

Upon receipt of due proof at the Fund Office that the Dependent Spouse of a Pensioner has fulfilled all of the foregoing requirements, such Spouse shall be eligible to receive the Postretirement Benefits described in this section.

Effective Date of Spouse's Coverage

The Spouse of a Pensioner will become covered for Postretirement Benefits as of the first day of the month following the month that proof of eligibility for such benefits has been received at the Fund Office.

In the event that the Dependent Spouse does not meet the specified age requirement at the time of the Pensioner's retirement or marries the Pensioner subsequent to his retirement, then, in such event, coverage shall become effective on the first day of the month following the month of Medicare eligibility, either at age 65 or due to Social Security Disability and upon approval for Medicare benefits by the appropriate Governmental agency, or, if later, the first day of the month following the date of marriage.

IMPORTANT NOTICE

Since the benefits provided by the Plan's Pensioners' Group Medicare Advantage Program add to, but do not replace, the benefits provided by Medicare, it is essential that you and your Spouse enroll in Medicare, including the voluntary Supplementary Medical Insurance provided under Part B of Medicare. Otherwise, there will be a serious gap in your protection against hospital and medical expenses.

In case the current normal retirement age of 65, which is applicable in determining eligibility for Medicare Benefits, becomes changed as a result of the Social Security Act being amended, such amended normal retirement age bearing on Medicare eligibility, as may be established, shall supersede the normal retirement age with respect to eligibility for Postretirement Benefits applied herein.

Change in Family Status

Prompt written notice of any change in your family status, such as marriage, divorce or death of your spouse, if you are a Pensioner, should be sent to the Fund Office.

When sending this notice, be sure to include your full name and Social Security Number.

TERMINATION OF POSTRETIREMENT BENEFIT COVERAGES

A Pensioners' benefit coverage shall be terminated by an act of the Board of Trustees or upon the death of the Pensioner.

A Pensioners' Spouse's benefit coverage shall be terminated as follows:

(1) By action of the Board of Trustees;

(2) As of the date that the Pensioner ceases to be eligible;

(3) As of the date that such individual ceases to be the Spouse of the Pensioner;

(4) As of the last day of the month in which the death of the Pensioner occurs; or

(5) Upon the death of the Spouse.

POST-RETIREMENT
BENEFITS SUMMARY
Aetna Medicare Plan (PPO)
www.aetnaretireeplans.com
Customer Service 1-855-660-1810
P.O. Box 14088
Lexington, KY 40512-4088

Schedule of Benefits — Benefit Period January 1 through December 31

(Deductibles, Coinsurance and Out-of-Pocket Maximums are based on the Benefit Period)

	In-Network/Out-of-Network Combined (You will pay more out-of-pocket with Out-of-Network Providers)
Deductible	**$147 (2016, subject to change annually)**
Out-of-Pocket Maximum	**$1,500 (2016, subject to change annually)**
Lifetime Maximum	**None**
PREVENTIVE CARE	
Annual Wellness Exams (One exam every 12 months)	**Covered 100%**
Routine Physical Exam (One exam every 12 months)	**Covered 100%**
Medicare Covered Immunizations (Pneumococcal, Flu, Hep B)	**Covered 100%**
Routine GYN Care (Cervical and Vaginal Cancer Screenings) (One routine GYN visit and pap smear every 24 months)	**Covered 100%**
Routine Mammograms (Breast Cancer Screenings)	**Covered 100%**
Routine Prostate Cancer Screening Exam (For covered males age 50 and over every 12 months)	**Covered 100%**
Routine Colorectal Cancer Screening (For all members age 50 and over)	**Covered 100%**
Routine Bone Mass Measurement (One exam every 24 months)	**Covered 100%**
Additional Medicare Preventive Services (See Aetna Medicare Advantage Plan Booklet under Appendix C)	**Covered 100%**
Routine Hearing Screening (One exam every 12 months)	**Covered 100%**
PHYSICIAN SERVICES	
Primary Care Physician Visits — includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	**Covered 100%**
Physician Specialist Visits	**Covered 100%**
Allergy Testing	**Covered 100%**

	In-Network/Out-of-Network Combined (You will pay more out-of-pocket with Out-of-Network Providers)
DIAGNOSTIC PROCEDURES	
Outpatient Diagnostic Laboratory	**Covered 100%**
Outpatient Diagnostic X-ray	**Covered 100%**
Outpatient Diagnostic Testing	**Covered 100%**
Outpatient Complex Imaging	**Covered 100%**
EMERGENCY MEDICAL CARE	
Urgently Needed Care	**Covered 100%**
Emergency Care; Worldwide (waived if admitted)	**Covered 100%**
Ambulance Services	**Covered 100%**
HOSPITAL CARE	
Inpatient Hospital Care — The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	**Covered 100%**
Outpatient Surgery	**Covered 100%**
MENTAL HEALTH SERVICES	
Inpatient Mental Health Care — The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	**Covered 100%**
Outpatient Mental Health Care	**Covered 100%**
ALCOHOL/DRUG ABUSE SERVICES	
Inpatient Substance Abuse (Detox and Rehab) — The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	**Covered 100%**
Outpatient Substance Abuse (Detox and Rehab)	**Covered 100%**
OTHER SERVICES	
Skilled Nursing Facility (SNF) Care — Limited to 100 days per Medicare benefit period. The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	**Covered 100%**
Home Health Agency Care	**Covered 100%**
Hospice Care	**Covered by Medicare at a Medicare certified hospice**
Outpatient Rehabilitation Services — Speech, physical and occupational therapy)	**Covered 100%**
Cardiac Rehabilitation Services	**Covered 100%**
Chiropractic Services — For manipulation of the spine to the extent covered by Medicare.	**Covered 100%**
Durable Medical Equipment/Prosthetic Devices	**Covered 100%**
Podiatry Services — Limited to Medicare covered benefits only.	**Covered 100%**
Diabetic Supplies	**Covered 100%**

	In-Network/Out-of-Network Combined (You will pay more out-of-pocket with Out-of-Network Providers)
Outpatient Dialysis Treatments	**Covered 100%**
Medicare Part B Prescription Drugs	**Covered 100%**
ADDITIONAL NON-MEDICARE COVERED SERVICES	
Healthy Lifestyle Coaching — One phone call per week	**Included**
PHARMACY — PRESCRIPTION DRUG BENEFITS	
Pharmacy Network	**Group Standard Network**
Formulary — Your cost for generic drugs is usually lower than your cost for brand drugs.	**Managed Standard (Three Tier)**
Initial Coverage Limit (ICL) — The Initial Coverage Limit includes the applicable plan deductible. Until covered Medicare Prescription Drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied), cost-sharing is as follows: **RETAIL** **Member Cost-Sharing up to the Initial Coverage Limit** Up to a one month (30 day) supply at indicated copay or coinsurance. Three month (90 day) supply available at retail. When you obtain a 90 day supply at retail, you pay your Mail Order cost share. **MAIL ORDER — AETNA Rx Home Delivery** **Member Cost-Sharing up to the Initial Coverage Limit** Up to a three month (90 day) supply available via Aetna preferred vendor, Aetna Rx Home Delivery.	$3,310 (2016) Covered Medicare Prescription Drug Expenditure **Member pays $5 copay for Tier 1 Generic** **Member pays $15 copay for Tier 2 Preferred Brand** (includes some high-cost generic and preferred brand drugs) **Member pays $30 copay for Tier 3 Non-Preferred Brand** (includes high cost non-preferred generic and non-preferred brand drugs) **Member pays $10 copay for Tier 1 Generic** **Member pays $30 copay for Tier 2 Preferred Brand** (includes some high-cost generic and preferred brand drugs) **Member pays $60 copay for Tier 3 Non-Preferred Brand** (includes high cost non-preferred generic and non-preferred brand drugs)

	In-Network/Out-of-Network Combined (You will pay more out-of-pocket with Out-of-Network Providers)
Coverage Gap** Once covered Medicare Prescription Drug expenses have reach the Initial Coverage Limit, the Coverage Gap begins. Member cost sharing under the plan between the Initial Coverage Limit and until $4,850 (2016) in true out-of-pocket costs for Covered Part D drugs is incurred as follows: **RETAIL** **Member Cost-Sharing during Coverage Gap**** Up to a one month (30 day) supply at indicated copay or coinsurance. Three month (90 day) supply available at retail. When you obtain a 90 day supply at retail, you pay your Mail Order cost share. **MAIL ORDER — AETNA Rx Home Delivery** **Member Cost-Sharing during Coverage Gap**** Up to a three month (90 day) supply available via Aetna preferred vendor, Aetna Rx Home Delivery.	**Member pays $5 copay for Tier 1 Generic** **Member pays $15 copay for Tier 2 Preferred Brand** (includes some high-cost generic and preferred brand drugs) **Member pays $30 copay for Tier 3 Non-Preferred Brand** (includes high cost non-preferred generic and non-preferred brand drugs) **Member pays $10 copay for Tier 1 Generic** **Member pays $30 copay for Tier 2 Preferred Brand** (includes some high-cost generic and preferred brand drugs) **Member pays $60 copay for Tier 3 Non-Preferred Brand** (includes high cost non-preferred generic and non-preferred brand drugs)
CATASTROPHIC COVERAGE **Catastrophic Coverage benefits start once $4,850 in true out-of-pocket costs is incurred.**	Greater of $2.95 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of $7.40 or 5% for all other covered drugs.
REQUIREMENTS: **Precertification — Yes** **Therapy — Yes**	

For updated detailed coverage information, refer to the 2016 Aetna Medicare Advantage Plan Booklet located in Appendix C in the back of this Summary Plan Description.

All benefits are subject to annual changes. Updated copies are available through the Fund Office at 215-236-6700.

PENSIONERS' VISION PLAN

Eligible Pensioners and their Eligible Spouses, as previously defined, are insured under the Fund's Vision Plan. The benefits provided are the same as those previously described in the Vision Plan Section of this Booklet, Section VI.

SECTION XIII

CLAIM REVIEW PROCEDURES

CLAIM REVIEW PROCEDURES

Claims Procedures General Information

The following chart provides the contact information for the claims administrator responsible for deciding claims and appeals for the separate benefits under the Plan. For certain benefits, the Plan Administrator has contracted with a third party to be the claims administrator.

To make a claim or file an appeal for benefits identified as having claims and appeals procedures described in booklets or certifications of insurance, follow the procedures set forth in the benefits booklet or the certificate of insurance for the applicable benefit.

Claims procedures for benefits identified as subject to these procedures are set forth below. If a benefits booklet or certificate of insurance does not identify procedures for claims and appeals, follow the procedures set forth below for the particular type of benefit.

For all claims under the Plan, you must go through the Plan's internal claims and appeals procedures before you can bring a case to court. Read these procedures carefully, as there are timeframes that must be met or you will lose your right.

Benefit	Claims Administrators	Claims and Appeals Procedure
Medical	Independence Blue Cross Personal Choice/Keystone 1901 Market Street Philadelphia, PA 19103-1480 1-800-ASK-BLUE Keystone 65 Customer Service: 1-800-645-3965	See the Independence Blue Cross/Keystone Health Plan Claims and Appeals Procedures for PPO Plans and for DPOS/HMO plans in Appendix A.
Prescription Drug	Express Scripts One Express Way St. Louis, MO 63121 1-800-467-2006	See the procedures set forth herein
Dental	Fidelio Insurance Company 2826 Mount Carmel Avenue Glenside, PA 19038 215-885-2443	See the procedures set forth herein
Vision	Claims: National Vision Administrators P.O. Box 2187 Clifton, NJ 07015 1-800-672-7723 Appeals: Fund Administrator Laborers' District Council Heavy and Highway Construction Health and Welfare Fund 665 N. Broad Street Philadelphia, PA 19123 215-236-6700	See the procedures set forth herein

Benefit	Claims Administrators	Claims and Appeals Procedure
Mental Health/Substance Abuse	Claims: Alicare 333 Westchester Avenue White Plains, NY 10604 1-800-220-5261 Appeals: Fund Administrator Laborers' District Council Heavy and Highway Construction Health and Welfare Fund 665 N. Broad Street Philadelphia, PA 19123 215-236-6700	See the procedures set forth herein
Life, AD&D	The Union Labor Life Insurance 8403 Colesville Road Silver Spring, MD 20910 1-800-431-5425 Please contact the Fund Administrator prior to submitting a claim.	See the insurance contract at Appendix C
Short Term Disability	The Union Labor Life Insurance 8403 Colesville Road Silver Spring, MD 20910 1-800-431-5425	See the procedures set forth herein
Pro Support Orthotics	Claims: Alicare 333 Westchester Avenue White Plains, NY 10604 1-800-220-5261 Appeals: Fund Administrator Laborers' District Council Heavy and Highway Construction Health and Welfare Fund 665 N. Broad Street Philadelphia, PA 19123 215-236-6700	See the procedures set forth herein

Benefit	Claims Administrators	Claims and Appeals Procedure
Medicare (C04) ESA PPO Plan — Medical	Claims: Aetna Medicare P.O. Box 14088 Lexington, KY 40512-4088 1-855-660-1810 Appeals: Aetna Medicare Grievance/ Appeal Unit P.O. Box 14067 Lexington, KY 40512 1-800-932-2159	See the Aetna Group Medicare booklet, Appendix C.
Medicare (C04) ESA PPO Plan — Prescription	Coverage Decisions: Pharmacy Management Precertification Unit 300 Highway 169 South, Suite 500 Minneapolis, MN 55426 1-800-414-2386 Expedited Appeals Only: Aetna Medicare Pharmacy Grievance/Appeal Unit P.O. Box 14579 Lexington, KY 40512 1-877-235-3755	See the Aetna Group Medicare booklet, Appendix C. See the Aetna Group Medicare booklet, Appendix C.

Appeals Relating to Eligibility

You may submit an appeal of an eligibility determination to the Plan within 180 days following receipt of notice that you are not eligible for or enrolled in the Plan. Such appeal must be made in writing and sent by U.S. mail to:

Fund Administrator
Laborers' District Council
Heavy and Highway Construction Health and Welfare Fund
665 N. Broad Street
Philadelphia, PA 19123

The Plan will provide you with notice of its eligibility determination on review not later than 60 days after receipt of your appeal. This time period may be extended for an additional 60 days in certain cases.

Claims and Appeals for Prescription Drug Benefits, Mental Health/Substance Abuse Benefits, and Custom Orthotic Benefits

Definitions

For purposes of these claims procedures, the following definitions apply:

Adverse Benefit Determination: A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit. Such adverse benefit determination may be based on:

- Your eligibility for coverage;
- The results of any utilization review activities;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not medically necessary.

An adverse benefit determination includes a rescission of coverage, which is generally a cancellation of coverage or discontinuance of coverage that has a retroactive effect, unless attributable to a failure to timely pay required premiums or contributions to the cost of coverage. This applies regardless of whether the rescission has an adverse effect on any particular benefit at the time.

Appeal: A written request to reconsider an adverse benefit determination.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-Service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received, but is not an "Urgent Care Claim."

Post-Service Claim: Any claim that is not a "Pre-Service Claim" or an "Urgent Care Claim."

Urgent Care Claim: Any claim in which a delay in treatment could:

- jeopardize your life or health;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Claim Determinations

Urgent Care Claims

The claims administrator will make notification of an urgent care claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, the claims administrator will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide the claims administrator with the additional information. The claims administrator will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the physician to provide the claims administrator with the information.

If the claimant fails to follow Plan procedures for filing a claim, the claims administrator will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

The claims administrator will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. The claims administrator may determine that due to matters beyond its control an extension of this 15 calendar days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if the claims administrator notifies you within the first 15 calendar day period. If this extension is needed because the claims administrator needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide the claims administrator with the required information.

Post-Service Claims

The claims administrator will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. The claims administrator may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if the claims administrator notifies you within the first 30 calendar day period. If this extension is needed because the claims administrator needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide the claims administrator with the required information.

Concurrent Care Claim Extension

Following a request for a concurrent care claim extension, the claims administrator will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a concurrent care claim extension.

Concurrent Care Claim Reduction or Termination

The claims administrator will make notification of a claim determination to reduce or terminate a previously approved course of treatment sufficiently in advance of such reduction or termination to permit you to file an appeal and obtain a determination on review before the benefit is reduced or terminated.

Change in Claim Type

The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim.

Questions About Claim Type

It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding what type of claim and/or what claims procedure to follow, contact the claims administrator.

Appeals of Adverse Benefit Determinations

You may submit an appeal if the claims administrator gives notice of an adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your appeal. You should contact the claims administrator to obtain any applicable forms. For an urgent care claim, the request for an expedited appeal may be submitted orally or in writing, and all necessary information, including the claim administrator's determination, shall be submitted by telephone, fax, or another expedited method.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to the claims administrator.

Urgent Care Claims

The claims administrator shall issue a decision within 72 hours of receipt of the request for an appeal.

Pre-Service Claims

The claims administrator shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Post-Service Claims

The claims administrator shall issue a decision within 60 calendar days of receipt of the request for an appeal.

Exhaustion of Process

You must exhaust the Plan's applicable appeal procedure before you establish any of the following regarding an alleged breach of the Plan terms; or any matter within the scope of the Appeals Procedure:

— litigation;

— arbitration; or

— external administrative proceeding (e.g., through a government agency).

Internal Claims and Appeals Processes and Notices

Upon request to the claims administrator, you may review, free of charge, all documents, records and other information relevant to the claim (as determined under ERISA regulations), that is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal, as well as present evidence and testimony.

A representative from the claims administrator will review the initial appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the claims administrator will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by the claims administrator. The claims administrator will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the claims administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal, and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Will provide the identification of medical or vocational experts whose advice was obtained on behalf of the claims administrator in connection with a claimant's adverse determination, without regard to whether the advice was relied upon in making the benefit determination.

Written notification shall be provided to the claimant of the claims administrator's adverse decision on a claim or appeal and shall include the following, in a manner calculated to be understood by the claimant:

- A statement of the specific reason(s) for the decision;
- Reference(s) to the specific Plan provision(s) on which the decision is based;
- After denial of the initial claim, a description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A description of the Plan procedures and time limits for appeal of the decision, and the right to obtain information about those procedures and, for a final appeal, the right to sue in federal or state court under Section 502 of ERISA;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request; and
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims.

Notification of the claim administrator's adverse decision on an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

The claims administrator will allow you to review the claim file and present evidence and testimony. Upon request, the claims administrator will:

- Provide you, free of charge, with any new additional evidence relied upon, considered or generated by the claims administrator in connection with the claim sufficiently in advance of the due date of the notice of final adverse benefit determination to give you a reasonable opportunity to respond; and

- If a final adverse benefit determination is based on new or additional rationale, provide you with the rationale, free of charge, sufficiently in advance of the due date of the notice of final benefit determination, to give you a reasonable opportunity to respond.

External Review

After a final internal adverse benefit determination, under certain circumstances, you may ask for review by an independent external review organization, generally known as an Independent Review Organization (IRO). The external review will be limited to claims involving rescissions of coverage and medical judgment. For these purposes, medical judgment includes, but is not limited to, determinations based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The determination of whether a claim involves medical judgment will be made by an IRO.

External review differs from the existing claims and appeals procedure because the final decision on the claim would be made by the IRO. The claims administrator has contracts with multiple IROs that are accredited by URAC or a similar national organization to conduct the external review. The decision of the IRO is binding on all parties except to the extent remedies are available under federal or state law. You must file a request for external review within four months from the final internal adverse benefit determination.

Standard External Review

Request for external review. In the case of a denied claim, the request for external review may be filed by either you or a health care provider, with your written consent in the format required by or acceptable to the Plan. The request for external review should include any reasons, material justification and all reasonably necessary supporting information as part of the external review filing.

Preliminary review: Within five business days following the date of receipt of the external review request, the claims administrator will complete a preliminary review of the request to determine whether:

- you are or were covered under the Plan at the time the health care item or service was requested;
- the adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- you have exhausted the Plan's internal appeal process or you are not required to exhaust the internal review appeals process; and
- you have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the claims administrator will issue a notification in writing to you or your authorized representative. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3372)).

If the request is not complete, such notification shall describe the information or materials needed to make the request complete, and the Plan must allow you to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization (IRO)

The claims administrator will assign an independent review organization (IRO) to conduct the external review. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The assigned IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review.

Expedited External Review

Generally, the claims administrator will permit an expedited external review if:

- You receive an adverse benefit determination and completing an expedited internal appeal would seriously jeopardize your life or health or your ability to regain maximum function, and you have filed a request for an expedited internal appeal, or
- You receive a final internal adverse benefit determination and completing a standard external appeal would seriously jeopardize your life or health or your ability to regain maximum function, or, if the claim involves an admission, availability of care, continued stay, or emergency services, and you have not been discharged from a facility.

With expedited review, the claims administrator must immediately determine whether the request is eligible for external review and assign it to an IRO. The IRO must make a determination within 72 hours.

Claims and Appeals for Vision and Dental Benefits

Definitions

For purposes of these claims procedures, the following definitions apply:

Adverse Benefit Determination: A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Appeal: A written request to reconsider an adverse benefit determination.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-Service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Claim Determinations

Urgent Care Claims

The claims administrator will make notification of an urgent care claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, the claims administrator will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide the claims administrator with the additional information. The claims administrator will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the physician to provide the claims administrator with the information.

If the claimant fails to follow Plan procedures for filing a claim, the claims administrator will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

The claims administrator will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. The claims administrator may determine that due to matters beyond its control an extension of this 15 calendar days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if the claims administrator notifies you within the first 15 calendar day period. If this extension is needed because the claims administrator needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide the claims administrator with the required information.

Post-Service Claims

The claims administrator will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. The claims administrator may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if the claims administrator notifies you within the first 30 calendar day period. If this extension is needed because the claims administrator needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide the claims administrator with the required information.

Concurrent Care Claim Extension

Following a request for a concurrent care claim extension, the claims administrator will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a concurrent care claim extension.

Concurrent Care Claim Reduction or Termination

The claims administrator will make notification of a claim determination to reduce or terminate a previously approved course of treatment sufficiently in advance of such reduction or termination to permit you to file an appeal and obtain a determination on review before the benefit is reduced or terminated.

Change in Claim Type

The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim.

Questions About Claim Type

It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding what type of claim and/or what claims procedure to follow, contact the claims administrator.

Appeals of Adverse Benefit Determinations

You may submit an appeal if the claims administrator gives notice of an adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request an appeal. You should contact the claims administrator to obtain any applicable claims form. For an urgent care claim, the request for an expedited appeal may be submitted orally or in writing, and all necessary information, including the claims administrator's determination, shall be submitted by telephone, fax, or another expedited method.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to the claims administrator.

Urgent Care Appeal

A representative of the claims administrator shall issue a decision within 72 hours of receipt of the request for an appeal.

Pre-Service Appeal

A representative of the claims administrator shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Post-Service Appeal

A representative of the claims administrator shall issue a decision within 60 calendar days of receipt of the request for an appeal.

For an urgent care claim, the request for an expedited appeal may be submitted orally or in writing, and all necessary information, including the claim administrator's determination, shall be submitted by telephone, fax, or another expedited method.

Exhaustion of Process

You must exhaust the Plan's applicable appeal procedure before you establish any of the following regarding an alleged breach of the Plan terms; or any matter within the scope of the appeals procedure:

- litigation;
- arbitration; or
- external administrative proceeding (e.g., through a government agency).

Internal Claims and Appeals Processes and Notices

Upon request to the claims administrator, you may review, free of charge, all documents, records and other information relevant to the claim (as determined under ERISA regulations) that is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

A representative from the claims administrator will review the appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the claims administrator will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by the claims administrator. The claims administrator will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the claims administrator's representative will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal, and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal. As part of the appeal process, you consent to this referral and the sharing of pertinent medical information. If a medical or vocational expert is contacted in connection with an appeal, you will have the right to learn the identity of such individual.

Written notification shall be provided to the claimant of the claims administrator's adverse decision on a claim or appeal and shall include the following, in a manner calculated to be understood by the claimant:

- A statement of the specific reason(s) for the decision;
- Reference(s) to the specific Plan provision(s) on which the decision is based;
- After denial of the initial claim, a description of any additional material or information necessary to perfect the claim and why such information is necessary;

- A description of the Plan procedures and time limits for appeal of the decision, and the right to obtain information about those procedures and, for a final appeal, the right to sue in federal or state court under Section 502 of ERISA;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request; and
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims.

Notification of the claims administrator's adverse decision on an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

Claims and Appeals for Short-Term Disability Benefits

Submitting a Claim

Contact the claims administrator listed in the chart above to submit a claim for short-term disability benefits.

If Your Claim Is Denied

If a claim is denied, in whole or in part, you, your beneficiary or your representative will receive written notice from the claims administrator within the time frames set forth on the chart below. The notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of the additional information that must be submitted to process the claim, and an explanation of the claim review procedure.

How to Appeal a Denied Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, send a written request to the claims administrator. If you are submitting an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of all claim forms relating to your claim. All review requests must be made within the time frames set forth on the chart below.

The process and the time frames for claims and appeals are shown below.

Time Frames for Processing and Appealing Short Term Disability Claims	
Claims Process	**Time Frame**
Claims administrator reviews initial claim and makes determination	Within 45 days of the date claim is received
Extension period, if required due to special circumstances beyond control of claims administrator*	Additional 30 days, with the possibility of another 30, if required
Claimant's time to respond, if claimant fails to submit necessary information	45 days
You may submit an initial appeal of denied claim	Within 180 days of receiving notice of denied claim
Representative of the claims administrator makes a determination on your appeal	Within 45 days, unless special circumstances require additional 45 day extension
* *Whenever an extension is required, the claims administrator must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.*	

Internal Claims and Appeals Processes and Notices

Upon request to the claims administrator, you may review, free of charge, all documents, records and other information relevant to the claim (as determined under ERISA regulations) that is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

In rendering a decision on your appeal, the claims administrator will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by the claims administrator. The claims administrator will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

Written notification shall be provided to the claimant of the claims administrator's adverse decision on a claim or appeal and shall include the following, in a manner calculated to be understood by the claimant:

- A statement of the specific reason(s) for the decision;
- Reference(s) to the specific Plan provision(s) on which the decision is based;
- After denial of the initial claim, a description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A description of the Plan procedures and time limits for appeal of the decision, and the right to obtain information about those procedures and, for a final appeal, the right to sue in federal or state court under Section 502 of ERISA;

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request); and
- If the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request.

Exhaustion/Limitation to File a Lawsuit

For all claims under the Plan (i.e., claims for all benefit and for claims relating to eligibility or enrollment), if your claim for benefits and appeal is finally denied in whole or in part, and provided that you timely complete the above procedures, you may file suit only in a state or federal court. **Again, before you may file suit in a state or federal court, you must exhaust the Plan's administrative claims procedures within the time frames set forth above. If any such judicial proceeding is undertaken, the evidence presented will be strictly limited to the evidence timely presented to the claims administrator. In addition, any such judicial proceeding must be filed within 12 months after the claims administrator's final decision or it will be forever barred.**

Failure to Follow Claims Procedures

In the case of the failure of the claims administrator to follow the claims procedures, you shall be deemed to have exhausted the administrative remedies under the Plan and shall be entitled to pursue any available remedies under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

SECTION XIV

GENERAL PROVISIONS

PLAN NAME

The name of the Plan is the Laborers' District Council Heavy and Highway Construction Health and Welfare Fund which is affiliated with the Laborers' District Council of the Metropolitan Area of Philadelphia and Vicinity. The Plan is a welfare plan, as defined under ERISA section 3(1), which provides medical, prescription, dental, vision, short-term disability, accident, and death benefits under different component plans to Covered Members.

PLAN ADMINISTRATION

Overall administration of the Plan is the responsibility of the Board of Trustees whose members are appointed by the Contractors Association of Eastern Pennsylvania and the Laborers' District Council of Metropolitan Area of Philadelphia. The Board of Trustees has delegated plan administration responsibilities to:

Alan Parham
Laborers' District Council
Heavy and Highway Construction Health and Welfare Fund
665 N. Broad Street
Philadelphia, PA 19123

In the discharge of its duties, the Board of Trustees is aided and advised by legal counsel, actuarial and accounting services as well as administrative personnel who are responsible for all Plan and Fund records, communications and the processing of claims.

Under the Trust Agreement creating the Laborers' District Council Heavy and Highway Construction Health and Welfare Fund, the Board of Trustees has the sole and exclusive discretion and authority to make final decisions about any application or eligibility for benefits, interpretation of the Plan, findings of fact, and administrative rules adopted by the Board of Trustees. In these situations, the Board of Trustee's decisions are final and binding, and to be upheld unless an arbitrator or a court of competent authority decides that the Board of Trustees' decision is arbitrary or capricious.

AMENDMENT AND TERMINATION

The Board of Trustees has the sole and exclusive discretion and authority to increase, decrease, change, or terminate benefits, eligibility rules or other provisions of the Plan at any time as they deem necessary for efficient administration of the Fund. These changes must be consistent with the law and with the provisions of the Trust Agreement.

The Board of Trustees may amend or terminate this Plan by a majority vote of the trustees present at a duly constituted Board of Trustees meeting with a quorum present. Benefits may be adjusted upward or downward in the future reflecting the claims experience of the Plan and changing levels of income available. If the Plan is terminated, benefits for covered expenses incurred before the termination date will be paid as long as the Plan's assets are more than the Plan's liabilities.

If any provision or amendment of the Trust Agreement or the Plan is determined to be unlawful or illegal, this illegality will apply only to the provision in question, not to any other provisions of the Trust Agreement or the Plan.

PERSON DESIGNATED FOR SERVICE OF LEGAL PROCESS

The person designated by the Board of Trustees as agent for service of legal process and the address to which process may be served is:

Alan Parham
Laborers' District Council
Heavy and Highway Construction Health and Welfare Fund
665 N. Broad Street
Philadelphia, PA 19123

Legal Service may also be brought upon any of the trustees.

PLAN RECORDS

All Plan records are available to you for inspection upon request. Any information regarding your benefits, and/or your rights under the Plan can be obtained by contacting the Fund Administrator, in writing.

TRUST QUALIFICATIONS

The Laborers' District Council Heavy and Highway Construction Health and Welfare Plan has been qualified and determined exempt for tax purposes by the U.S. Internal Revenue Service. The Fund's Identification Number is 23-1527636.

The Plan number assigned by the Board of Trustees is 501.

The Plan's fiscal year for record keeping purposes is May 1 through April 30. The separate benefits under the Plan may operate on a calendar year or other 12 month period. Please see the separate benefits section for more information.

FUND ASSETS

Assets of the Fund are held in a Trust Fund and invested by professional investment manager(s) selected by the Board of Trustees.

TYPE OF ADMINISTRATION/SOURCE OF CONTRIBUTIONS AND FUNDING

The medical, prescription, dental, vision, and EAP benefits under the Plan are self-funded by the Fund, but are administered by third party administrators. The short-term disability, life and AD&D benefits are fully-insured and administered by the respective insurance companies. Contact information for the third party administrators and insurers is located in Section XV.

Contributions to the Fund are made by Contributing Employers.

COLLECTIVE BARGAINING AGREEMENTS

The Plan's benefits are funded through contributions determined from time to time under Collective Bargaining Agreements. Information as it relates to the Plan's contributions is available through the Fund Office.

CONTRIBUTING EMPLOYERS

Complete listings of the Contributing Employers and unions party to the Collective Bargaining Agreement are available at the Fund Office. Members and Eligible Dependents interested in examining an agreement can contact the Fund Office.

ASSIGNMENT OF BENEFITS

No person entitled to any benefit under this Plan shall have any right to assign, alienate, anticipate or commute any such benefits and, except as otherwise prescribed by law, no such benefits shall be subject to the debts, contracts or engagements or any person entitled to such benefits, nor to any judicial process to levy upon or attach the same for the payment of such debts. This rule does not apply if the Fund Administrator determines that a domestic relations order is a Qualified Medical Child Support Order (QMCSO). The Plan does permit an exception to the general rule against assignment of benefits in limited situations; for example, for some benefits, such as medical or dental coverage, benefit payments may be assigned by a Covered Member to the physician rendering the service.

GENERAL BENEFIT EXCLUSIONS AND LIMITATIONS

Important Notice Regarding Relationship Between the Fund and Health Care Providers:

No health care provider is an agent or representative of the Plan or Fund. The Plan does not control or direct the provision of health care services and/or supplies to Covered Members or Eligible Dependents by anyone. The Plan makes no representation or guarantee of any kind concerning the quality of health care services or supplies furnished by any provider. The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan. The statement also applies to all networks or other health-related supplies to Covered Members and Eligible Dependents. Nothing in this Plan affects the ability of a health care provider to disclose alternative treatment options to a Covered Member or Eligible Dependent. Although subject to benefit allowances and limitations in the Plan with regard to payment, the choice of a provider and/or treatment remains with the patient.

In addition to the exclusions provided elsewhere in this booklet, benefits are not payable for the following:

1. Charges arising from, or occurring in the course of, any gainful occupation or employment. This exclusion applies regardless of whether a claim is actually made or filed under any applicable workers' compensation statute or program.
2. Charges for services or supplies which are not medically necessary or medically appropriate as determined by the Plan and/or its medical consultant.
3. Charges for treatments or procedures that are experimental or investigative. However, the Plan does cover routine patient costs for items and services furnished in connection with participation in an approved clinical trial as required by Section 2709 of the Public Health Service Act.
4. Charges for treatments which are not approved by the attending physician.
5. Charges which are not usual, customary and reasonable.
6. Charges in excess of the payment the provider of service accepted as payment in full from any other source.

7. Charges for custodial care.
8. Charges for service rendered by a member of the patient's immediate family (including in-laws).
9. Charges that are made because this coverage exists, or charges that no covered individual is legally obligated to pay.
10. Charges for treatments, services and/or supplies provided by the United States government, unless you were legally required to pay for such treatments.
11. Charges resulting from war or service connected injuries or diseases.
12. Charges associated with any treatment for weight reduction.
13. Charges for hearing aids or the examination and fitting of hearing aids.
14. Charges to the extent that they are recovered from any person or organization other than an insurer of the patient.
15. Charges for cosmetic treatment and/or surgery for purposes other than breast reconstruction following a mastectomy, correction of damages caused by accidental injury, or for correction of a birth defect, providing that the patient was covered under this Plan on the date of the accident or date of birth and is still eligible as of the date of the cosmetic treatment or surgery. NOTE: SURGERY GENERALLY CONSIDERED COSMETIC IN NATURE (EVEN THOUGH FOR MEDICAL REASONS) REQUIRES PRIOR APPROVAL FROM THE PLAN.
16. Charges for orthotic shoe inserts other than through the custom orthotic benefits.
17. Charges for immunizations and vaccines (unless specifically covered under either the Personal Choice or Keystone HMO Programs).
18. Charges for eye exercises, psychological testing, and learning disabilities, school or DOT physicals.
19. Charges for counseling (including marriage counseling) or group therapy.
20. Charges for treatment of temporomandibular joint dysfunction in excess of any coverage under the dental component.
21. Charges for sex change operations.
22. Charges for penile prosthetic devices.
23. Charges for the surgical correction of myopia.
24. Charges for treatment of infertility, including but not limited to, in-vitro fertilization, artificial insemination, gamete intra-fallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and/or reversal of a sterilization procedure.
25. Charges for any other medical, dental, vision, or pharmacy service except as provided in your Plan.
26. Also, benefits will only be paid in accordance with provisions of the Plan's various components. For example, vision care is provided under the vision component and will not be provided under any other provision of the Plan unless specifically included in such other Plan provision.

SUBROGATION/REIMBURSEMENT

The purpose of this provision is to insure that the limited funds available to finance the benefits provided by the Plan are not used to provide benefits where other Available Funds (defined below) may be available to pay the cost of the benefits provided by the Plan.

For the purposes of this subsection the following definitions shall apply:

(1) The term "Participant" shall mean any Covered Member or Eligible Dependent.

(2) The term "Illness or Injury" shall mean any illness or injury of whatever kind or description, whether arising out of a work related cause or whether unrelated to the work of the Participant.

(3) The term "Available Funds" shall mean monies and/or compensation from any source whatsoever (whether called pain and suffering, weekly indemnity, workers compensation, damages, restitution, wage loss, medical treatment, out-of-pocket expenses, or any like or similar terms).

(4) The terms "Claim" or "Third Party Claim" or "Third Party Injury" shall mean any claim for monetary or non-monetary compensation of whatever kind or description whether made by petition (e.g., workers compensation petition), court complaint, insurance claim or written or oral demand as the result of an Illness or Injury caused (or allegedly caused) by another party to a Participant. It includes any payment, settlement, recovery, or judgment including, but not limited to, the following sources:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any lawsuit settlements from payments made from any source;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Any medical payments coverage under any: automobile policy; premises or homeowners' medical payments coverage; or premises or homeowners' insurance coverage (whether the Participant's or another's); and
- Any other payments from a responsible party, including any party responsible for payment of expenses associated with the care or treatment of Third Party Injuries, or another source intended to compensate the Participant for injuries resulting from an accident or alleged negligence.

(5) The term "Third Party" means any party that is, or may be, or is claimed to be responsible for Illness or Injuries to a Participant that are "Claims," "Third Party Injuries" or "Third Party Claims."

As a condition to the receipt of benefits, by any Participant from the Plan, each Participant shall agree that in the event that the Plan has made, does make, or is obligated to make payments to the Participant arising out of any Illness or Injury, then, as a condition for receiving benefits from the Plan, the Participant shall execute an agreement providing that the Participant (or where appropriate their representative) will:

(1) Notify the Plan in writing, within 30 days of the time when notice is given to the Participant or any related party, of the intention to investigate or pursue a Claim, or that a Claim has been filed by the Participant against a Third Party seeking to recover damages or obtain compensation or Available Funds, relating to such Illness or Injury.

(2) Notify the Plan in writing of the name and address of the Participant's attorney, provide said attorney with a copy of the agreement and require said attorney to comply with its terms. The agreement shall serve as authorization to the Participant's attorney to comply with its terms and to release all requested information about the Claims to the Plan.

(3) Keep the Plan informed in writing of the progress and/or settlement of his/her Third Party Claim.

(4) Cooperate with the Plan and its designees and do whatever is necessary to secure the Plan's rights of subrogation and reimbursement, as described below.

(5) Include in all Claims a claim for benefits paid by the Plan to and/or claimed from the Plan by the Participant, plus interest accruing from the date of payment of such benefits.

(6) Agree that the Plan has the right to be reimbursed in full for the cost of any and all benefits that are provided by the Plan to or on behalf of the Participant, plus interest accruing from the date of payment of such benefits, as the result of an Illness or Injury caused by another party. This process is called subrogation. The Plan has this right of subrogation and by accepting the benefits under the Plan, a Participant acknowledges this right of subrogation. The Plan's right to subrogation applies to any Claim made by or on the Participant's behalf.

The Plan's right of subrogation consists of both a right of a subrogation and a right of reimbursement.

- *Subrogation* means the Plan shall be subrogated to a Participant's right of recovery against any party to the extent of the full cost of all benefits provided by this Plan. The Plan may proceed against any party with or without the Participant's consent.
- The Plan's right of *reimbursement* attaches to any Claim received by a Participant or their representative from any party responsible for paying for expenses associated with the care or treatment of Third Party Injuries or any other Claim. By providing any benefit under this Plan, the Plan is granted an assignment of the proceeds of any Claim received by the Participant to the extent of the full cost of all benefits provided by this Plan.

The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

The Plan's subrogation right is a first priority right and the Plan is entitled to reimbursement even if such reimbursement results in a recovery to the Participant that is insufficient to compensate the Participant in whole or in part for the Participant's damages from a Third Party Injury. The Plan may recover the full cost of all benefits paid by this Plan without regard to any claim of fault on the Participant's part, whether by comparative negligence or otherwise. No court costs or attorney's fees may be deducted from the Plan's recovery, and the Plan is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by the Participant to pursue their Claim without the prior express written consent of the Plan.

The Plan's subrogation right applies to all benefits under the Plan, even if the underlying benefit booklets contain no language or different language on subrogation and reimbursement.

Certain other agreements, described below, are related to the Plan's right of subrogation.

(7) The Participant shall authorize any person or entity paying Available Funds to or on behalf of the Participant to pay over to the Plan such monies as the Plan is entitled to receive under

the terms of the Plan and the agreement, and the agreement shall constitute their warrant to do so. In case of any dispute over what monies are due the Plan, Available Funds shall be escrowed pending resolution of such dispute.

This includes giving the Plan a first-priority lien on any Claim or Available Funds to the extent of the full cost of all benefits associated with Third Party Injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).

This also includes an agreement to pay, as the first priority, from any Claim or Available Funds, any and all amounts due to the Plan as reimbursement for the full cost of all benefits associated with Third Party Injuries paid by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement), unless otherwise agreed to by the Plan in writing.

(8) Require and authorize his/her attorney, if any, to withhold from Available Funds any monies due the Plan pursuant to the agreement and to forward them to the Plan as required by the agreement. In case of any dispute over what monies are due the Plan, Available Funds are to be escrowed pending resolution of such dispute.

(9) Do nothing to prejudice the Plan's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery that specifically attempts to reduce or exclude the full cost of all benefits paid by the Plan.

(10) Serve as a constructive trustee for the benefits of this Plan over any Available Funds, including any settlement or recovery funds, received as a result of Third Party Injuries.

In the event that the Participant or the Participant's representative fails or refuses to comply with the provisions of the Plan and the agreement, then the Participant shall be responsible for all benefits paid by this Plan in addition to costs and attorney's fees incurred by the Plan in obtaining repayment. The Plan, in addition to any other rights to which the Plan or the Board of Trustees thereof might have, shall have the right to withhold from any payments due or which become due to the Participant or to third parties on behalf of the Participant from the Plan any amount necessary until the Plan is fully reimbursed for all benefits paid by this Plan in addition to costs and attorney's fees incurred by the Plan in obtaining repayment.

The Participant shall authorize the Plan to record and/or use the agreement in any proceedings involving the Participant, including using the agreement in any Third Party Claims that the Participant may have.

Any Participant making a Claim on behalf of any minor child under the plan of benefits and who shall make the agreement on behalf of said minor child shall warrant that he/she is authorized to make the agreement on behalf of said minor child.

It is agreed that any payment received by the Participant from any health insurance carrier, from Blue Cross, from Blue Shield or from any like or similar plan (and excluding motor vehicle insurance), for which the Participant has paid in the full premium in order to secure individual, as distinguished from group coverage, shall be excluded from requirements of this provision.

HIPAA DISCLOSURE

With respect to protected health information ("PHI"), as defined under the Health Insurance Portability and Accountability Act and guidance issued thereunder ("HIPAA"), the Board of Trustees agrees to:

- Reasonably and appropriately safeguard PHI created, received, maintained, or transmitted to or by the Board of Trustees on behalf of the Plan.
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Not use or further disclose the information other than as permitted or required by this Plan Document or as required by law.
- Ensure that any agents, including a subcontractor, to whom the Board of Trustees provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information.
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual.
- Not use or disclose the information in connection with any other benefit or employee benefit plan of the Board of Trustees unless authorized by the individual.
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
- Make PHI available to the individual in accordance with the access requirements of HIPAA.
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.
- Make available the information required to provide an accounting of disclosures.
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA.
- If feasible, return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
- Maintain adequate separation between the Plan and the Board of Trustees. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
  - Plan Administration Department
  - Accounting Department

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Board of Trustees performs for the Plan. If the persons described above do not comply with this Plan Document, the Board of Trustees shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

RIGHTS AND PROTECTION UNDER ERISA

Important information required by the Employee Retirement Income Security Act ("ERISA"). As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. ERISA provides that all Covered Members and Eligible Dependents shall be entitled to:

(1) Examine, without charge, at the Fund Administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

(2) Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

(4) Continue health care coverage for yourself, or your Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible Dependents may have to pay for such coverage. Review this booklet and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

(5) Until December 31, 2014, be provided with a certificate of creditable coverage for pre-existing conditions, free of charge, when you lose coverage under the Plan, 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. Until December 31, 2014, 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.

In addition to creating rights for Covered Members and Eligible Dependents, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Covered Members and Eligible Dependents. 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 benefit under this Plan or exercising your rights under ERISA.

If your claim for a benefit under this Plan 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 a 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 Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file a 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 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 costs and legal fees. If you are success-

ful 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.

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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, 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 publication hotline of the Employee Benefits Security Administration.

SECTION XV

LIST OF INSURERS/THIRD PARTY ADMINISTRATORS

LIST OF INSURERS/THIRD PARTY ADMINISTRATORS

MEDICAL BENEFITS Independence Blue Cross Personal Choice/Keystone 1901 Market Street Philadelphia, PA 19103-1480 Personal Choice/Keystone: 1-800-ASK-BLUE Keystone 65 Customer Service — 1-800-645-3965	**SHORT TERM DISABILITY, LIFE AND AD&D INSURANCE** The Union Labor Life Insurance Co. 8403 Colesville Road Silver Spring, MD 20910 1-800-431-5425
PRESCRIPTION BENEFITS Express Scripts One Express Way St. Louis, MO 63121 1-800-467-2006	**EMPLOYEE ASSISTANCE PROGRAM/ MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS** Allied Trades Assistance Program (ATAP) 2791 Southampton Road, Suite 100 Philadelphia, PA 19154 (215) 677-8820 or (800) 258-6376
DENTAL BENEFITS Fidelio Insurance Company 2826 Mount Carmel Avenue Glenside, PA 19038 215-885-2443	**CUSTOM ORTHOTIC BENEFIT** Pro Support, Inc. 327 Montgomery Avenue Bala Cynwyd, PA 19004 www.prosupportsystems.com (click LDC logo) 610-664-0848 or 800-262-FEET (3338)
VISION BENEFITS National Vision Administrators P.O. Box 2187 Clifton, NJ 07015 1-800-672-7723	**POST RETIREE BENEFIT (65 & Over)** Aetna Medicare P.O. Box 14088 Lexington, KY 40512-4088 1-855-660-1810 www.aetnaretireeplans.com

APPENDIXES

APPENDIX A
MEDICAL CLAIMS PROCEDURES AND MEMBER APPEAL PROCESS

APPENDIX B
LIFE/AD&D/LOSS OF TIME — ULLICO CONTRACT

APPENDIX C
POST RETIREMENT MEDICARE ADVANTAGE AETNA SUMMARIES

Some of these documents may be subject to annual changes. Updated copies are available through the Fund Office at (215) 236-6700.

APPENDIX A

MEDICAL — PPO AND DPOS/HMO CLAIMS PROCEDURES AND MEMBER APPEAL PROCEDURES

CLAIM PROCEDURES AND MEMBER APPEAL PROCESS MEDICAL — DPOS/HMO PLANS

CLAIM PROCEDURES

Most claims are filed by Providers in the Claims Administrator's network. The following applies if the Member must submit a claim.

Written notice of a claim must be given to the Claims Administrator within 20 days, or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to the Claims Administrator that includes information sufficient to identify the Member that received the Covered Services, shall constitute sufficient notice of a claim to the Claims Administrator.

The Member can give notice to the Claims Administrator by calling Customer Service. The telephone number and address of Customer Service can be found on the Member's ID Card. A charge shall be considered Incurred on the date a Member receives the Covered Service for which the charge is made.

Proof of Loss

Claims cannot be paid until a written proof of loss is submitted to the Claims Administrator. Written proof of loss must be provided to the Claims Administrator within **90 days** after the charge for Covered Services is incurred. Proof of loss must include all data necessary for the Claims Administrator to determine benefits. Failure to submit a proof of loss to the Claims Administrator within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the Claims Administrator be required to accept a proof of loss later than **12 months** after the charge for Covered Services is Incurred.

Claim Forms

If a Member (or if deceased, by his/her personal representative) is required to submit a proof of loss for benefits under this Program, it must be submitted to the Claims Administrator on the appropriate claim form. The Claims Administrator, upon receipt of a notice of claim will, within **15 days** following the date notice of claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within **15 days** after the giving of such notice, the Member shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bills for Covered Services as described below. Itemized bills may be submitted to the Claims Administrator at the address appearing on the Member's ID Card. Itemized bills cannot be returned.

Submission of Claims Forms

For Member-submitted claims, the completed claim form, with all itemized bills attached, must be forwarded to the Claims Administrator at the address appearing on the claim form in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Program.

To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing all of the following information:

1. Person or organization providing the service or supply;
2. Type of service or supply;
3. Date of service or supply;
4. Amount charged; and
5. Name of patient.

A request for payment of a claim will not be reviewed and no payment will be made unless all the information and evidence of payment required on the claim form has been submitted in the manner described above. The Claims Administrator reserves the right to require additional information and documents as needed to support a claim that a Covered Service has been rendered.

Timely Payment of Claims

Claims payment for benefits payable under this Program will be processed immediately upon receipt of proper proof of loss.

Physical Examinations and Autopsy

The DPOS/HMO at its own expense shall have the right and opportunity to examine the Member when and so often as it may reasonably require during the pendency of claim under the Contract; and the DPOS/HMO shall also have the right and opportunity to make an autopsy in case of death, where it is not prohibited by law.

Payment of Claims

If any indemnity of the Contract shall be payable to the estate of the Member, or to a Member or beneficiary who is a minor or otherwise not competent to give a valid release, the DPOS/HMO may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the Member or beneficiary who is deemed by the DPOS/HMO to be equitably entitled thereto. Any payment made by the DPOS/HMO in good faith pursuant to this provision shall fully discharge the DPOS/HMO to the extent of such payment.

Time Limit on Certain Defenses

After three (3) years from the date of issue of the Contract, no misstatements, except fraudulent misstatements made by the Applicant in the Application for such Contract, shall be used to void said Contract or to deny benefits for a claim incurred commencing after the expiration of such three (3) year period.

COMPLAINT AND GRIEVANCE APPEAL PROCESS
RESOLVING PROBLEMS

MEMBER COMPLAINT PROCESS

The Claims Administrator has a process for Members to express complaints. To register a Complaint, Members should call the Member Services Department at the telephone number on the Identification Card or write to the Claims Administrator at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Claims Administrator is unable to immediately resolve the Member Complaint, it will be investigated and the Member will receive a response in writing within **30 days.**

MEMBER APPEAL PROCESS

Filing an Appeal — The Claims Administrator maintains procedures for the resolution of Member appeals. Member appeals may be filed within **180 days** of the receipt of a decision from the Claims Administrator stating an adverse benefit determination. An appeal occurs when the Member or, after obtaining the Member's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Claims Administrator by following the procedures described here. (In order to authorize someone else to be the Member's representative for the appeal, the Member must complete a valid authorization form. The Member must contact the Claims Administrator as directed below to obtain a Member/Enrollee Authorization to appeal by Provider or Other Representative" form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member (Designee), may request an appeal by calling or writing to the Claims Administrator, as defined in the letter notifying the Member of the decision or as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820
Toll Free 1-888-671-5276 (TTY: 711)
Toll Free Fax 1-888-671-5274 or
Philadelphia Fax: 215-988-6558

Definitions

MEDICAL NECESSITY APPEAL — An appeal by or on behalf of a Member that focuses on issues of Medical Necessity and requests the Claims Administrator to change its decision to deny or limit the provision of a Covered Service. Medical Necessity Appeals include appeals of adverse benefit determinations based on the exclusions for Experimental/Investigative or cosmetic services.

ADMINISTRATIVE APPEAL — An appeal by or on behalf of a Member that focuses on unresolved member disputes or objections regarding the Claims Administrator decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, claims payment issues, participating or Non-Participating healthcare Provider status, cost sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions).

Although an Administrative Appeal may present issues related to Medical Necessity, these are not the primary issues that affect the outcome of the appeal.

PRE-SERVICE REVIEW — A request for benefits that, under the terms of this Program, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained, in order for coverage to be available.

POST-SERVICE REVIEW — A request for benefits that is not a Pre-Service request. (Post-Service Reviews concerning claims for services that the Member has already obtained do not qualify for review as Urgent/Expedited Appeals.)

URGENT/EXPEDITED/APPEAL — Any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. This process is handled by the Plan Administrator.

General Information

The Member/Designee may at any time request the aid of a plan employee in preparing the appeal, at no charge. This employee has not participated in the previous decision to deny coverage for the issues in dispute and is not a subordinate of anyone who previously reviewed the file.

The Member/Designee is entitled to a full and fair review. Specifically, at any time during the process, the Member/Designee may submit additional information pertaining to the case, to the Claims Administrator. The Member/Designee may specify the remedy or corrective action being sought. At the Member's request, the Claims Administrator will provide access to, and copies of, all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The Claims Administrator will automatically provide the Member/Designee with any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member/Designee at no charge.

The Claims Administrator will not terminate or reduce an-ongoing course of treatment without providing the Member/Designee with advance notice and the opportunity for advanced review.

If the appeal is upheld, the letter states the reason(s) for the decision. If a benefit provision, internal, rule, guideline, protocol, or other similar criterion is used in making the determination; the Member/Designee may request copies of this information at no charge. The letter explains the scientific or clinical judgment, if applicable, for the determination. The letter also indicates the qualifications of the individual/individuals who decided the appeal and their understanding of the nature of the appeal. The Member/Designee may request in writing, at no charge, the name of the individuals who participated in the decision to uphold the denial.

If the health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following the appeal the Member may have the right to bring civil action under Section 502(a) of the Act.

Changes in Members Grievance Processes: Please note that the Appeals Process described here may change at any time due to changes in the applicable regulations and/or accreditation standards, to improve or facilitate the review process, or to reflect other decisions regarding the administration of the Member Appeals processes for this Program.

All Internal Appeals can be initiated by contacting:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820
Toll Free 1-888-671-5276 (TTY: 711)
Toll Free Fax 1-888-671-5274

INTERNAL APPEALS — There are two levels of appeal. The internal, standard appeal process for Administrative Appeals and Medical Necessity Appeals consists of two internal levels of review — the first by the Claims Administrator and a second by the Plan Administrator. Further review, if any, is only available through the Plan Administrator. There is also an internal Urgent/Expedited Appeal Process available through the Plan Administrator in the event **the Member's** condition involves an issue that may jeopardize the Member's life, health, ability to regain maximum function, or would subject **the Member** to severe pain that cannot be adequately managed, as determined and validated by the Member's Physician, if reviewed in **standard Pre-Service appeal timeframes.**

Level One Standard Appeal

The initial request for an appeal will be evaluated and the decision completed within the following timeframes for a standard appeal on an Administrative or Medical Necessity Appeal issue:

- Standard Pre-Service Appeal — within **15 days** of receipt of the Appeal request;
- Standard Post-Service Appeal — within **30 days** of receipt of the Appeal request.

An employee of the Claims Administrator, who has had no previous involvement with the case and who is not the subordinate of anyone involved in the previous determination, reviews the appeal. A Medical Necessity Appeal is decided by a health professional. This individual holds an active, unrestricted license to practice medicine or another health profession. Additionally, either this individual or an independent consultant is of the same profession and similar specialty that typically manages the care under review.

The Member/Designee will be sent written notice of the First Level decision within the timeframe stated above along with a description on how the Member/Designee can appeal to the next level.

Level Two Standard Appeal

If not satisfied with the First Level decision, the Member or designee may request a Second Level Appeal within **60 days** of receipt of the First Level decision notice.

Under the appeal process in effect for this Program, the Plan Administrator is responsible for the standard Second Level Administrative Appeal and Medical Necessity Appeal processes. Once the request for a Second Level Standard Appeal is received, the Claims Administrator forwards the request and all Appeal documents to the Plan Administrator for a determination. The Plan Administrator advises the Member/Designee of the decision regarding the Administrative Appeal or Medical Necessity Appeal and of any additional Appeal rights that may be available for an external review.

Urgent/Expedited Appeals

Under the appeal process in effect for this Program, the Plan Administrator is responsible for the Expedited Administrative Appeal and Expedited Medical Necessity Appeal processes. Once the

request for an Urgent/Expedited Appeal is received, the Claims Administrator forwards the request and all appeal documents in its possession to the Plan Administrator. The Plan Administrator advises the Member/Designee of the decision regarding the Expedited Administrative Appeal or Medical Necessity Appeal and of any additional appeal rights that may be available for an external review.

RESOLVING PROBLEMS

MEMBER COMPLAINT PROCESS

The Claims Administrator has a process for Members to express complaints. To register a Complaint, Members should call the Member Services Department at the telephone number on the Identification Card or write to the Claims Administrator at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Claims Administrator is unable to immediately resolve the Member Complaint, it will be investigated and the Member will receive a response in writing within **30 days.**

MEMBER APPEAL PROCESS

Filing an Appeal — The Claims Administrator maintains procedures for the resolution of Member appeals. Member appeals may be filed within **180 days** of the receipt of a decision from the Claims Administrator stating an adverse benefit determination. An appeal occurs when the Member or, after obtaining the Member's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Claims Administrator by following the procedures described here. (In order to authorize someone else to be the Member's representative for the appeal, the Member must complete a valid authorization form. The Member must contact the Claims Administrator as directed below to obtain a Member/Enrollee Authorization to appeal by Provider or Other Representative" form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member (Designee), may request an appeal by calling or writing to the Claims Administrator, as defined in the letter notifying the Member of the decision or as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820
Toll Free 1-888-671-5276 (TTY: 711)
Toll Free Fax 1-888-671-5274 or
Philadelphia Fax: 215-988-6558

Definitions

MEDICAL NECESSITY APPEAL — An appeal by or on behalf of a Member that focuses on issues of Medical Necessity and requests the Claims Administrator to change its decision to deny or limit the provision of a Covered Service. Medical Necessity Appeals include appeals of adverse benefit determinations based on the exclusions for Experimental/Investigative or cosmetic services.

ADMINISTRATIVE APPEAL — An appeal by or on behalf of a Member that focuses on unresolved member disputes or objections regarding the Claims Administrator decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, claims payment issues, participating or Non-Participating healthcare Provider status, cost sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions). Although an Administrative Appeal may present issues related to Medical Necessity, these are not the primary issues that affect the outcome of the appeal.

PRE-SERVICE REVIEW — A request for benefits that, under the terms of this Program, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained, in order for coverage to be available. A maximum of 15 days is available for each of the two (2) levels of Internal Review available for a Standard Pre-Service Appeal.

POST-SERVICE REVIEW — A request for benefits that is not a Pre-Service request. (Post-Service Reviews concerning claims for services that the Member has already obtained do not qualify for review as Urgent/Expedited Appeals.) A maximum of 30 days is available for each of the two levels of Internal Review available for a Standard Post-Service Appeals.

URGENT/EXPEDITED/APPEAL — Any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. The Claims Administrator will notify the Member/Designee of the decision within 72 hours of receipt of the request by the Claims Administrator.

General Information

The Member/Designee may at any time request the aid of a plan employee in preparing the appeal, at no charge. This employee has not participated in the previous decision to deny coverage for the issues in dispute and is not a subordinate of anyone who previously reviewed the file.

The Member/Designee is entitled to a full and fair review. Specifically, at any time during the process, the Member/Designee may submit additional information pertaining to the case, to the Claims Administrator. The Member/Designee may specify the remedy or corrective action being sought. At the Member's request, the Claims Administrator will provide access to, and copies of, all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The Claims Administrator will automatically provide the Member/Designee with any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member/Designee at no charge.

The Claims Administrator will not terminate or reduce an-ongoing course of treatment without providing the Member/Designee with advance notice and the opportunity for advanced review.

If the appeal is upheld, the letter states the reason(s) for the decision. If a benefit provision, internal, rule, guideline, protocol, or other similar criterion is used in making the determination; the Member/Designee may request copies of this information at no charge. The letter explains the scientific or clinical judgment, if applicable, for the determination. The letter also indicates the qualifications of the individual/individuals who decided the appeal and their understanding of the nature of the appeal. The Member/Designee may request in writing, at no charge, the name of the individuals who participated in the decision to uphold the denial.

If the health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following the appeal the Member may have the right to bring civil action under Section 502(a) of the Act.

Changes in Members Grievance Processes: Please note that the Appeals Process described here may change at any time due to changes in the applicable regulations and/or accreditation standards, to improve or facilitate the review process, or to reflect other decisions regarding the administration of the Member Appeals processes for this Program.

All Internal Appeals can be initiated by contacting:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820
Toll Free 1-888-671-5276 (TTY: 711)
Toll Free Fax 1-888-671-5274

INTERNAL APPEALS

Level One Standard Appeal

The initial request for an internal appeal will be reviewed and the decision completed within the following timeframes for a standard appeal on an Administrative or Medical Necessity Appeal issue:

- Standard Pre-Service Appeal — within **15 days** of receipt of the Appeal request;
- Standard Post-Service Appeal — within **30 days** of receipt of the Appeal request.

An employee of the Claims Administrator, who has had no previous involvement with the case and who is not the subordinate of anyone involved in the previous determination, reviews the internal appeal. A Medical Necessity Appeal is decided by a health professional. This individual holds an active, unrestricted license to practice medicine or another health profession. Additionally, either this individual or an independent consultant is of the same profession and similar specialty that typically manages the care under review.

The Member will be sent written notice of the First Level decision within the timeframe stated above along with a description on how the Member can appeal to the next level.

Level Two Standard Appeal

If not satisfied with the First Level decision, the Member/Designee may request a Second Level Appeal within **60 days.** The appeal will be reviewed and the decision completed within the following timeframes for an Appeal on an Administrative or Medical Necessity Appeal issue:

- Standard Pre-Service Appeal — within **15 days** of receipt of the appeal request:
- Standard Post-Service Appeal — within **30 days** of receipt of the appeal request.

The Member/Designee has the right to present the Member's Appeal to the Second Level Appeal Committee in person or via conference call. The committee is composed of an employee/employees of the Claims Administrator who have no previous involvement with the case and are not subordinates of anyone previously involved with the case. For Medical Necessity reviews, at least one of these individuals is a Plan Medical Director who holds an active, unrestricted license. Second Level Appeal Committee meeting is a forum where Members/Designees each have an equal amount of

time to present their issues in an informal setting that is not open to the public. Two other people may accompany the Member/Designee, unless the Member receives prior approval from the Claims Administrator for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member's representative. Members/Designees may not audiotape, videotape, or transcribe the committee proceedings. The Claims Administrator will contact the Member/Designee to schedule the Committee meeting for the Standard Appeal. The Appeal review may also occur based on the Appeal record without the Member's participation if he/she does not want to participate or repeated attempts to schedule the Member's participation fail. Written notice of the second level decision will be sent within the timeframes stated above.

The second level decision is the final standard level of internal appeal. The external review process for both Medical Necessity and Administrative Appeals is described under the section entitled "External Standard and Expedited Reviews" below.

Urgent/Expedited Appeals

If the case involves an urgent condition, the Member/Designee may request an Urgent/Expedited Internal Appeal. The Internal Appeal mirrors the process described under the "Level Two Standard Appeal" above.

A determination is made and the Member/Designee is notified within 72 hours of receipt of the Urgent/Expedited request by the Claims Administrator. Additionally, the Claims Administrator sends written notification to the Member/Designee within three calendar days of the verbal decision.

Individuals with Urgent Care conditions or who are receiving an on-going course of treatment may proceed with an Expedited External Review at the same time as the Internal Urgent/Expedited Appeal Process.

Additional Appeal rights for both Medical Necessity and Administrative Appeals are described below under "External Standard and Expedited Reviews."

EXTERNAL STANDARD AND URGENT/EXPEDITED REVIEWS

If the Member/Designee is not satisfied with the decision of the Internal Standard Second Level or Urgent/Expedited Appeal, the Member/Designee may file an external review — Standard or Expedited — as described below for either an Administrative or Medical Necessity issue. Both types of external review are submitted to Independent Review Organizations (IROs).

External Standard Review

The Member/Designee may request an external review by an IRO by calling or writing to the Claims Administrator within **180 calendar days** of receipt of the Internal Appeal decision letter. The Member/Designee is not required to pay any of the costs associated with the external review.

The Member/Designee is sent written confirmation of receipt of his/her external review request from the Claims Administrator within five business days of receipt of the request. This confirmation includes the name and contact information for the Claims Administrator staff person assigned to facilitate the processing of the Member's Appeal and information on the IRO assignment. Information on the IRO assignment identifies the assigned IRO by name and states the qualifications of the individual who reviews the appeal.

Whenever possible, the IRO assigned to the external review request, is a different organization than the one that supplied the same/or similar specialty review for the internal Appeal process. The

individual appointed by the IRO to review the Member's external review, has not been previously involved in any aspect of decision-making on the appeal, nor are they a subordinate of any previous decision-maker.

The IRO has no direct or indirect professional, familial or financial conflicts of interest with the Claims Administrator, with the Member, or the Designee. The Claims Administrator's arrangements for assignment of an IRO and payment for the services of an IRO do not constitute a conflict of interest. When a conflict of interest is raised or another material objection is recognized, the Claims Administrator assigns a new IRO and/or requires the assigned IRO to appoint a new reviewer. This reviewer is not the same person who served as a matched specialist for the internal appeal process, nor a subordinate of that person. If the Member/Designee feels that a conflict exists, he/she should call or write the contact person listed on the acknowledgement letter from the Claims Administrator no later than two business days from receipt of the acknowledgment letter from the Claims Administrator.

Within 15 calendar days of receipt of the Member's request, the Claims Administrator sends the Member/Designee and the IRO, a letter listing all documents forwarded to the IRO. These documents include copies of all information submitted for the Internal Appeal process, as well as any additional information that the Member/Designee or the Claims Administrator may submit. If the Member wishes to submit additional information for consideration by the IRO, he should do so within ten calendar days of the Member's request for an external review.

The Claims Administrator does not interfere with the IRO's proceedings or appeals decisions. The IRO conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the Internal Appeal process.

The IRO makes its final decision within **30 calendar days** of receipt of the Member's request by the Claims Administrator and simultaneously issues its decision in writing to the Member or Designee and to the Claims Administrator. The established deadline for a decision from the IRO may only be exceeded for good cause when a reasonable delay for a specific period is acceptable to the Member or Designee. If the decision of the IRO is that the services are covered, the Claims Administrator authorizes the service and/or pays the claims. The Member/Designee is notified in writing of the time and procedure for claim payment or approval of the service in the event of an overturn of the Member's Internal Appeal. The Claims Administrator implements the IRO's decision within the time period, if any, specified by the IRO.

The external review decision is binding on the Claims Administrator.

External Urgent/Expedited Review

The Member/Designee may request an external review for urgent/expedited situations through an IRO. The Member or designee is not required to pay any of the costs associated with the external review.

With the exception of time frames, the Urgent/Expedited External Review mirrors the process described above under the External Standard Review.

Within **24 hours** of receipt of the Member's request for an Urgent/Expedited Review, the Claims Administrator confirms the request and faxes the request to the assigned IRO. During this time, the Claims Administrator also forwards to the IRO, by secure electronic transmission or overnight delivery, all information submitted in the Internal Appeal Process and any additional information that the Member, Designee, or the Claims Administrator wishes to submit to the IRO.

The IRO makes a decision and simultaneously notifies the Member/Designee and the Claims Administrator in writing within **48 hours** of receipt of all relevant documentation. The decision letter identifies the assigned IRO by name and states the qualifications of the individual that the IRO appoints to review the external review.

The time period for issuing the final decision on the Urgent/Expedited Review can be extended for **five calendar days** for good cause when such a delay is acceptable to the Member or his authorized representative.

If the decision of the IRO is that the services are eligible, the Claims Administrator authorizes the service and/or pays the claims. The Member is notified in writing of the time and procedure for claim payment and/or approval of the service in the event of an overturn of the appeal. The Claims Administrator implements the IRO's decision within the time period, if any, specified by the IRO.

The external review decision is binding on the Claims Administrator.

CLAIM PROCEDURES AND MEMBER APPEAL PROCESS PPO PLANS

CLAIM PROCEDURES

How to File a Claim

The Member is never required to file a claim when Covered Services are provided by In-Network Providers. When the Member receives care from an Out-of-Network Provider, the Member will need to file a claim to receive benefits. If the Member does not have a claim form, the Member should call the Claims Administrator's Member Services Department at the number listed on the Member's Identification Card, and a claim form will be sent to the Member. The Member should fill out the claim form and return it with their itemized bills to the Claims Administrator at the address listed on the claim form no later than 20 days after completion of the Covered Services. The claim should include the date and information required by the Claims Administrator to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

If it was not possible to file the claim within the 20-day period, the Member's benefits will not be reduced, but in no event will the Claims Administrator be required to accept the claim more than 12 months after the end of the Benefit Period in which the Covered Services are rendered.

Release of Information

Each Member agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Program may furnish to the Claims Administrator, upon its request, any information (including copies of records relating to the illness or injury). In addition, the Claims Administrator may furnish similar information to other entities providing similar benefits at their request.

The Claims Administrator may furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

When the Claims Administrator needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Member who is unable to provide it, the Claims Administrator will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Member.

Limitation of Actions

No legal action may be taken to recover benefits prior to 60 days after notice of claim has been given as specified above, and no such action may be taken later than three years after the date Covered Services are rendered.

Claim Forms

The Claims Administrator will furnish to the Member or to the Group, for delivery to the Member, such claim forms as are required for filing proof of loss for Covered Services provided by Out-of-Network Providers.

Timely Filing

The Claims Administrator will not be liable under this Program unless proper notice is furnished to the Claims Administrator that Covered Services have been rendered to a Member. Written notice must be given within 20 days after completion of the Covered Services. The notice must include the date and information required by the Claims Administrator to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to give notice to the Claims Administrator within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Claims Administrator be required to accept notice more than 12 months after the end of the Benefit Period in which the Covered Services are rendered.

The above is not applicable to claims administered by In-Network Providers.

Special Circumstances

In the event that Special Circumstances result in a severe impact to the availability of providers and services, to the procedures required for obtaining benefits for Covered Services under this Program (for example, obtaining Precertification, use of In-Network Providers), or to the administration of this Program by the Claims Administrator, the Claims Administrator may on a selective basis, waive certain procedural requirements of this Program. Such waiver shall be specific as to the requirements that are waived and shall last for such period as required by the Special Circumstances as defined below.

The Claims Administrator shall make a good faith effort to provide access to Covered Services in so far as practical and according to its best judgment. Neither the Claims Administrator nor the Providers in the Claims Administrator's PPO network shall incur liability or obligation for delay or failure to provide or arrange for Covered Services if such failure or delay is caused by Special Circumstances.

Special Circumstances as recognized in the community, and by the Claims Administrator and appropriate regulatory authority, are extraordinary circumstances not within the control of the Claims Administrator, including but not limited to:

- Major Disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;

- Riot; or
- Civil insurrection

COMPLAINT AND APPEAL PROCESS

Member Complaint Process

The Claims Administrator has a process for Members to express complaints. To register a Complaint, Members should call the Member Services Department at the telephone number on their Identification Card or write to the Claims Administrator at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Claims Administrator is unable to immediately resolve the Member Complaint, it will be investigated, and the Member will receive a response in writing within 30 days.

Member Appeal Process

Filing an Appeal. The Claims Administrator maintains procedures for the resolution of Member Appeals. Member Appeals may be filed within 180 days of the receipt of a decision from the Claims Administrator stating an adverse benefit determination. An Appeal occurs when the Member or, after obtaining the Member's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Claims Administrator by following the procedures described here. (In order to authorize someone else to be the Member's representative for the Appeal, the Member must complete a valid authorization form. The Member must contact the Claims Administrator as directed below to obtain a 'Member/Enrollee Authorization to Appeal by Provider or Other Representative' form or for questions regarding the requirements for an authorized representative.

The Member or other authorized person on behalf of the Member, may request an Appeal by calling or writing to the Claims Administrator, as defined in the letter notifying the Member of the decision or as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll Free Phone: 1-888-671-5276 (TTY: 711)
Toll Free Fax: 1-888-671-5274 or
Phila. Fax: 1-215-988-6558

Changes in Member Appeals Process. Please note that the Member Appeals process may change at any time due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve or facilitate the Member Appeals process, or to reflect other decisions regarding the administration of Member Appeals process for this Program.

Copies of the Member Appeals Process Descriptions. Descriptions of the timeframes and procedures for the Member Appeals process maintained by the Claims Administrator are available from the following sources:

On the Internet at the Website for the Member's Health Plan. Copies are available there at any time. To see samples of the Member Appeals process, search for 'member appeals' in the general search engine. To review a description of the Member Appeals process for the Member's health plan, the Member must log in with the Member's personalized password.

Customer Service. To obtain a description of the Member Appeals process for the Member's health plan, call Customer Service at the telephone number listed on the Member's Identification Card. Customer Service will mail the Member a copy of the description.

When an Appeal Is Filed. As part of the Member Appeal process, a description is provided for the type of Member Appeal that has been filed. The description is sent with the acknowledgment letter for the Member Appeal.

APPENDIX B

LIFE/AD&D/LOSS OF TIME
ULLICO CONTRACT

The Union Labor Life Insurance Company
Incorporated Under the laws of the State of Maryland
WASHINGTON, D.C.

(the Company)
Statutory Home Office: 32 South Street, Baltimore, Maryland 21202
Main Administrative Office: 111 Massachusetts Ave., N.W., Washington, D.C. 20001
Phone: (202) 682-0900 or 1-(800) 431-5425

Certifies that it has issued Life Policy No. G-2955
and Health Policy No. C-3970

to

TRUSTEES OF THE LABORERS' DISTRICT COUNCIL HEAVY AND HIGHWAY CONSTRUCTION HEALTH AND WELFARE FUND
(the Policyholder)

This Certificate describes the benefits and main points of the Policy for individuals who are eligible for insurance under the Policy. The benefits described in this Certificate apply to individuals only if they are eligible, become insured, and remain insured in accordance with all the terms and conditions of the Policy. If there is a discrepancy between the terms of the Policy and this Certificate, the Policy will control.

This Certificate replaces any prior Certificates issued by the Company to individuals covered under the Policy.

READ YOUR CERTIFICATE CAREFULLY!

THE UNION LABOR LIFE INSURANCE COMPANY

PRESIDENT

CERTIFICATE OF GROUP INSURANCE
(The Certificate)

GC-9700 **(04/02)**

ULL-GRP-0813

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SECTION 1 - SCHEDULE OF BENEFITS
(Effective May 1, 2015)

THE AMOUNT OF INSURANCE OF ANY PERSON SHALL BE BASED UPON THE FOLLOWING:

FORMS OF INSURANCE	**AMOUNT OF INSURANCE**
All Eligible Persons	$ 25,000.00*

* For Persons disabled on or after April 1, 1998, the amount of Life Insurance that will be continued under the Waiver of Premium provision under the Policy will be reduced to $ 3,000.00.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT
(Principal Sum)

All Eligible Persons	$ 25,000.00

LOSS OF TIME BENEFIT

Weekly Amount	$ 500.00**
Waiting Period for Disability	
While Hospital Confined	None
While Not Hospital Confined:	
Due to Injury	None
Due to Illness	7 Days
Maximum Benefit Period (Per Disability)	30 Weeks

** Those Persons who were receiving disability benefits on or after the effective date of this increase will be entitled to the higher benefit.

SECTION 2 - DEFINITIONS

Defined terms are shown in the Policy with an initial capital letter. The following definitions apply to these terms when used in the Policy, unless otherwise defined where such term is used.

Claims Administrator

The entity assigned to pay claims in accordance with the terms and conditions of the Policy. The Claims Administrator may be the Company, the Policyholder, or a third party with whom the Company or the Policyholder has a valid contract to pay claims.

Company

The Union Labor Life Insurance Company, 111 Massachusetts Avenue, N.W., Washington, D.C. 20001.

Doctor

An individual licensed as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). The term "Doctor" shall also include any licensed or certified health care provider as required by state law, for services which are within the scope of the health care provider's license or certificate.

Illness

A disorder or disease of the body or mind. Illness shall include: (a) pregnancy; (b) childbirth; and (c) related medical conditions.

Injury

Bodily harm that: (a) the Person sustains while this benefit is in force; and (b) is not the result of an Illness.

Officer of the Company

The Chairman, Chief Executive Officer, President, a Vice President, the Secretary or Assistant Secretary of the Company.

Person

An employee and/or member of a Participating Employer who is insured under the Policy and in a Class of Eligible Persons.

Policy

The contract, the application, and any subsequent amendment that the Company issues to the Policyholder.

SECTION 3 - ELIGIBILITY

PERSONS

Classes of Eligible Persons

All active employees of Participating Employers, whose employment is the subject of a Collective Bargaining Agreement by and between the Participating Employers and the Laborers' District Council Heavy and Highway Construction Health and Welfare Plan.

When A Person First Becomes Eligible

A Person, who is in a Class of Eligible Persons on or after the Policy Effective Date, will be eligible for the insurance provided by the Policy on the later of the:

1. Policy Effective Date; or

2. the first day of the Eligibility Period which follows any one corresponding Work Period during which such Person has had at least 300 hours reported to the Fund on his or her behalf from Participating Employers.

Work Period and **Eligibility Period** means the corresponding six-month periods which are listed below:

WORK PERIOD	ELIGIBILITY PERIOD
September 1 thru February 28	May 1 thru October 31
March 1 thru August 31	November 1 thru April 30

Effective Date of Person's Insurance

A Person's insurance will become effective on the date he or she is eligible.

Continuation of Eligibility

1. Once insured, a Person will continue to be eligible for a subsequent Eligibility Period, as an active employee, provided he or she has a minimum of 300 hours reported on his or her behalf in the Work Period immediately following.

2. A Person will also be allowed to establish and maintain eligibility if he or she has:

   a. at least 750 hours reported on his or her behalf during either one of the two Work Periods. The Person will then be eligible for two consecutive Eligibility Periods; or

   b. has less than 300 hours reported on his or her behalf during one Work Period, he or she may still remain eligible for the insurance by having a combined total of at least 750 hours for the two consecutive Work Periods. The Person will be eligible for benefits for the Eligibility Period following the Work Period in which the eligibility is created.

SECTION 3 – ELIGIBILITY
(Continued)

3. Any hours reported in excess of the hours required for eligibility will be held in an Hour Bank. The hours in a Person's Hour Bank may not exceed 50 hours for any Work Period, nor may it exceed more than 200 hours in total.

4. A Person will be credited with 6 hours per day if he or she is disabled as a result of an on the job injury or illness and is receiving benefits from the Worker's Compensation, which is provided up to the maximum of six months. No hours will be credited beyond this six-month period. The Fund Office must receive a letter on the Person's behalf from his or her Participating Employer, stating the date of the accident and the length of time the Person was out of work.

When a Person's Insurance Terminates

A Person's insurance under the Policy will terminate upon the earliest of:

1. the date the Policy terminates;

2. the date the Person is no longer in a Class of Eligible Persons under the Policy;

3. the date premium payments on behalf of the Person cease; or

4. the date the Person fails to pay the required premium, if any, when due.

Reinstatement of Insurance

If a Person's insurance terminates for any reason, he or she may again become eligible for the insurance by satisfying the requirement of eligibility as a new employee under the provision titled *When a Person First Becomes Eligible* in this Section of the Policy.

SECTION 4 - LIFE INSURANCE BENEFIT

PERSONS

The Life Insurance Benefit will be paid if a Person dies while insured under this benefit.

Benefit Determination

The amount of benefit to be paid will be the Amount of Insurance as shown in the **Schedule of Benefits** Section which is in force for the Person on the date of his or her death, subject to all the terms and conditions of the Policy.

Benefit Payment

The benefit will be paid to the Person's named Beneficiary, upon receipt of due proof of death, as provided in the **Claim Payment** Section.

Assignment of Benefits

A Person may not assign his or her Life Insurance Benefit under the Policy to any individual or entity.

CONVERSION PRIVILEGE

If an individual's Life Insurance Benefit, or any portion thereof, terminates, he or she is entitled to convert all or a portion of the Amount of Insurance which has been terminated. This conversion will be to an individual policy of life insurance ("Conversion Policy"). The individual will not be required to submit proof of good health to convert.

Conversion Rights for Persons

Conversion Rights, upon Individual Termination or Class Change

If a Person's Life Insurance Benefit, or any portion thereof, terminates because he or she:

1. ceases to be eligible under "Classes of Eligible Persons" appearing under PERSONS in the **Eligibility** Section; or

2. transfers from one Class of Eligible Persons to another, and the class to which he or she has transferred, offers lesser benefits;

he or she may convert up to the Amount of Insurance which terminated, less any amount for which he or she becomes eligible under the Life Insurance Benefit of the Policy or under any other group policy within 31 days from the date of termination.

SECTION 4 - LIFE INSURANCE BENEFIT
(Continued)

Conversion Rights Upon Individual Reduction due to Age or Retirement

If a Person's Life Insurance Benefit is reduced because of the individual's:

1. age; or

2. retirement;

he or she may convert up to the amount of the reduction.

Conversion Rights upon Policy or Class Termination

If a Person's Life Insurance Benefit terminates because the Policy:

1. terminates; or

2. is amended to terminate coverage for a Class of Eligible Persons under which the Person was insured;

he or she may convert to an amount that does not exceed the lesser of the following, provided the Person has been continuously insured under the Life Insurance Benefit of the Policy (or the plan which the Policy replaced) for at least 5 years:

1. the amount of Life Insurance Benefit in effect for the Person on the date of termination, less any amount for which he or she is or becomes eligible under the Policy or any other group policy (which replaces the Policy) within 31 days after the date of termination; or

2. $2,000.

Notice of Conversion Privilege

The Policyholder must notify an individual of his or her right to convert. If the notice is not given by the 16th day of the 31-day Conversion Period, the individual will have an additional period in which to convert. The additional period will expire 15 days from the date he or she is notified, but in no event will the right to convert be extended more than 90 days beyond the date the individual's insurance terminated under the Policy. Written notice presented to the individual, or mailed to his or her last known address, shall constitute notice for purposes of this provision.

In no event is the individual's Life Insurance Benefit extended beyond the end of the 31-day Conversion Period, whether or not notice is given.

Conversion Period

To qualify for a Conversion Policy, an individual must submit a written application to the Company and pay the first premium due within 31 days from the date his or her Life Insurance Benefit terminates under the Policy, unless an additional period in which to convert has been granted as shown in *Notice of Conversion Privilege* in this Section.

SECTION 4 - LIFE INSURANCE BENEFIT
(Continued)

Conversion Policy

An individual who is eligible to convert is entitled to convert to any individual policy which is then being offered by the Company, other than term insurance, or insurance which provides disability or other supplemental benefits.

Premium Rates

The premium rates for the Conversion Policy will be the Company's premium rates in effect for the amount and type of policy elected and based on the individual's class of risk and attained age (age nearest birthday at the date of issue of the Conversion Policy) on the effective date of the Conversion Policy.

Effective Date

The individual life insurance Conversion Policy will take effect:

1. at the end of the 31-day period; or

2. 31 days after the date of the notice, but not beyond 60 days after insurance terminated under the Policy;

provided the premium has been paid before the end of such period.

Death Within the Conversion Period

If an individual dies during the 31-day Conversion Period, the maximum Amount of Insurance which he or she was entitled to convert under the Life Insurance Benefit will be paid as a benefit under the Policy, to the last Beneficiary named by the individual, whether or not conversion was applied for, and premium paid.

If a Conversion Policy was applied for, such Conversion Policy will be null and void even if the Conversion Policy had been issued; and no death claim will be payable under the Conversion Policy. The Company will return any premium paid for the Conversion Policy.

Limitation on Amount Converted

No individual who is insured or who becomes insured under the Policy and who holds an individual life insurance policy obtained through exercise of the Conversion Privilege of the Policy, shall again be entitled to exercise the Conversion Privilege for which he or she is otherwise eligible as long as such individual policy of life insurance remains in effect.

SECTION 4 - LIFE INSURANCE BENEFIT
(Continued)

WAIVER OF PREMIUM (Active Persons Only)

A Person under the age of 60:

1. who becomes Totally Disabled while insured under the Policy;

2. who has been Totally Disabled for at least 9 months; and

3. for whom premium payments continue to be made or whose coverage is terminated for failure to meet the Eligibility requirements stated in the Policy because of Total Disability;

may apply to continue his or her life insurance under this Waiver of Premium provision. The initial continuation of insurance under this provision will be for 12 months from the date premium payments on behalf of the Person cease; the date Total Disability began; or the date the application for waiver is approved; whichever occurs first.

Waiver of Premium will continue until the earlier of:

1. the date the Person's Total Disability ends; or

2. the end of the 12-month period.

"Totally Disabled" and "Total Disability" mean the Person's complete inability; due to Injury or Illness; to engage in any business, occupation or employment for which the Person is qualified, or becomes qualified by reason of education, training, or experience, for pay; profit; or compensation.

The Person must submit satisfactory written proof (the "Initial Proof") of Total Disability within 12 months from the date the premium payments on behalf of such Person cease; or he or she becomes Totally Disabled.

The Initial Proof must show that the Total Disability:

1. began while the Person was insured under the Policy;

2. began before the attainment of age 60; and

3. has rendered the Person Totally Disabled for at least 9 consecutive months.

Notice of Application for Waiver Determination

The Company will give written notice to the applicant within 10 days of receipt of an application for waiver. The notice will state whether or not the application is approved and give the reasons for any disapproval. If the application for waiver is disapproved, the Person may continue eligibility under the Policy for Life Insurance only if the Policyholder continues the Person on a premium-paying basis.

SECTION 4 - LIFE INSURANCE BENEFIT
(Continued)

A Person who is denied continuation of his or her group Life Insurance through Waiver of Premium and:

1. is not continued by the Policyholder on a premium-paying basis; or

2. did not exercise his or her right to convert to an individual policy of life insurance;

may be entitled to the same conversion rights that applied to the Person on the date his or her Life Insurance would have terminated in the absence of this Waiver of Premium provision.

A Person who holds an individual conversion policy and who has been denied continuation of his or her group Life Insurance through Waiver of Premium, may continue his or her coverage under the individual conversion policy.

Death of Person Before or While Waiver of Premium is in Effect

If a Person applies for waiver under this provision and dies before this Waiver of Premium is in effect, the Beneficiary must submit written proof that Total Disability continued without interruption from the date the Person became Totally Disabled to the date of death. Except that if at the time of death, Life Insurance on the Person has been continued on a premium paying basis, the Amount of Insurance inforce under the Policy will be paid to the beneficiary, subject to the all the terms and conditions of the Policy.

If a Person dies while this Waiver of Premium is in effect, the Beneficiary must submit written proof that Total Disability continued without interruption from the last anniversary of the Company's receipt of proof Total Disability to the date of death.

Benefit Amount

The amount of Life Insurance continued under this Waiver of Premium, will be the Amount of Insurance in force for the Person on the date the premium payments on behalf of such Person cease; he or she became Totally Disabled. The amount of Life Insurance continued under this Waiver of Premium is subject to any reduction or termination in the Amount of Insurance, as shown on the Schedule of Benefits.

Any Person who:

1. is approved for waiver under this provision and

2. holds an individual policy of life insurance through exercise of the Conversion Privilege under the Policy;

is not entitled to receive benefits under both the Policy and the individual conversion policy for the same amounts of insurance. At the time of the Person's death, payment will be made under the Policy only if the individual policy is surrendered to the Company without claim other than for return of the premiums paid, less dividends.

SECTION 4 - LIFE INSURANCE BENEFIT
(Continued)

Continuance of Waiver of Premium

A Person who has applied for and received approval of Waiver of Premium for the Life Insurance Benefit under the Policy, may continue the Waiver of Premium for additional 12-month periods, provided the Person:

1. remains Totally Disabled and

2. submits written proof of continued Total Disability each year within 3 months of the anniversary date of the date the Person becomes Totally Disabled.

Right to Require Examination

The Company, at its own expense, may require a Person whose Life Insurance has been continued by this Waiver of Premium to be examined by a Physician of its choice, at any reasonable time during the Person's first two years of Total Disability. After two years, the Company will not require such examination more than once a year.

Conversion Privilege

A Person, whose Life Insurance was continued by this Waiver of Premium, may be entitled to the same conversion rights that applied to the Person on the date his or her Life Insurance would have terminated in the absence of this Waiver of Premium provision.

SECTION 5 - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Upon receipt of due proof of loss, the Accidental Death and Dismemberment Benefit will be paid if:

1. a Person, while insured under this benefit, suffers an accidental Injury; and

2. as the direct result of the accident, and independent of all other causes, the Person:

   a. suffers a Covered Loss, other than death, within 90 days after the accident; or
   b. dies at any time after the accident.

A "Covered Loss" means permanent loss of:

1. life;

2. a hand, by complete severance at or above the wrist joint;

3. a foot, by complete severance at or above the ankle joint; or

4. an eye, involving irrecoverable and complete loss of sight in the eye;

except as excluded under *Exclusions* in this Section, and subject to all the terms and conditions of the Policy. The amount of benefit to be paid for a Covered Loss is determined as follows:

SCHEDULE OF LOSSES

FOR LOSS OF:	**THE BENEFIT IS:**
LIFE	THE PRINCIPAL SUM
TWO HANDS	THE PRINCIPAL SUM
TWO FEET	THE PRINCIPAL SUM
SIGHT OF TWO EYES	THE PRINCIPAL SUM
ONE HAND AND ONE FOOT	THE PRINCIPAL SUM
ONE HAND AND SIGHT OF ONE EYE	THE PRINCIPAL SUM
ONE FOOT AND SIGHT OF ONE EYE	THE PRINCIPAL SUM
ONE HAND OR ONE FOOT	ONE-HALF THE PRINCIPAL SUM
SIGHT OF ONE EYE	ONE-HALF THE PRINCIPAL SUM

If the Person suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

SECTION 5 - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT
(Continued)

Exclusions

No benefit will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

1. bodily or mental Illness or disease of any kind;

2. ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);

3. suicide or attempted suicide;

4. intentional self-inflicted Injury;

5. participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion;

6. war or act of war, declared or undeclared; or any act related to war, or insurrection;

7. service in the armed forces of any country while such country is engaged in war; or

8. police duty as a member of any military, naval or air organization.

SECTION 6 - LOSS OF TIME BENEFIT

The Loss of Time Benefit will be paid upon receipt of due proof, that a Person, while insured under this benefit, becomes Totally and Continuously Disabled as a result of:

1. accidental Injury; or

2. an Illness.

The Company will pay the Weekly Amount, subject to the: (a) Waiting Period; and (b) Maximum Benefit Period, as shown in the **Schedule of Benefits** Section. For any Period of Disability that is less than 1 week in duration, the benefits will be paid at one-seventh of the Weekly Amount multiplied by the number of days.

Definitions

Occupational Disease

A disease for which the Person is provided benefits under the applicable Workers' Compensation, Occupational Disease Law or similar law.

Period of Disability

The entire period of time a Person is Totally and Continuously Disabled and for which benefits are payable.

Totally and Continuously Disabled

The Person, as a result of a covered Injury or Illness, is prevented from performing all of the material and substantial duties of his or her employment. The Person must be under the regular care of a Doctor acting within the scope of his or her license. After 24 months of Continuous Disability. Total Disability is defined as the Person's inability to perform all of the substantial and material duties of any occupation for which he or she is reasonably suited by reason of:

1. education;

2. training; or

3. experience.

Proof of Disability

The Person must provide the Company with due proof of disability. The treating Doctor must, within the scope of his or her license, certify the: (a) Person's disability; (b) probable duration of the disability; and (c) medical facts within his or her knowledge.

SECTION 6 - LOSS OF TIME BENEFIT
(Continued)

Successive Period(s) of Disability

Successive Period(s) of Disability are considered one Period of Disability unless:

1. the Person has returned to continuous active full-time employment for 2 consecutive weeks;

2. the disability is due to causes entirely unrelated to and different from those that caused the previous disability, and such Person has returned to work for at least 1 full day.

Exclusions

No benefits are payable for any Period of Disability:

1. during which the Person is not under the direct care of a Doctor. It is understood that no disability will be considered as having begun more than 3 days prior to the first visit made to or by a Doctor for the condition which caused the disability;

2. due to accidental bodily Injury arising out of and in the course of the Person's employment;

3. due to Occupational Disease; or

4. which did not start while the Person was covered under this Benefit.

SECTION 7 - CLAIM PAYMENT

BENEFICIARY (Life Insurance and Accidental Death and Dismemberment Benefits)

For Persons

A Person's Beneficiary is the party or parties named by the Person, as shown on the Company's records, to receive the benefits payable under the Policy upon the Person's death. The Person may name one or more Beneficiaries to receive the death benefit.

The Person may change the Beneficiary at any time, without the consent of the previously named Beneficiary. Such change must be requested in writing on a form furnished by or satisfactory to the Company. Such change will take effect upon receipt of the signed form at the Main Administrative Office of the Company.

Upon receipt of Satisfactory Proof of Claim, the Claims Administrator will pay the death benefit due under the Life Insurance and Accidental Death and Dismemberment Benefits to the Person's named Beneficiary as follows:

1. If the Person has named more than one Beneficiary, each surviving Beneficiary will share equally, unless otherwise indicated by the Person when the Beneficiaries were named.

2. If there is no named Beneficiary, or if no named Beneficiary is surviving at the time of death of the Person, payment will be made to the first surviving class in the following order of preference:

   a. the surviving spouse;
   b. the Person's children, in equal shares;
   c. the Person's parents, in equal shares;
   d. the Person's brothers and sisters, in equal shares; or
   e. the executors or administrators of the Person's estate.

   In order to determine which class of individuals is entitled to the death benefit, the Claims Administrator may rely on an affidavit made by any individual listed above. If payment is made based on such affidavit, the Company will be discharged of its liability for the amount so paid, unless written notice of claim by another individual listed above is received before payment is made.

3. If the Beneficiary is a minor or someone not able to give a valid release for payment, the Claims Administrator will pay the benefit to his or her legal guardian. If there is no legal guardian, the Claims Administrator may pay the individual or institution who has, in its opinion, custody and principal support of such Beneficiary. The Company will be fully discharged of its liability for any amount of benefit so paid in good faith.

SECTION 7 - CLAIM PAYMENT
(Continued)

LIFE INSURANCE

Proof of Claim

Satisfactory Proof of Claim will include a certified copy of the individual's death certificate and any other data that the Claims Administrator may require to establish the validity of the claim.

Facility of Payment

If an individual appears to the Claims Administrator to be equitably entitled to compensation because he or she has incurred expenses on behalf of the Person's burial, the Claims Administrator may pay to such individual the expenses incurred up to $500. Such payment, however, shall not exceed the amount due under the Policy. The Company will be fully discharged of its liability for any amount of benefit so paid in good faith.

Mode of Payment

Death benefit proceeds will be paid to the Beneficiary in one lump sum.

Maximum Payment of Benefits

The total benefit payable under the Policy for Life Insurance will never exceed the Amount of Insurance shown in the **Schedule of Benefits** Section. In no event will payment be made under more than one of the following Life Insurance provisions:

1. Life Insurance Benefit;

2. Waiver of Premium; or

3. Conversion Privilege.

SECTION 7 - CLAIM PAYMENT
(Continued)

ACCIDENT AND HEALTH INSURANCE

Notice and Claim Forms

In order to receive a claim form for filing a claim, written notice of a claim must be given to the Claims Administrator within 90 days after the date of a loss which is covered under the Policy. Otherwise, the Claims Administrator must be notified as soon as it is reasonably possible to do so. If claim forms are available from the Policyholder, written notice of a claim is not required in order to receive a claim form.

Upon receipt of the written notice of claim, the Claims Administrator or Policyholder will provide claim forms for filing proof, to the Person making a claim. If the Person does not receive the claim forms within 15 days after he or she sent notice of a claim, the Person can file a claim without a claim form by sending the Claims Administrator written proof of claim which includes the information required under *Proof of Loss* as described below.

Proof of Loss

Proof of the loss for which a claim is made must be given to the Claims Administrator no later than 90 days after the date of loss. A claim will not be reduced or denied for failure to provide proof within this time, if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible.

The proof of the loss must include all information necessary for the Claims Administrator to determine the:

1. nature of the loss; and

2. date of the loss.

The Claims Administrator may require, as part of the proof, authorization to obtain medical and non-medical information. The Claims Administrator will notify the Person of any additional information required to process a claim.

Payment of Claims

For a covered loss, benefits shall be paid directly to the Person. In case of loss of life, benefits will be made to the Person's Beneficiary.

Facility of Payment

If any benefit is payable to the Person's estate or to a person who is a minor or someone who lacks the capacity to give a valid release for payment, the Claims Administrator may pay the benefit, up to an amount of $1,000, to any relative by blood or connection by marriage of the Person who is deemed by the Company to be equitably entitled to the benefit. The Company will be fully discharged of its liability for any amount of benefit so paid in good faith.

SECTION 7 - CLAIM PAYMENT
(Continued)

Right to Examination and Autopsy

The Claims Administrator, at its own expense, has the right to have:

1. the Person whose claim is pending examined, by a Doctor of its choice; and

2. an autopsy performed, if it is not prohibited by law.

Legal Actions

A claimant, or the claimant's authorized representative cannot start any legal action with respect to a claim:

1. until 60 days after proof of claim, as required above, has been given; nor

2. more than 3 years after the time proof of claim is required.

SECTION 8 – GENERAL PROVISIONS

New Entrants

Eligible new individuals may be added from time to time, to the group or class of individuals originally insured, in accordance with the terms and conditions of the Policy.

Statements; Incontestability of Insurance

All statements made by the Policyholder or a Person are considered, except for fraud, to be representations and not warranties. No such statements may be used to contest the validity of the Policy, or a Person's insurability unless:

1. it is in writing and signed by the Policyholder or the Person; and

2. a copy of the statement is given to the Policyholder, the Person or his or her Beneficiary.

A Person's insurance, for which proof of good health was required, will not be contested after such insurance has been in force for 2 years during his or her lifetime. This provision does not preclude the Company from asserting defenses based upon the Person's ineligibility for insurance or non-payment of premium.

Misstatement of Age

If the age of a Person has been misstated, the Company will use the Person's true age to determine:

1. the effective date or termination date of the Person's insurance under the Policy;

2. the amount of insurance; and

3. any other rights or benefits affected by age.

Based on true age, the Company may make an adjustment to the premiums, the benefits, or both.

Policy Not in Lieu of Workers' Compensation Insurance

The Policy is not in lieu of, and does not affect any requirements for insurance by state Workers' Compensation Insurance laws.

Conformity with State Statutes

Any provision of the Policy that is in conflict with the laws of the state in which the Policy is delivered, or issued for delivery, is amended to conform to the minimum requirements of those laws.

APPENDIX C

POST-RETIREMENT MEDICARE ADVANTAGE PLAN

AETNA SUMMARIES

aetna®

Laborers District Council of Philadelphia
Aetna Medicare SM Plan (PPO)
Medicare (C04) ESA PPO Plan
Rx $5/$15/$30

Benefits and Premiums are effective January 1, 2016 through December 31, 2016

National

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network & Out-of-Network Providers
Combined In and Out of Network Deductible (Plan Level/includes Network Deductible)	$147

Unless otherwise indicated, the Deductible must be met prior to benefits being payable.
Services exempt from the plan level deductible: annual wellness exams, routine physical exam, routine mammograms, routine hearing exam, routine colorectal screening, routine prostate screening, bone mass measurement, immunization, routine GYN, routine eye care, additional Medicare preventive care services, emergency room, emergency ambulance services, urgently needed care.
Deductible is NOT applicable to any additional non-Medicare covered services that may be available on your plan.

Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%
Annual Maximum Out-of-pocket amount (Combined network and out-of-network and the deductible)	$1,500

Annual Maximum Out-of-pocket Limit amount applies to all medical expenses EXCEPT Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.

Primary Care Physician Selection	Not Applicable

Certification Requirements
There is not a requirement for member pre-certification. If a member fails to obtain pre-certification they will not be denied services or will any penalty amount be applied. However, pre-certification is requested on certain services including inpatient hospital care, inpatient mental health and substance abuse, skilled nursing facility, home health care and some durable medical equipment.

Referral Requirement	Not Applicable
PREVENTIVE CARE	
Annual Wellness Exams One exam every 12 months	Covered 100%

aetna®

Laborers District Council of Philadelphia
Aetna Medicare SM Plan (PPO)
Medicare (C04) ESA PPO Plan
Rx $5/$15/$30

Benefits and Premiums are effective January 1, 2016 through December 31, 2016

National

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Physical Exams One exam every 12 months	Covered 100%
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	Covered 100%
Routine GYN Care (Cervical and Vaginal Cancer Screenings) One routine GYN visit and pap smear every 24 months	Covered 100%
Routine Mammograms (Breast Cancer Screening) One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over	Covered 100%
Routine Prostate Cancer Screening Exam For covered males age 50 and over every 12 months	Covered 100%
Routine Colorectal Cancer Screening For all members age 50 and over.	Covered 100%
Routine Bone Mass Measurement One exam every 24 months	Covered 100%
Additional Medicare Preventive Services* **	Covered 100%
Routine Eye Exams One annual exam every 12 months	Covered 100%
Routine Hearing Screening One exam every 12 months	Covered 100%
PHYSICIAN SERVICES	

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Primary Care Physician Visits	Covered 100%
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	Covered 100%
Allergy Testing	Covered 100%
DIAGNOSTIC PROCEDURES	
Outpatient Diagnostic Laboratory	Covered 100%
Outpatient Diagnostic X-ray	Covered 100%
Outpatient Diagnostic Testing	Covered 100%
Outpatient Complex Imaging	Covered 100%
EMERGENCY MEDICAL CARE	
Urgently Needed Care	Covered 100%
Emergency Care; Worldwide (waived if admitted)	Covered 100%
Ambulance Services	Covered 100%
HOSPITAL CARE	
Inpatient Hospital Care	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Surgery	Covered 100%
MENTAL HEALTH SERVICES	
Inpatient Mental Health Care	Covered 100%

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The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	Covered 100%
ALCOHOL/DRUG ABUSE SERVICES	
Inpatient Substance Abuse (Detox and Rehab)	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay	
Outpatient Substance Abuse (Detox and Rehab)	Covered 100%
OTHER SERVICES	
Skilled Nursing Facility (SNF) Care	Covered 100%
Limited to 100 days per Medicare benefit period. The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Home Health Agency Care	Covered 100%
Hospice Care	Covered by Medicare at a Medicare certified hospice
Outpatient Rehabilitation Services	Covered 100%
(speech, physical, and occupational therapy.)	
Cardiac Rehabilitation Services	Covered 100%
Chiropractic Services	Covered 100%
For manipulation of the spine to the extent covered by Medicare	
Durable Medical Equipment/ Prosthetic Devices	Covered 100%
Podiatry Services	Covered 100%

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Limited to Medicare covered benefits only	
Diabetic Supplies	Covered 100%
Outpatient Dialysis Treatments	Covered 100%
Medicare Part B Prescription Drugs	Covered 100%
ADDITIONAL NON-MEDICARE COVERED SERVICES	
Healthy Lifestyle Coaching One phone call per week	Included
PHARMACY - PRESCRIPTION DRUG BENEFITS	**Cost Share**
Prescription drug calendar year deductible	$0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network	Group Standard Network
Formulary	Managed Standard (Three Tier)

Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers. Refer to the "Coverage Tier Chart" below to find which drug types are included in each tier of your plan design.

Initial Coverage Limit (ICL)	$3,310	Covered Medicare Prescription Drug Expenditure

The Initial Coverage Limit includes the applicable plan deductible. Until covered Medicare Prescription Drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied), cost-sharing is as follows:

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Retail - Member Cost-Sharing up to the Initial Coverage Limit	Member pays $5 Copay for Tier 1 Generic Member pays $15 Copay for Tier 2 Preferred Brand (includes some high-cost generic and preferred brand drugs) Member pays $30 Copay for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs)

Up to one month (30 day) supply at indicated copay or coinsurance
Three month (90 day) supply available at retail. When you obtain a 90 day supply at retail, you pay your Mail Order cost share.

Mail Order through Aetna Rx Home Delivery - Member Cost-Sharing up to Initial Coverage Limit	Member pays $10 Copay for Tier 1 Generic Member pays $30 Copay for Tier 2 Preferred Brand (includes some high-cost generic and preferred brand drugs) Member pays $60 Copay for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs)

Up to a three month (90 day) supply available via our preferred vendor, Aetna Rx Home Delivery.

Coverage Gap**
Once covered Medicare Prescription Drug expenses have reached the Initial Coverage Limit, the Coverage Gap begins. Member cost sharing under the plan between the Initial Coverage Limit and until $4,850 in true out-of-pocket costs for Covered Part D drugs is incurred is as follows:

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Retail - Member Cost-Sharing during Coverage Gap**	Member pays $5 Copay for Tier 1 Generic Member pays $15 Copay for Tier 2 Preferred Brand (includes some high-cost generic and preferred brand drugs) Member pays $30 Copay for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs)

Up to one month (30 day) supply at indicated copay or coinsurance
Three month (90 day) supply available at retail. When you obtain a 90 day supply at retail, you pay your Mail Order cost share.

Mail Order through Aetna Rx Home Delivery - Member Cost Sharing during Coverage Gap**	Member pays $10 Copay for Tier 1 Generic Member pays $30 Copay for Tier 2 Preferred Brand (includes some high-cost generic and preferred brand drugs) Member pays $60 Copay for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs)

Up to a three month (90 day) supply available via our preferred vendor, Aetna Rx Home Delivery.

Catastrophic Coverage	Greater of $2.95 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of $7.40 or 5% for all other covered drugs.

Catastrophic Coverage benefits start once $4,850 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Yes
Step-Therapy	Yes

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Non-Part D Drug Rider	Rider B Enhanced

Coverage Tier Chart

Tier 1 Generic: includes low-cost generic drugs
Tier 2 Preferred Brand: includes some high-cost generic and preferred brand drugs
Tier 3 Non-Preferred Brand: includes some high-cost non-preferred generic and non-preferred brand drugs

*** Additional Medicare Preventive Services include:

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease and HIV screening
- Behavioral therapy for HIV screening

Aetna Medicare is a Medicare Advantage organization with a Medicare contract. A Medicare approved Part D sponsor. Enrollment in Aetna Medicare depends on contract renewal. The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B Premium.
Members must be entitled to Medicare Part A and continue to pay the Part B premium and Part A, if applicable.

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Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

This material is for informational purposes only. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage. Plan features and availability may vary by location and are subject to change Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy participation is subject to change.
Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline, or go directly to an emergency care facility.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare unless otherwise noted in the plan.
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some in-network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

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This material is for informational purposes only and is not medical advice. Health information programs provide general health information are not a substitute for diagnosis or treatment by a physician or other health care professional. Contact a health care professional with any questions or concerns about specific health care needs. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna is not a provider of health care services and, therefore, cannot guarantee any results or outcomes. The availability of any particular provider cannot be guaranteed and is subject to change. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

**Your plan sponsor/former employer provides additional coverage during the Coverage Gap phase for covered brand-name drugs. This means that you will generally continue to pay the same amount for covered brand-name drugs throughout the Coverage Gap phase of the plan as you paid in the Initial Coverage phase.

Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied.

Your plan includes a reduced copay on some generic drugs, called Select Care generics. These generic drugs provide cost-effective options to treat high blood pressure, high cholesterol and diabetes. The list of SelectCare generic drugs can be found in the Medicare formulary guide.

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offering as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS; we receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

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- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs". These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Barbiturates (except as identified by Original Medicare for Part D inclusion)
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over the counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

We receive rebates from drug manufacturers that may be considered when determining our Preferred Drug List. Rebates do not reduce the amount you pay the pharmacy for covered prescriptions.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances when a network pharmacy is not available. If you become ill, while traveling in the United States but are outside of your plan's service area, you may need to use an out-of-network pharmacy. An additional cost may be charged for drugs received at an out-of-network pharmacy. Quantity limits and restrictions may apply.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

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- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24/7.
- The Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778**.
- Your state Medicaid office.

If you qualify, Medicare could pay for up to 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it.

This information is available for free in other languages. Please call our customer service number at **1-888-982-3862** (TTY/TDD 711) for additional information. Hours of operation: 7 days per week, 8am to 8pm.

Esta información está disponible en otros idiomas de manera gratuita. Si desea más información, comuníquese con Servicios al Cliente al **1-888-982-3862** (TTY/TDD: 711). Horario de atención: los 7 días de la semana, de 8 a.m. a 8 p.m.

Aetna Medicare non-Part D Drug Rider

Certain types of drugs or categories of drugs are not normally covered by Medicare prescription drug plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs."

This plan offers additional coverage for some prescription drugs not normally covered under a Medicare prescription drug plan. The amount paid when filling a prescription for these drugs does not count towards qualifying for catastrophic coverage.

For those receiving Extra Help from Medicare to pay for prescriptions, the Extra Help will not pay for these drugs.

Non-Part D drugs covered under the Supplemental Benefit Prescription Drug Rider are:

- Agents when used for weight loss, weight gain or anorexia
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Cough/cold drugs
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth

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List of non-Part D drugs that are not covered under the Supplemental Benefit Prescription Drug Rider are:

- Non-prescription drugs
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

Non-Part D drugs covered under the rider can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan. The physician can contact Aetna for prior authorization, toll free at **1-800-414-2386**.

You can call Member Services at the toll free phone number on the back of your Aetna Medicare member ID card if you have questions.

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to **www.aetna.com**.
2015 Aetna Medicare

*****This is the end of this plan benefit summary*****