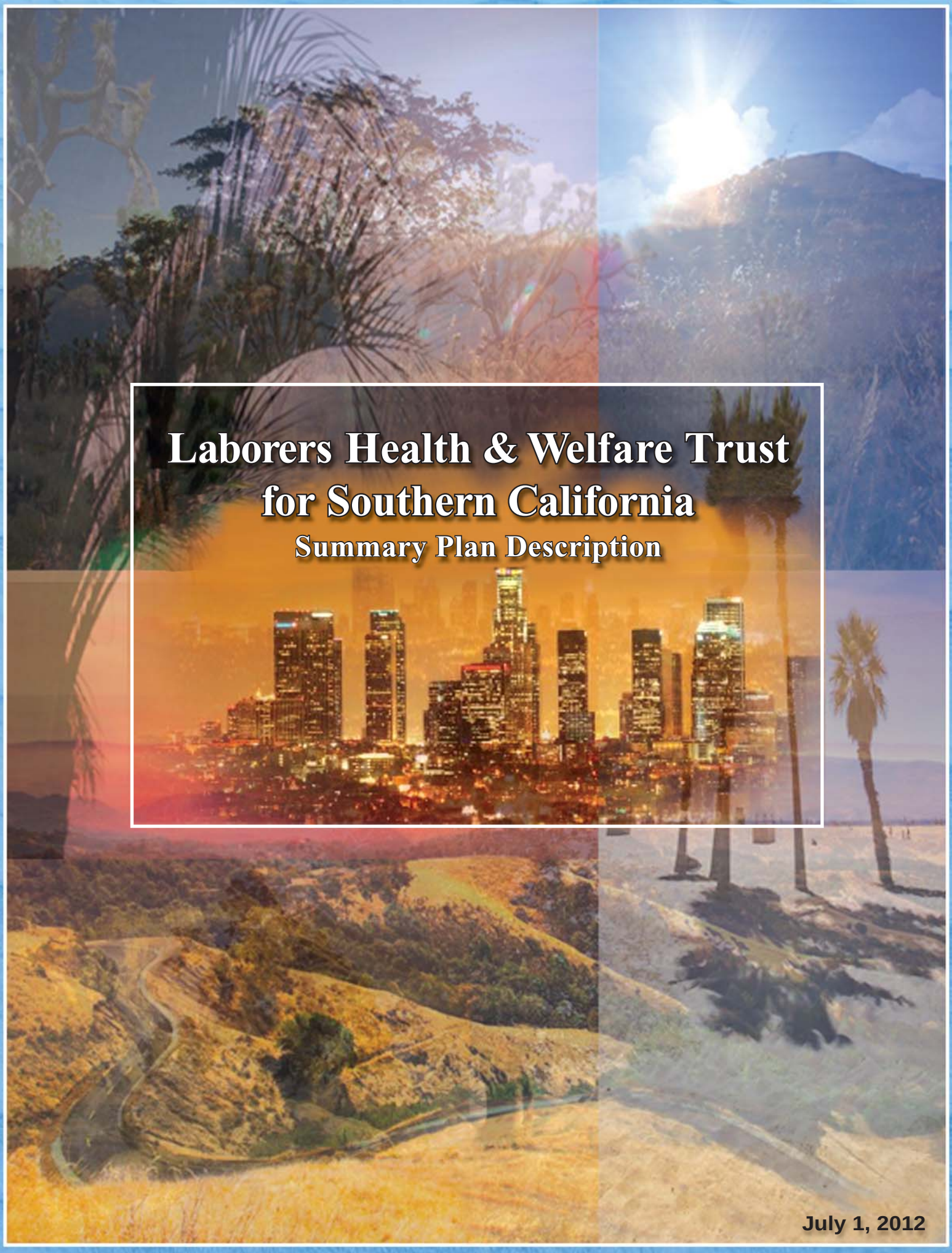

Laborers Health & Welfare Trust for Southern California

Summary Plan Description

July 1, 2012

Summary Plan Description

July 1, 2012

Active Employees
and their eligible Spouses and Dependents

Retired Employees
Not eligible for Medicare and their eligible Spouses
and Dependents not eligible for Medicare

Surviving Spouses
and their eligible Dependents
Not eligible for Medicare

Si usted tiene alguna pregunta tocante a este asunto, una persona bilingue esta disponible para ayudarle dentro de las horas de 7:00 a.m. a 6:00 p.m., Lunes a Viernes hora Pacifico

Para asistencia bilingue debe llamar al 626-279-3000.

Las horas de oficio son de 8:00 a.m. a 5:00 p.m. y
las horas de servicio al cliente son de
7:00 a.m. a 6:00 p.m., de lunes a viernes

La Oficina de Fideicomiso está situada en
4399 Santa Anita Avenue, Suite 200
El Monte, CA 91731

Harman Press
28
Est. 1943

Letter to Participants

Dear Member,

We are pleased to provide you with this Summary Plan Description (SPD) for the Laborers Health and Welfare Trust for Southern California ("Trust" or "Plan"). This SPD summarizes the benefits offered by the Trust, as amended, through December 31, 2012. It applies to Active Employees and their eligible Dependents, to Retirees and their eligible Dependents, who are not eligible for Medicare, and to Surviving Spouses and their eligible Dependents, who are not eligible for Medicare.

This booklet presents valuable information about your Plan, including:

- When you and your Dependents can become eligible for benefits;
- The types of coverage provided;
- Your choices of benefit plans;
- How to file a claim for benefits;
- When your coverage will terminate;
- How to continue coverage; and
- What you should do if a claim is denied.

The Plan continues offering participants a choice between the Preferred Provider Organization (PPO) Plan and the Exclusive Provider Organization (EPO) Plan, or the Kaiser Permanente HMO Plan. This SPD describes the eligibility requirements for all three plans, and describes the benefits provided by the PPO and the EPO plans only. The benefits provided by the Kaiser Permanente HMO plan are described in the booklet provided directly by Kaiser Permanente to eligible participants who have chosen the HMO. Except for the booklet provided by Kaiser Permanente describing Kaiser Permanente benefits, this SPD is both the SPD and the Plan Document for the Trust.

The primary purpose of this booklet is to provide you with a general explanation of the most important features of the Plan in plain language. It is important that you understand how the Plan works. We urge you to read this booklet very carefully so that you are aware of all the benefits to which you are entitled as well as some important restrictions and responsibilities.

Since the provisions of the Plan may also apply to your Spouse and Dependent children, we suggest and encourage you review this booklet with them so that they are aware of the Plan's benefits.

Every effort has been made to provide you with a clear description of the Plan in plain language. Certain words and phrases, however, may seem technical to you. If you still have questions after reading this booklet, please contact the Trust Fund Office at 1-800-887-5679 or 626-279-3000.

This booklet (which is a Plan document) does not change or otherwise interpret the terms of other official Plan documents, such as the Trust Agreement establishing the Plan, applicable Collective Bargaining Agreements, or insurance policies issued to the Trustees. Your rights can be determined only by referring to the official documents that are available upon request for your inspection at the Trust Fund Office during normal business hours.

Sincerely Yours,
The Board of Trustees

Introduction and Preamble

Nature of Plan and Powers of Trustees to Restrict Use of The Plan and to Modify, Reduce and Eliminate Plan Benefits

The benefits provided under this Plan are made possible by monies received by the Laborers Health & Welfare Trust for Southern California ("Trust" or "Plan"). These monies are received primarily as a result of the Collective Bargaining Agreements negotiated between Employers and the Southern California District Council of Laborers and its affiliated local unions.

You are covered by the Plan if you meet the eligibility requirements and if you are:

1. An Employee working under a Collective Bargaining Agreement between your Employer and the Union; or
2. An Employee working under a Participation Agreement with the Plan, either of which provides for contributions to the Plan on your behalf; or
3. An Employee whose hour bank is frozen as a result of disability; or
4. A Qualified Beneficiary making the required monthly continuation coverage premium payment; or
5. A Retired Employee making required monthly premium payment.

When this booklet refers to "you," it assumes that you are an Employee covered by the Plan. The monies received by the Trust and the benefits provided by the Plan are maintained and administered under the direction of the Board of Trustees for the Trust. Half of the Trustees are representatives appointed by the Union and the other half are representatives appointed by the employer associations. The Trustees serve without pay and as a service to the construction industry, the Employees and other beneficiaries participating in the Plan.

The Board of Trustees attempts to develop and maintain an overall program of benefits that can be purchased with the monies being received and that will be of value to all Plan participants and beneficiaries. Some of the benefits provided under this Plan are not insured by any contract or insurance. Thus, the benefits and limits described in this Plan are only payable to the extent that the Trust has monies on hand and available for payment of such benefits.

To maintain responsible control over the financial condition of the Trust, the Trustees must constantly monitor and control the level of benefits being offered. The Trustees may, at any time, make changes in the type and amount of benefits provided under the Plan and in the eligibility requirements of the Plan. This may include, for example, increases or decreases in the number of hours, which a participating Employee is permitted to accumulate in his hour bank. It may include the immediate elimination or addition of any type of benefit such as dental care. And, it may include increases or decreases in the amounts of co-payments or premiums required.

The Board of Trustees must ensure that all who benefit from the Plan do so appropriately, and only as they are entitled. For example, if the Trustees determine that an Employee, his dependents, or health care provider has made any misrepresentation (whether or not intentional) in connection with claims for benefits or has committed any act or omission resulting in abuse or misuse of the Plan, the Board of Trustees reserves the right and authority to impose upon Employees and their Dependents, restrictions with respect to their future rights to receive benefits from the Trust. The Trustees reserve the right to seek reimbursement and other damages, together with attorney's fees (to the extent provided by law) and other costs incurred in connection with recovering any benefits incorrectly paid, or not reimbursed when reimbursement is required under the Plan. To be reimbursed for benefits improperly paid, the Trustees may also exercise a right of offset against future benefits payable on

behalf of the Employee and his Dependents. The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees deem necessary.

This Summary Plan Description is not a contract of employment and the benefits and coverage provided under the Plan are not contractual benefits. Therefore, the benefits and coverage may be reduced, modified or discontinued by action of the Trustees at any time. The Board of Trustees does not promise to continue the benefits and coverage in full or in part in the future and rights to future benefits and coverage are not vested.

The Trustees and the Benefits Appeals Committee have the sole and absolute discretionary authority to:

- Adopt and promulgate all such reasonable rules and regulations;
- Construe the meaning of any provisions of the Plan;
- Take all actions and make all decisions with respect to the eligibility for, and the amount of benefits payable under the Plan;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;
- Make factual findings;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, Trust Agreement, or any other Plan documents, and
- Process, approve, reduce or deny, benefit claims and rule on any plan provisions, benefit coverage or limitations.

Any decision made by the Trustees or the Benefits and Appeals Committee shall be final and binding. While the Trustees will attempt to give notice of changes and notice of the imposition of restrictions, they reserve full power and authority to make such changes and impose such changes or restrictions without giving advance notice to any Participant, Employers and beneficiaries or health care providers.

The Trustees may terminate the Plan when there is no longer in effect an agreement between the signatory Employers and the Union requiring payment to the Fund. Upon termination of the Plan, the Trustees shall apply the monies of the Fund to provide benefits or otherwise carry out the purposes of the Plan in an equitable manner until the entire remainder of the Fund has been disbursed.

All benefits described in this Summary Plan Description are subject to terms, provisions, limitations and exclusions. If you have any questions about the Plan, please call the Trust Fund Office at 1-800-877-5679 or 626-279-3000 or write to the Trust Fund Office at
P.O. Box 8024, El Monte, CA 91734.

Plan Areas Under the Jurisdiction of the Local Union

Local Union	Plan Areas (Jurisdictions)
Local 89	San Diego County
Local 220	Kern, Santa Barbara & San Luis Obispo Counties
Local 300	Los Angeles County
Local 345	Burbank – Gunite Workers
Local 507	Long Beach
Local 585	Ventura County
Local 652	Orange County
Local 783	San Bernardino, Inyo, Mono Counties
Local 802	Wilmington
Local 1184	Riverside, Imperial Counties
Local 1414	Pomona – Plaster Tenders

See page 10, “If You Change Employers And Work For A Non-signatory (Non-Union) Employer.”

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SECTION 1. CHOOSING A BENEFIT PLAN

You Can Choose Among Three Plans of Benefits:

1. PPO Plan – Preferred Provider Organization;
2. EPO Plan – Exclusive Provider Organization; or
3. HMO Plan – Health Maintenance Organization

When you have met the eligibility requirements to be covered by the Trust, you will be asked to decide if you and your eligible Dependents wish to be covered by a Preferred Provider Organization (PPO), an Exclusive Provider Organization (EPO), or a Health Maintenance Organization (HMO). In the Trust, these three types of benefit programs are known as the PPO Plan, the EPO Plan and the Kaiser Permanente HMO. The three plans of benefits are distinctly different in several ways. The following are brief explanations.

PPO Plan (See page 3 for additional information)

PPO is an abbreviated term for Preferred Provider Organization. The Plan's PPO is the Anthem Blue Cross of California Prudent Buyer PPO. The PPO is a network of health care facilities and medical professionals that have agreed to provide your medical care anywhere within their service area at contracted rates. When you receive the services of a PPO network provider, you must first meet an annual deductible and pay certain co-payments and co-insurance amounts and the Plan pays the provider based on a contracted rate. By using a PPO network provider, you will not be balance billed for any amounts that are over and above your deductible, co-payment and co-insurance amounts, provided that you received covered services under the Plan.

If you enroll in the PPO Plan, you may also go to any provider outside of the network. However, it will cost you more because your benefits will be reduced and there may be no provider discounts available.

EPO Plan

EPO is an abbreviated term for Exclusive Provider Organization. The Plan's EPO is also the Anthem Blue Cross of California Prudent Buyer EPO. You must receive all of the services from EPO contracted facilities and medical professionals, except for authorized referrals and emergency care. If you fail to do so, you will be balanced billed by non-contracted providers and responsible for any charges.

There are some similarities, however, between the PPO Plan and the EPO Plan. The EPO is also a network of health care facilities and medical professionals that have agreed to provide your medical care anywhere within the EPO network at contracted rates. Also, when you receive the services of an EPO network provider, you must pay certain co-payments and co-insurance amounts and the Plan pays the provider a contracted rate. You will receive no balance billing for any amounts that are over and above your co-payment and co-insurance amounts provided that you received services from an EPO network provider for covered services under the Plan. The annual deductible, however, does not apply in the EPO Plan.

Kaiser Permanente HMO Plan

HMO is an abbreviated term meaning Health Maintenance Organization. The Plan's HMO is the Kaiser Permanente HMO. The Kaiser Permanente HMO is a benefit plan that the Plan has contracted with to provide benefits to eligible plan participants and eligible Dependents in lieu of the benefits that are provided through the PPO or EPO. The Kaiser Permanente HMO has established medical centers and medical offices throughout Southern California where all enrolled Employees and Dependents must go to receive all medical care.

If you enroll in the HMO and need medical attention, you will have to pay certain co-payments and co-insurance amounts and you will not receive a balance billing, You must, however, receive all your medical care services from the HMO Plan facilities and providers. Some exceptions are authorized referrals, the visiting member program, emergency care, out-of-the area urgent care and post-stabilization care. The details about these exceptions can be found in the Kaiser Permanente publications. With certain exceptions, you may choose to enroll in any one of the three plans when you gain initial eligibility in the Plan.

Choice of Plans

If you do not choose a plan within 30 days of becoming eligible, you will be automatically enrolled in the PPO Plan by default. You may only change plans after you have been in that plan for 12 consecutive months.

The plans of benefits have different annual deductible levels as well as different annual maximums of benefits that can be provided. All of the plans of benefits require some patient payments for co-payments, the annual deductible and the percentage of some billings that are shared by the Plan and the patient. This percentage (or sharing) of Patient responsibility is referred to as co-insurance. When however, patient co-payments and co-insurance amounts, in combination with the deductible, reach certain level, the patient will have no further out-of-pocket costs for covered services for the remainder of the year.

The annual deductibles, annual benefit maximums and annual out-of-pocket maximums are shown in the Active Employees "Summary of Benefits" booklet.

If you need information about:

- your eligibility;
- enrollment or COBRA continuation coverage;
- your PPO, EPO, dental or vision care claims or
- if you need claim forms or enrollment forms,

contact the Trust Fund Office. The telephone numbers are 1-800-887-5679 and 626-279-3000. The mailing address of the Trust Fund Office is PO Box 8024, El Monte, California 91734. The Fund's location is 4399 Santa Anita Avenue, Suite 200, El Monte, California 91731. The Trust Fund Office opens Monday through Friday, except for some holidays. Walk-in hours are 8:00 a.m. to 5:00 p.m. and call-in hours are 7:00 a.m. to 6 p.m., Pacific Time.

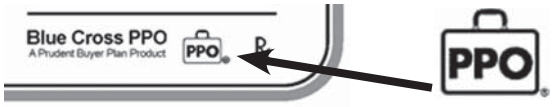
EPO and PPO Network Hospital, Medical or Surgical Provider Information

If you are enrolled in the Anthem Blue Cross of California Prudent Buyer Program and you need to locate a Hospital or medical or surgical network provider, check your PPO/EPO directory or go online

at http://www.anthembluecross.com. The directory may contain providers that have discontinued their relationship with Anthem Blue Cross of California (Anthem). Also, the directory may not include providers who have recently joined the network. You may call, go online, or visit the Trust Fund Office to be sure that your PPO or EPO Plan covers your selected provider. Please check carefully that all of your medical care providers are still within the network.

Prudent Buyer Plan

Your current Anthem Blue Cross identification card should now have this logo displayed at the bottom right corner:



The luggage symbol means that you have access to the contracted providers in the Blue Cross Prudent Buyer Network throughout the United States. The Plan will only cover you when you use contracted providers and facilities within the United States. If you go to contracted facilities, it is important you ask that you receive services from contracted PPO providers at the facilities.

PPO and EPO Managed Care and Pre-Admission Review Anthem Blue Cross of California Directory	
For PPO and EPO Managed Care or Pre-Admission Review, call	1-800-274-7767

Kaiser Permanente HMO Information

Refer to your Kaiser Permanente Guidebook for a listing of medical office locations and services or call Member Services. The Kaiser Permanente/A Healthy Living Helpline is available to you Monday through Thursday, from 8:00 a.m. to 6:00 p.m., and on Friday, from 8:00 a.m. to 4:00 p.m.

Kaiser Permanente HMO Directory	
For Member Services, call	1-800-464-4000 (English) 1-800-788-0616 (Spanish)
For A Healthy Living Helpline, call	1-888-883-STOP (7867)

Kaiser Permanente has created a website where you can conveniently get valuable health care information. Sign on to the Internet at http://www.members.kp.org.

Dental Provider Directory	
For Delta Care Customer Service, call	1-800-422-4234
For verification of your dental eligibility, call the Laborers' Indemnity Dental Plan	626-279-3000 or 1-800-887-5679

For PPO and EPO Prescription Drug Information

The OptumRx Mail Order customer service line is available to you Monday through Friday, from 6:00 a.m. to 9:00 p.m., and on Saturday and Sunday, from 7:00 a.m. to 7:00 p.m., Pacific Time.

OptumRx Directory (fka Prescription Solutions)	
	Telephone
For Customer Service, call	1-800-797-9791
For Mail Order Service, call	1-800-562-6223

You can also obtain more information on the OptumRx website by signing on to www.optumrx.com.

For Information About Social Security

Call the Social Security Administration at 1-800-772-1213. The Social Security Office staff will assist you step-by-step to file an application. You can also obtain more information at http://www.ssa.gov.

For Information About Medicare

For more information about Medicare, Medigap Advantage Plans, Medigap coverage or any other Medicare coverage issue, call 1-800-633-4227 toll free. TTY users should call 1-877-486-2048. You can also visit Medicare's website at http://www.medicare.gov.

HEALTH CARE REFORM

This booklet contains important information about changes that are required by the Affordable Care Act. As other changes occur, you will receive additional notices, which should be kept with this booklet for your reference.

The Patient Protection and Affordable Care Act (Affordable Care Act) was signed into law on March 23, 2010. The Affordable Care Act seeks to expand health coverage and provides you with certain rights regarding your health care. This law calls for changes to be made gradually over a period of years. The first set of changes to this Plan became effective on January 1, 2011, because that was the first day of the plan year beginning on or after September 23, 2010.

As of January 1, 2011, the Plan's various benefit packages are "grandfathered" (except the self-funded PPO Plan for actives). A plan is considered a grandfathered plan if the benefits were in effect on March 23, 2010, at least one participant was enrolled in the plan, and the plan has not made certain types of changes that would otherwise cause it to lose grandfathered status. A grandfathered health plan will not include certain consumer protections of the Affordable Care Act that apply to non-grandfathered plans. A grandfathered benefit package plan will also deny eligibility to your dependents from ages 19 to 26 if they are eligible for their (or their spouse's) employment-based health plan. For example, if you are covered under the EPO Plan and your dependents from ages 19 to 26 have coverage through their employment (or their spouse's), the Trust will not extend eligibility to your dependents under the EPO Plan.

On the other hand, a benefit package that is non-grandfathered, such as the PPO Plan for actives, is required to: (1) provide certain preventive health services without any cost sharing; and (2) permit your dependents from ages 19 to 26 to enroll in the PPO Plan, even if they are eligible for their (or their spouse's) employment-based health plan.

SECTION 2. ELIGIBILITY REQUIREMENT FOR ACTIVE EMPLOYEES

The rules determining eligibility are the same whether you choose the PPO Plan, the EPO Plan, or the Kaiser Permanente HMO Plan. Some eligible participants are limited to the PPO Plan.

To qualify for coverage, you must be an Employee working for a participating Employer and covered by a Collective Bargaining Agreement or a Participation Agreement, which requires the payment of contributions to the Fund on your behalf.

Bargaining Unit Employee

If you are a Bargaining Unit Employee, you and your Dependents will become eligible for the full schedule of benefits after you have worked enough hours in Covered Employment. You need to work at least 300 hours over a period of no more than three consecutive months to become initially eligible. After you have met the initial eligibility requirement of 300 hours, you must wait one additional month for your coverage to become effective.

There is a one-month lag period between the Covered Employment period and the start of your coverage. The one-month lag is necessary because your Employers report your hours to the Trust Fund Office in the month after you work.

If, for example, you work in Covered Employment for 300 or more hours during the period of January, February and March, your initial eligibility will begin on May 1. If you work the required 300 hours in just two months (January and February, for example), your initial eligibility will begin on April 1.

Once eligibility has been established, you and your eligible Dependents will be covered for a minimum of three consecutive months.

Apprentice

If you are dispatched as an Apprentice under the applicable provisions of the Master Labor Agreement, you and your eligible Dependents will become covered by the PPO Plan only after you have worked enough hours in Covered Employment.

The initial eligibility requirement is the same as that of a Bargaining Unit Employee. You need to work at least 300 hours over a period of no more than three consecutive months to become initially eligible. After you have met the initial eligibility requirement of 300 hours, you must wait one additional month for your coverage to become effective.

There is a one-month lag period between the Covered Employment period and the start of your coverage. The one month lag is necessary because your Employers report your hours to the Fund Office in the month after you work.

If, for example, you work in Covered Employment for 300 or more hours during the period of January, February and March, your initial eligibility will begin on May 1. If you work the required 300 hours in just two months (January and February, for example), your initial eligibility will begin on April 1.

Once eligibility has been established, you and your Dependents will be covered for a minimum of three consecutive months.

When you first become eligible as an Apprentice, you and your Dependents are eligible for all benefits, except for dental coverage.* This means that while you are an Apprentice, you and your Dependents will be eligible for medical (PPO), prescription drug, vision benefits, life and accidental death and dismemberment benefits, but no dental coverage. Once you become a journeyman, you and your Dependents are eligible for all benefits, which includes dental benefits.

*Only fourth period Plaster Tender Apprentices are eligible for dental benefits, plus other benefits.

Trainee

If you are dispatched as a Trainee under the applicable provisions of the Master Labor Agreement, you and your eligible Dependents will become covered by a limited plan of benefits after you have worked enough hours in Covered Employment.

The initial eligibility requirement is the same as that of a Bargaining Unit Employee. You need to work at least 300 hours over a period of no more than three consecutive months to become initially eligible. After you have met the initial eligibility requirement of 300 hours, you must wait one additional month for your coverage to become effective.

If, for example, you work in Covered Employment for 300 or more hours during the period of January, February and March, your initial eligibility will begin on May 1. If you work the required 300 hours in just two months (January and February, for example), your initial eligibility will begin on April 1.

There is a one-month lag period between the Covered Employment period and the start of your coverage. The one-month lag is necessary because your Employers report your hours to the Trust Fund Office in the month after you work.

Once eligibility has been established, you and your Dependents will be covered for a minimum of three consecutive months.

When you first become eligible as a Trainee, your benefit schedule is limited. However, trainees with less than 2,000 hours may enroll in the Kaiser Permanente HMO Plan, which includes both medical and prescription benefits. During the first 2,000 hours of Covered Employment, you and your Dependents will be eligible for medical benefits only (no prescription, vision, dental or life and accidental death and dismemberment coverage). Once you have worked 2,000 hours, you and your family will be eligible for prescription and vision benefits in addition to the medical benefits. Once you have completed 4,000 hours of Covered Employment, you are a journeyman and become eligible for all benefits.

Non-Bargaining Unit Employee

With the consent of the Trustees, Employees of Local Unions and non-represented Employees of contributing Employers may participate in the Plan. All such full-time Employees who are not eligible to participate as members of a unit covered by a Collective Bargaining Agreement must be enrolled. Contact the Trust Fund Office for details.

If you are a non-bargaining unit Employee, you and your Dependents will become eligible for benefits on the first day of the second month following any three consecutive months during which your Employer have made sufficient contributions for you. Once eligibility has been established, you and your Dependents will be covered for a minimum of three consecutive months.

There is a one-month lag period between the Employer contribution period and the initial three month eligibility period. The one-month lag is necessary because your Employers pay the contributions to the Fund in the month after you work.

Eligible Dependents of Active Employees

Dependent Coverage

If you have eligible Dependents at the time your coverage starts, the coverage of your eligible Dependents will begin on the same day. If you have no eligible Dependents when your coverage starts, Dependent coverage will begin on the date a person becomes your eligible Dependent, because of marriage, birth, adoption, or placement of adoption (under age 18), provided you properly enroll them within 30 days of the marriage, birth, adoption, or placement of adoption.

A person is an eligible Dependent if he or she is your:

- Lawful Spouse (not legally separated or divorced);
- Dependent children who are under the age of 26 years; or
- Unmarried disabled Dependent children who are over the age of 26 years provided they were enrolled in the Plan by age 19 and disabled by age 19 as well.

For the purposes of the above, the term child means your biological child, any legally adopted child, stepchild, or grandchild for whom you have legal custody, and any child who has been placed with you for adoption.

In addition, the Plan is required to recognize court orders, called Qualified Medical Child Support Orders (QMCSOs), directing you to provide health benefit coverage for your Dependent children, even if you do not have custody of the children. If you have any questions about QMCSOs or think you might have received one, please refer to the section of this booklet entitled “Qualified Medical Child Support Orders (QMCSOs)” or contact the Trust Fund Office.

SECTION 3. REPORTED HOURS FOR EMPLOYEES, APPRENTICES AND TRAINEES

In each month after coverage has begun, all hours reported by your Employers will be credited to your hour bank and 100 hours will be subtracted from your hour bank for your coverage during that month. Each month, 100 hours are required for your coverage to continue.

More Than 100 Hours Each Month

If you work more than 100 hours each month, your hour bank will accumulate more than the 300 hours required to establish your initial coverage. You may accumulate these excess hours up to a maximum of 400 hours, including the hours accumulated during the current month.

Fewer Than 100 Hours Each Month

If you work fewer than 100 hours per month, the remaining number of hours in your hour bank will decline since 100 hours will be subtracted from your bank each month for continuation of coverage.

If you are out of work, your coverage will continue for as long as you have enough hours in your hour bank for 100 hours for coverage. For example, if you had accumulated the maximum of 400 hours in your bank and then worked no more, your hour bank would provide four more months of coverage, including the current month.

Note: If your Employer fails to make the contributions on your behalf after 90 days, the Trust may not credit hours that you worked toward your eligibility. Your eligibility in the benefit plan will be terminated when the hours in the hour bank total less than 100.

Waiving Lag Month to Establish Earlier Eligibility

Lag waiver requests is an option available to members who work on the field. This would allow the member to receive coverage a month in advance as it will waive the lag month, which would normally occur after the first three months in which the member accumulates the required 300 hours worked. Lag waiver requests are only granted due to medical emergency.

Members who accumulate the 300 hours within two work months do not qualify for the lag waiver. Once the member meets the required 300 hours within the first three months, the member must submit a request for a lag waiver to the Trust Fund Office through their Local Union.

SECTION 4. ENROLLING IN A HEALTH PLAN

Enrollment Forms/Documentation

You must complete an enrollment form and furnish appropriate documentation to the Trust Fund Office before any claims can be paid for you or any of your eligible Dependents.

If you are married, you will have to furnish the Trust Fund Office with certified copies of your marriage certificate. You must also submit a certified copy of your decree of divorce if either of you have been previously married.

If you have Dependent children, certified copies of their birth certificates or placement of adoption papers must be submitted with your enrollment form. If you wish to cover your stepchildren, you must submit a certified copy of your marriage certificate and a copy of the court order showing that your Spouse has legal custody of the stepchildren.

You may also cover your grandchildren by submitting a certified copy of the court order showing that you or your Spouse has legal custody of the grandchildren. If your Spouse has custody, you must also submit a certified copy of your marriage certificate and an affidavit to verify that you are furnishing full support of the grandchildren.

Coverage may be continued for unmarried totally disabled Dependent children who are 26 years of age or older if the children are chiefly dependent upon you for support and maintenance and are totally prevented from earning a living because of mental or physical disability. The disability must have occurred prior to the age of 19. Proof of incapacity and dependency must be furnished within one year following the 19th birthday of the children and at least annually and at any other times as may be required by the Trustees and the Trust Fund Office.

Note: The rules regarding continuing eligibility are the same whether you choose the PPO Plan or the EPO Plan or the Kaiser Permanente HMO Plan.

SECTION 5. CONTINUING COVERAGE

Bargaining Unit Employees, Apprentices and Trainees

In each month after coverage has begun, all hours reported by your Employers will be credited to your hour bank and 100 hours will be subtracted.

Non-Bargaining Unit Employees

After you have become initially eligible, your coverage will be continued for each month that your Employer has made sufficient contributions for you.

Continuing Coverage When You Change Employers

If you change Employers and your new Employer is signatory to a Collective Bargaining Agreement that requires contributions to this Plan, your coverage may not be interrupted as long as your hour bank is not reduced below 100 hours.

If You Change Employers And Work For A Non-Signatory (Non-Union) Employer

If you work for an Employer in the Plan area, which is under the jurisdiction of the Local Unions listed in the front of this booklet and the Employer is not signatory to one of the agreements establishing this Welfare Plan, you will lose eligibility immediately upon commencing work for that Employer. Your hour bank will be immediately reduced to zero.

If You Work Outside Of The Plan Area

If you work for an Employer in an area that is not under the jurisdiction of one of the Local Unions listed in the front of this booklet or the agreements establishing the Plan, or if you cease to perform work covered by the Collective Bargaining Agreement, your Employer is not required to contribute to this Fund on your behalf.

Except as provided through reciprocity arrangements with certain other Trust Funds, work outside of the plan's jurisdiction will be treated as a period of unemployment as far as your eligibility for benefits is concerned. Your hour bank will be reduced by 100 hours for each such month. Your benefits will terminate on the last day of the first month in which your hour bank is less than 100 hours.

Reciprocity With Other Trust Funds

From time-to-time, the Board of Trustees may approve reciprocity arrangements with other Health and Welfare Trust Funds affiliated with the Laborers International Union of North America (LIUNA). If a Reciprocity Agreement is in place with a LIUNA affiliated Trust Fund and you work in that jurisdiction, you can arrange to have your hours transferred back to this Trust Fund. Contact the Trust Fund Office for more information.

Continuing Dependent Coverage After Death Of Employee

Eligible Dependents of a deceased Employee will continue to be covered as long as sufficient hours remain in the deceased Employee's hour bank. Once the hours in the hour bank total less than 100, coverage will be terminated. Dependents may also continue eligibility for limited periods of time by making payments directly to the Plan. Refer to the COBRA Continuation provisions on page 21.

Continuing Coverage During Absence From Work Due To Sickness Or Injury

> The Trust Fund Office will require you to submit medical proof of the continuing disability periodically.

If you become Totally Disabled while you are covered under the Plan (see "Definition of Totally Disabled" on page 85), your coverage may be maintained in the following ways:

1. Your hour bank can be frozen.

   This applies whether you are enrolled in the PPO Plan, EPO Plan or HMO Plan. If, while covered, you become unable to work either because of a work-related or non-work-related disability, your hour bank can be frozen during the period of disability up to a maximum of 12 months from the end of the month in which the disability began. The period of time, which can be frozen, depends upon the nature of the disability, the recommendation of your doctor, and the determination of the Trust.

   To apply for a freeze of your hour bank, you must have your doctor verify the disability by completing an Attending Physician's Statement. Obtain a form from your Local Union or the Trust Fund Office, then submit the completed form to the:

   Freeze Department
   Laborers Health & Welfare Trust for Southern California
   PO Box 8024
   El Monte, CA 91734-2325

   During the time your hour bank is frozen and you are disabled, coverage will continue for you and your family with the following exception: If your disability is work-related, the Plan will not cover the charges related to the disabling illness or injury, since they are excluded under this Plan.

   If your physician certifies that you cannot continue working due to your disabling condition, your freeze can continue up to 12 months from the date you originally became disabled.

2. You may use hours from your hour bank after your freeze has expired. If you continue to be totally disabled, coverage will continue for your and your Dependents for as long as you have hours in your hour bank up to a maximum of four months.

3. You may continue limited disability coverage for up to 12 additional months after your freeze and hour bank have terminated. Once your coverage is terminated (after your hour bank has less than 100 hours), the Plan will continue medical coverage, but only for your disabling medical condition. This coverage is only for a non-work-related illness/injury, since work-related disabilities are excluded under the Plan.

If you return to work and work 50 or more hours, you cannot re-establish your freeze until you have re-established your eligibility as outlined on page 5, unless you cannot continue to work due to your original disabling condition.

Coverage for the disability will continue until the earliest of time following dates:

- When you are no longer totally disabled;
- When you become eligible for coverage under any Plan, which provides similar benefits; or
- The end of the 12-month period following the date when coverage terminated under your freeze or hour bank extension.

If you are enrolled in Kaiser Permanente, you may continue full coverage in Kaiser Permanente for you and your eligible dependents for up to 12 additional months after your freeze and hour bank have terminated.

Continuing Coverage – Family Medical Leave Act

Your coverage may be continued for a period of up to 12 or 26 weeks of approved unpaid leave if:

- Your Employer is covered by the Family Medical Leave Act of 1993 (FMLA); and
- You are on an approved FMLA leave of absence.

SECTION 6. WHEN COVERAGE IS TERMINATED

COBRA Continuation Coverage

Under certain circumstances known as Qualifying Events, you and your Dependents may be eligible to make direct payments to the Fund to maintain coverage for a limited period of time under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Refer to the COBRA Continuation Coverage section of this booklet for more information.)

Conversion To An Individual Kaiser Permanente Plan

If your eligibility in the Plan is terminated and you have been enrolled in the Kaiser Permanente HMO Plan, you will receive information about options that may be available to continue coverage through Kaiser Permanente by paying Kaiser Permanente directly for the cost of continuation coverage. Information about individual conversion plans and their costs may be obtained from Kaiser Permanente.

You may apply to convert your group health coverage with Kaiser Permanente to an individual policy at the time your eligibility terminates in the Plan or at the end of any period of COBRA continuation coverage.

Conversion To An Individual Life Insurance Policy

If your eligibility in the Plan is terminated, you and your Dependents may convert the Group Life Insurance coverage to individual life insurance policies.

Conversion to individual life insurance policies must be made within 31 days of the loss of eligibility under this Plan. You must apply for conversion and pay the first premium payment to Aetna Life Insurance Company within the 31-day period. Should you or your dependents die within this 31-day conversion period, the death benefit will be payable.

If you have any questions, contact the Trust Fund Office for more information.

Note: The rules regarding termination of coverage are the same whether you choose the PPO Plan or the EPO Plan, or the Kaiser Permanente HMO Plan.

If your eligibility cannot be continued under any of the Plan provisions, your coverage in the Plan will terminate and the coverage of your Dependents will terminate at the same time.

Employee Coverage Termination

Your coverage in the Plan will terminate at the earlier of:

- on the last day of the month in which your hour bank has less than 100 hours;
- if you change Employers and work for a non-signatory (non-union) Employer;
- if your Employer fails to pay the required contributions for 90 or more days;
- failure to otherwise meet the disability or other eligibility requirements;
- on the last day of the month for which COBRA continuation premiums have not been paid or as otherwise described on pages 24 and 25;
- at the end of the allowed COBRA continuation coverage period;
- when inducted into the U.S. military for 31 days or more (see USERRA section on page 36);

- at the end of an approved FMLA leave if you do not return to Covered Employment at the end of the leave; or
- if you do not provide the Plan with any required information or reports; or
- if the Plan is terminated.

Dependent Coverage Termination

The coverage of all Dependents will terminate at the earlier of:

- when your coverage terminates;
- on the last day of the month for which COBRA continuation premiums have not been paid or as otherwise described on pages 24 and 25;
- at the end of the allowed COBRA continuation coverage period; or
- if the Plan is terminated.

In addition to the reasons listed for termination of Dependents, your Dependent children coverage will terminate:

- on the last day of the month of their 26th birthday;
- on the last day of the month for which COBRA continuation premiums have not been paid or as otherwise described on pages 24 and 25;
- at the end of the allowed COBRA continuation coverage period;
- when they otherwise are no longer your Dependents as set out in this Plan; or
- upon entering the military.

Reinstatement Of Eligibility

If your eligibility has terminated and you are later reemployed by a contributing Employer, you must re-qualify in accordance with the initial eligibility rule.

SECTION 7. ELIGIBILITY REQUIREMENTS FOR RETIRED EMPLOYEES

Except for Prescription Coverage, Retiree coverage cannot be provided to any persons who are eligible for Medicare.

Choosing a Benefit Plan

> Retirees' coverage cannot be provided to any persons eligible for Medicare.

When you have met the eligibility requirements to be covered by the Trust's Retiree plan of benefits, you must decide if you and your eligible Dependents wish to be covered by the PPO, the EPO or the HMO Plan.

Please refer to page 1 for more information about these three types of benefit plans. The rules regarding Retiree eligibility are the same whether you choose the PPO Plan, the EPO Plan, the HMO Plan, the Special Retiree Plan I or the Special Retiree Plan II. You must carefully choose your benefit plan. Once a selection is made, you will not be permitted to change plans of benefits until after you have been in that plan for 12 months.

The plans of benefits have different annual deductible levels as well as different annual maximums of benefits that can be provided. All of the plans of benefits require some patient payments for co-payments, the annual deductible and the percentage of some billings that are shared by the Plan and the patient. This percentage (or sharing) of patient responsibility is referred to as co-insurance. When, however, patient co-payments and co-insurance amounts, in combination with the deductible, reach a certain level, the patient will have no further out-of-pocket costs for covered services for the remainder of the year.

> The annual deductibles, annual benefit maximums, and annual out-of-pocket maximums are shown in the Retired Employees Summary of Benefits for Retired Participants and their Eligible Dependents (hereafter referred to as "Retirees' Chart").
>
> (See that separate booklet explaining those benefits.)

The coverage can only be provided to Retirees and Dependents who:

- are not covered by Medicare;
- meet the eligibility requirements; and
- make the required monthly premium payments to maintain coverage.

Note: If you are a new Retiree, you or your Dependents may be eligible to elect to continue coverage under the COBRA provisions. Refer to the information about COBRA benefits starting from page 19.

Retiree Health Plan Eligibility Requirements

Medicare-eligible Retirees and their Medicare-eligible Dependents are eligible for only Prescription coverage under the Plan. (See "Retirees' Chart" explaining those benefits.)

To be eligible for enrollment in a Retiree plan of benefits:

- You must have retired and been receiving benefits under at least one (or a combination) of the Construction Laborers Pension Trust for Southern California; the San Diego County Construction Laborers Pension Trust; the Plaster Tenders Pension Trust of Los Angeles and Orange Counties, and/or the Local 585 Plaster Tenders Pension Trust.

- You must have at least 20 years of vested pension credits in the Construction Laborers Pension Trust (15 years of vested pension credits if you retired prior to January 1, 2005) or 15 years of vested pension credits in the San Diego County Construction Laborers Pension Trust.

Only Employees who have worked under a Collective Bargaining Agreement that required contributions to the Laborers Health and Welfare Trust for Southern California during the five-year period immediately preceding retirement and without a two-year break in service under the Construction Laborers Pension Trust for Southern California or the San Diego County Construction Laborers Pension Trust during this period may qualify for health coverage. (This rule does not apply to Employees on disability retirement.)

A medical examination is not required in order to become eligible although the Trustees may require a medical examination to assist them in considering a claim.

The coverage selection must be made at the time of retirement and prior to cashing the first pension check.

Retirees who are eligible for Medicare do not qualify for Retiree coverage from this Plan.

Eligible Retirees Must Contribute To Obtain Benefits

To obtain Retiree health benefits, eligible Retirees must contribute to the Plan in the amount and under the rules established from time-to-time by the Board of Trustees. This contribution is called the ***monthly premium***. The type of benefit plan you select and the number persons to be covered determine the amount of your monthly premium.

If your Spouse is eligible for Medicare, either because your Spouse is age 65 or disabled, then your Spouse is not eligible for medical benefits under the Plan.

Monthly premiums will be deducted and transferred to the Trust directly from your pension benefit by the Trust Fund Office for you and your Spouse and one Dependent child if covered.

If you cover two or more Dependent children in addition to your Spouse, you may pay to the Trust Fund Office the monthly premium for your Dependent children in lieu of having this monthly premium transferred from your pension benefit. This monthly premium is due on the first of each month for which the Dependents are to be covered and must be received by the Trust Fund Office no later than

the due date. Late payment could cause your Dependent children to lose their eligibility under this Plan.

If you pay the Trust Fund Office directly, the Trust Fund Office must receive your monthly payment by the first day of the month in which the payment is due. Failure to make the monthly payment by the last day of the month in which it is due will result in termination of coverage without the possibility of reinstatement.

Retiree Monthly Premium and Subsidy

The monthly premium amount you must pay is established by the Trust to cover the costs of benefits for Retirees and any Dependents. The premium will be discounted by an amount of subsidy that is determined by your total years of vested pension credits.

The monthly premiums and subsidy program can be modified or terminated at any time by the Board of Trustees of the Plan.

The premium amount will vary according to the plan of benefits selected and the number of persons who are to be covered by the Plan. (Please ask the Trust Fund Office for a listing of the current premium amounts for the various Retiree benefit plans.)

Health coverage must be selected at the time of retirement and prior to cashing the first pension check.

> The required total of vested pension credits and the amounts of subsidy are shown in the "Retirees' Chart."

Election May Be Postponed

If an Employee's Spouse has coverage under a different plan for which the Employee is eligible or where the Employee is on total disability, the time for election is extended to the 30-day period following termination of the Spouse's coverage or termination of the total disability, whichever is applicable.

If the Employee does not elect coverage at the time of retirement or within the extended election period, the retired Employee and any Dependents will no longer be eligible for health coverage under the terms of the Plan.

Only Retirees under the age of 65, who elect to be covered by the medical benefits, may purchase prescription drug coverage. To obtain coverage, Retirees under the age of 65 are required to pay the Plan's full monthly charge for providing this benefit. All rules, procedures, limitations and exclusions of the Plan's prescription coverage shall apply. Retirees over the age of 65 or otherwise eligible for Medicare can only elect to be covered under the Trust's Prescription Plan. (See "Prescription Drug Benefits" section starting on page 55.)

If you die after retiring and while covered under this Plan and you selected the Joint and Survivor option under the Pension Plan, health coverage will be continued for your Surviving Spouse and eligible Dependents, subject to other applicable rules and provisions of this

Plan and the Pension Plan. A surviving Spouse who meets the eligibility rules must pay a monthly charge established by the Trustees to cover the full costs of medical and prescription benefits, less any subsidy that is based on the number of years of vested pension credits of the deceased Retiree. (Refer to the "Schedule of Trust Subsidy" in the "Retirees' Chart.")

You must agree to make monthly payments for you and your Eligible Dependents either by having the premium automatically deducted from your pension check or by paying the co-payment directly to the Trust Fund Office. If you pay the Trust Fund Office directly, the Trust Fund Office must receive your monthly payment by the first day of the month in which the payment is due. Failure to make the monthly payment by the last day of the month in which it is due will result in termination of coverage without the possibility of reinstatement.

Eligible Dependents of Retirees

A person is an eligible Dependent of a Retiree if that Dependent is a:

- Lawful Spouse (not legally separated or divorced);
- Dependent child who is under the age of 26 years; or
- An unmarried disabled Dependent child who is over the age of 26 years provided he/she was enrolled in the Plan by age 19 and disabled by age 19 as well.

For purposes of the above, the term **child** means your biological child, any legally adopted child, stepchild, grandchild and any child who has been placed with you for adoption.

SECTION 8. ENROLLING IN A PLAN

Enrollment Forms/Documentation

You must complete an enrollment form and furnish appropriate documentation to the Trust Fund Office before any claims can be paid for you or any of your eligible Dependents.

If you are married, you will have to furnish the Trust Fund Office with certified copies of your marriage and birth certificates. You must also submit certified copies of decrees of divorce if either one of you has been previously married.

If you have Dependent children, certified copies of their birth certificates, placement of adoption papers or adoption papers must be submitted with your enrollment form.

If you wish to cover your stepchildren, you must submit a certified copy of your marriage certificate and a copy of the court order showing that your Spouse has legal custody of the stepchildren. You may also cover your grandchildren by submitting a certified copy of the court order showing that you or your Spouse has legal custody of the children. If your Spouse has custody, you must also submit a certified copy of your marriage certificate and an affidavit to verify that you are furnishing full support of the children.

Coverage may be continued for unmarried, disabled Dependent children who are 26 years of age or older if the children are chiefly dependent upon you for support and maintenance and are totally prevented from earning a living because of a mental or physical disability. The disability must have occurred prior to the age of 19. Proof of incapacity and dependency must be furnished within one year following the nineteenth birthday of the children and at least annually and at any other times as may be required by the Trustees and the Trust Fund Office.

SECTION 9. WHEN RETIREE COVERAGE IS TERMINATE

Events That Can Terminate Retiree Coverage

Your coverage terminates when you become age 65 or become eligible for Medicare due to disability. In this event (and provided that you pay the monthly premium), you become automatically eligible for the prescription coverage, if any, that is available to Retirees age 65 or older or eligible for Medicare. If your Dependent Spouse is under age 65 and not eligible for Medicare, coverage may be continued for benefits described in this Plan, subject to payment of the appropriate monthly premium until such time as your Dependent Spouse becomes eligible for Medicare.

Eligible Dependent children who do not qualify for Medicare may also be covered, subject to payment of the appropriate monthly premium.

If you cancel the monthly premium from your Pension benefit, your coverage will terminate at the end of the last month for which you made the monthly premium.

Coverage for your Dependents will terminate when either your coverage or the coverage of your Dependent Spouse under age 65 terminates, or your Surviving Spouse terminates, or whenever your Dependents cease to be eligible Dependents, whichever is earlier.

Coverage for a Surviving Spouse will terminate upon death, remarriage, at age 65 or becoming eligible for Medicare due to disability, whichever is earlier.

Retiree Suspension of Coverage Rule

As a retiree eligible for Health and Welfare coverage, you must inform the Trust Fund Office if you are eligible for any other group health insurance coverage, such as through your spouse or permissible employment. If you are eligible for another group's health plan coverage because of your employment, you must enroll for coverage in that group health plan. If you are eligible for another group's health plan coverage because of your Spouse's employment (For example, you are an eligible dependent), you must enroll for coverage under your spouse's group health plan unless there is a cost for your spouse to add you.

Benefits under this Plan and your obligation to make co-payments will be suspended provided you make application to suspend coverage. Contact the Trust Fund Office for an application.

You will again be eligible under this Plan on the first of the month following the date your eligibility under the other group health plan ends, provided you tell us within 30 days that you are no longer eligible to be covered under the group health plan. After you notify the Trust Fund Office that your other group health coverage has terminated, you will again be eligible for coverage under this Plan and must pay the appropriate monthly premium by the first of the month following the month in which your other group health coverage terminates.

If you do not notify the Trust Fund Office within six months of the termination of your eligibility under the other group health plan, your right to be reinstated will be on a prospective basis only.

If you do not tell us that you are eligible for the other group health plan and we have paid any benefits, you will not be eligible for further benefits from this Plan until you pay back all the money that was paid by this Plan for benefits during the period you were eligible under the other group health plan. These rules apply to Retirees who are not eligible for Medicare and your covered Spouse if your Spouse is also not eligible for Medicare.

SECTION 10. COBRA CONTINUATION COVERAGE

Note: The rules regarding COBRA Continuation Coverage are the same whether you choose the EPO Plan, the PPO Plan, or the Kaiser Permanente HMO Plan.

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that group health plans offer Employees and their families the opportunity to purchase, at their own expense, a temporary extension of health coverage called COBRA continuation coverage. This section is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law.

COBRA allows you and your covered Dependents to continue coverage under the Plan for a limited period of time, generally 18, 29 or 36 months. The continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage when specific events (known as Qualifying Events) occur.

COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose coverage under the Plan because of a Qualifying Event. Depending on the type of Qualifying Event, Employees, Spouses of Employees and Dependent children of Employees may be qualified beneficiaries.

Qualifying Events

If you are an Employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following events occur:

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

If you are the Spouse of an Employee who is covered by the Plan, you will become a qualified beneficiary if you lose your coverage when any of these Qualifying Events occur:

- Your Spouse's employment ends for any reason other than gross misconduct, which causes your Spouse to become ineligible;
- Your Spouse's hours of employment are reduced;
- Your Spouse dies;
- You become divorced or legally separated from your Spouse; or
- Your Spouse is no longer an active Participant under the Plan and enrolls in Medicare Part A,
- Part B or both.

Your Dependent children who are covered by the Plan will become qualified beneficiaries if they lose their coverage when any of these Qualifying Events occur:

- The termination of your employment for any reason other than gross misconduct which causes you to become ineligible;
- Your hours of employment are reduced which causes you to become ineligible;
- Your death;
- You and your Spouse become divorced or legally separated;
- Your Dependent child ceases to be a Dependent as defined in this Summary Plan Description; or

- You are no longer an active Participant under the Plan and you enroll in Medicare Part A, Part B or both.

Refer to pages 5 through 7 and page 13 of this Summary Plan Description for more information regarding eligibility and termination of eligibility for Dependents.

COBRA Continuation Coverage Extension for Disability

If you or anyone in your family who is covered under the Plan should become disabled as determined by the Social Security Administration (SSA) at any time during the first 60 days of COBRA continuation coverage, you and your entire family can receive up to 11 months of additional COBRA coverage for a total maximum of 29 months.

The disability extension is only available when the disability began before or within the first 60 days of COBRA continuation coverage. The Trust Fund Office must be provided with a copy of the Social Security determination of disability before the expiration of the initial 18-month COBRA period. The extension period will end on the last day of the 29th month of continuation coverage; on the first of the month that is more than 30 days after the SSA makes a final determination that the disabled person has recovered from the disability; or the disabled person enrolls in Medicare (Part A, Part B, or both), whichever comes first.

The various Qualifying Events and the maximum continuation of covered period associated with each are listed in the charts section at the end of this booklet.

Multiple Qualifying Events

If your family experiences another Qualifying Event during the initial 18-month COBRA continuation coverage period, your Spouse and the Dependent children in your family can get additional months of coverage. Your Dependents may extend their COBRA coverage for an additional 18 months for a total of 36 months from the date your coverage was terminated.

Second Qualifying Events may include the death of the covered Employee, divorce or legal separation from the covered Employee, or the Employee is no longer an Active Employee under the Plan and enrolls in Medicare (Part A, Part B, or both), or a Dependent child ceases to be eligible for coverage as a Dependent under the Plan. These events can be a second Qualifying Event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred.

You must notify the Trust Fund Office in writing of the second Qualifying Event within 60 days of its occurrence. If you fail to provide timely notification in writing, you will not be able to extend you COBRA coverage beyond the initial COBRA eligibility period.

Time Notification Of Qualifying Events and Election of COBRA

Your contributing Employer has the responsibility to notify the Trust Fund Office of your death or termination of employment within 30 days. Failure to provide timely notice to the Trust Fund Office may subject the Employer to penalties.

You, your Spouse or your other Dependents must notify the Trust Fund Office in writing within 60 days of the following Qualifying Events: a divorce, legal separation, a change in Dependent status, or if you are no longer an Active Employee under the Plan and are enrolled in Medicare (Part A, Part B, or both).

If the Trust Fund Office determines you or your Dependents are entitled to continuation coverage, the Trust Fund Office will send you a COBRA Notice and Election Form. This notice will contain the details of the coverage options available, the cost, and the conditions under which the COBRA continuation coverage will terminate. You will have 60 days to make an election of COBRA coverage. The 60-day period is measured from the later of the date coverage was terminated under the Plan or the date you received the notice from the Trust Fund Office.

Failure to provide timely notification to the Trust Fund Office will terminate your coverage as of the date that you lost coverage under the Plan; and the persons who experienced the Qualifying Event will no longer be eligible to elect COBRA continuation coverage.

If you or your Dependent(s) do not return the election form within the required time, the coverage will be terminated as of the date that you lost coverage under the Plan and the persons who have experienced the Qualifying Event will no longer be eligible to elect COBRA continuation coverage.

If the Trust Fund Office receives notice from an individual that he or she has experienced a COBRA Qualifying Event and the Trust Fund Office determines that the individual is not entitled to continuation coverage, the Trust Fund Office will notify the individual that continuation coverage is not available. The notice will include an explanation as to why continuation coverage is not available.

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both you and your Spouse may elect continuation coverage or either of you may independently do so. Parents may elect to continue coverage on behalf of the Dependent children only. All qualified beneficiaries must timely elect the coverage. Failure to do so will result in loss of the right to elect continuation coverage. A qualified beneficiary may change a prior rejection of continuation coverage at any time before the election period expires.

If continuation coverage is chosen, the Fund will make health coverage available which is identical to the coverage, which is provided by the Plan to similarly situated covered persons who have not experienced a Qualifying Event. If coverage for similarly situated covered persons is modified after COBRA continuation coverage has been elected, the continuation coverage will be modified accordingly.

If you acquire a Spouse or have a newborn child or a child is placed with you for adoption while you are on COBRA coverage, that Spouse or child may be enrolled for coverage for the balance of your COBRA period provided that you notify the Trust Fund Office within 30 days after the marriage, birth or placement. Adding a Dependent may cause an increase COBRA premium if you are not already paying for family coverage.

Types Of Benefits Available

Only certain types of benefits may be elected for COBRA continuation. They are referred to as full benefits and core benefits. Core benefits may include the following types of coverage:

- Basic Hospital and medical benefits;
- Surgical expense benefit;
- Diagnostic X-ray and laboratory expenses;
- Major medical benefits; and
- Prescription drug benefits.

Full benefits include the benefits described above and:

- Vision benefits and
- Dental benefits.

You may select full benefits or core benefits. You may not, however, select vision and dental benefits only.

Note: None of the other benefits provided under the terms of this Plan, such as life insurance or accidental death and dismemberment insurance, are available through COBRA continuation. Life insurance may, however, be continued by conversion to an individual policy. Refer to the Life Insurance and Accidental Death and Dismemberment section of this Summary Plan Description for more information.

Continuation Coverage Premium Payments

When you, your Spouse, or any other Dependents become eligible for COBRA continuation coverage, you will be advised of the premium charge. It is 102 percent of the cost of coverage for similarly situated persons who have not experienced a Qualifying Event. If any family member qualifies for an extension due to a Social Security Disability, the premium is 150 percent of the cost of coverage during the 11-month disability extension. The premium rate is subject to change annually.

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form.

You must, however, make your first payment for continuation coverage within 45 days of the date that you return the COBRA election form and the initial payment must cover the period from the date of termination in the Plan to the current month. If you do not make your first payment for continuation coverage within the 45-day period, you will lose all continuation coverage rights under the Plan.

After the initial payment, monthly premiums for successive months of coverage should be received by the 20th day of the preceding month for the month in which you wish to have coverage so that eligibility is accurately reflected in the Trust records. You are given a grace period of 30 days of the beginning of the coverage month to make your periodic payment. Your continuation coverage will be provided for each month as long as the payment for that month is made before the end of that month. If you pay a periodic payment later than its due date but during the grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated when the periodic payment is made.

Any claim that you submit for benefits while your coverage is suspended may be denied and may have to be re-submitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period, you will lose all rights to continuation coverage under the Plan and any claims incurred during the period will not be covered.

The Fund does not issue billings for COBRA continuation coverage other than the initial notice. It is the responsibility of COBRA-covered persons to make timely payments of their premiums.

Remember: If a COBRA payment is not received within 30 days of the beginning of a coverage month or if you fail to make your COBRA payment, your continuation coverage under COBRA will terminate at the end of the last month for which you paid for coverage and you will be responsible for reimbursing the Plan for any benefits received in error.

Termination Of Continuation Coverage

Continuation coverage will be terminated before the end of the applicable maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage,
- the Social Security Administration (SSA) makes a final determination that a qualified beneficiary is no longer disabled beyond the initial 18-month period. In such a case, coverage will end for all qualified beneficiaries with the first month beginning more than 30 days after the SSA makes such a final determination, or
- the Plan no longer provides group health coverage.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap.

Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a pre-existing condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

The Trust Fund Office is responsible for administering COBRA coverage. For additional information regarding COBRA continuation coverage or to obtain COBRA continuation election forms, contact the Trust Fund Office of the Laborers Health & Welfare Trust for Southern California, PO Box 8024, El Monte, CA 91734. The telephone numbers are 1-800-887-5679 and 626-279-3000.

You may also obtain more information regarding COBRA continuation coverage or HIPAA by contacting the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

SECTION 11. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

STATEMENT OF YOUR ERISA RIGHTS

About HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its privacy regulations, you have certain rights with respect to your health information. The Trust must protect the privacy of your personal health information and establish normal policies and procedures for maintaining the privacy of your Protected Health Information (PHI).

HIPAA also allows special enrollment periods for you and your eligible Dependents, and reduce or eliminate the period during which a group health plan or insurer may exclude or limit coverage for pre-existing conditions if you had previous coverage under other health plans.

HIPAA requires your health plan or insurer to provide you with a certificate of Creditable Coverage at the time your coverage or that of any Dependent should be terminated.

Protected Health Information (PHI) And Notice Of Information Practices

The Plan is committed to maintaining the confidentiality of your private medical information. This section describes our efforts to safeguard your health information from improper or unnecessary use or disclosure. This section only applies to health-related information created or received by or on the Plan's privacy practices and related legal duties, and your rights in connection with the use and disclosure of your Plan information.

In this section, the terms "Plan," "we," "us," and "our" refer to the Plan and third parties to the extent they perform administrative services for the Plan. When third party service providers perform administrative functions for the Plan, we require them to appropriately safeguard the privacy of your information.

Please note: If you are enrolled in an HMO, you will also receive a separate notice from your HMO provider that describes the HMO provider's specific use and disclosure of your health information. Your rights with respect to their use and disclosure of your health information are set forth in that separate notice.

What Is Protected?

Federal law requires the Plan to have a special policy for safeguarding a category of medical information called "protected health information," or "PHI," received or created in the course of administering the Plan. PHI is health information that can be used to identify you and that relates to:

- your physical or mental health condition,
- the provision of health care to you, or
- payment for your health care.

Your medical and dental records, your claims for medical and dental benefits, and the explanation of benefits ("EOBs") sent in connection with payment of your claims are all examples of PHI.

The remainder of this section regarding HIPAA generally describes our rules with respect to your PHI received or created by the Plan.

Uses and Disclosures of Your PHI

To protect the privacy of your PHI, the plan guards the physical security of your PHI and also limit the way your PHI is used or disclosed to others. We may use or disclose your PHI in certain permissible ways described below. To the extent required under federal health information privacy law, we use the minimum amount of your PHI necessary to perform the following tasks:

- To determine proper payment of your Health Plan benefit claims.

  The Plan uses and discloses your PHI to reimburse you or your doctors or health care providers for covered treatments and services. For example, your diagnosis information may be used to determine whether a specific procedure is medically necessary or to reimburse your doctor for your medical care.

- For the administration and operation of the Plan.

  We may use and disclose your PHI for numerous administrative and quality control functions necessary for the Plan's proper operation. For example, we may use your claims information for fraud and abuse detection activities or to conduct data analysis for cost-control or planning-related purposes.

- To inform you or your health care provider about treatment alternatives or other health-related benefits that may be offered under the Plan.

  For example, we may use your claims data to alert you to an available case management program if you are diagnosed with certain diseases or illnesses, such as diabetes.

- To a health care provider if needed for your treatment.

- To a health care provider or to another health plan to determine proper payment of your claim under the other plan. For example, we may exchange your PHI with your spouse's health plan for coordination of benefits purposes.

- To another health plan for certain administration and operations purposes.

- We may share your PHI with another health plan or health care provider who has a relationship with you for quality assessment and improvement activities, to review the qualifications of health care professionals who provide care to you, or for fraud and abuse detection and prevention purposes.

- To a family member, friend, or other person involved in your health care if you are present and you do not object to the sharing of your PHI, or it can reasonably be inferred that you do not object, or in the event of an emergency.

- For Plan design activities or to collect Plan contributions. The Plan may use summary or de-identified health information for Plan design activities. In addition, Plan employees may use information about your enrollment or disenrollment in a Plan in order to collect contributions that pay for your Plan participation.

- To the Plan Sponsor. The Plan may disclose PHI to the Plan sponsor, the Board of Trustees, to the extent provided by a rule of the Plan, provided that the sponsor protects the privacy of the PHI and it is only used for the permitted purposes described in this HIPAA section.

- To the Business Associates. The Plan may disclose PHI to other people or businesses that provide services to the Plan and which need the PHI to perform those services. These people or businesses are called business associates, and the Plan will have a written agreement with each of them requiring each of them to protect the privacy of your PHI. For example, the Plan may have hired a consultant to evaluate claims or suggest changes to the Plan, for which he needs to see PHI.

- To comply with an applicable federal, state, or local law, including workers' compensation or similar programs.

- For public health reasons, including (1) to a public health authority for the prevention or control of disease, injury or disability; (2) to a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; or (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.

- To report a suspected case of abuse, neglect or domestic violence, as permitted or required by applicable law.

- To comply with health oversight activities, such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services.

- To the U.S. Department of Health and Human Services to demonstrate our compliance with federal health information privacy law.

- To respond to an order of a court or administrative tribunal.

- To respond to a subpoena, warrant, summons or other legal request if sufficient safeguards, such as a protective order, are in place to maintain our PHI privacy.

- To a law enforcement official for a law enforcement purpose.

- For purposes of public safety or national security.

- To allow a coroner or medical examiner to make an identification or determine cause of death or to allow a funeral director to carry out his or her duties.

- To respond to a request by military command authorities if you are or were a member of the armed forces.

- For cadaveric organ, eye or tissue donation. The Plan may use and disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

- For research. The Plan may use and disclose protected health information to assist in research activities, regardless of the source of the funding for the research, where a privacy board or an Institutional Review Board has approved an alteration to or waived entirely the authorization requirements of the law and the Plan receives certain specific representations and documentation.
- To avert serious threat to health or safety. The Plan may use and disclose protected health information to prevent or lessen a serious threat to health or safety of any one person or the general public and the use or disclosure is: (1) to a person or persons reasonably able to

prevent or lessen the threat to health or safety; or (2) necessary for law enforcement authorities to identify or apprehend an individual.

- Incident to a permitted use or disclosure. The Plan may use and disclose protected health information incident to any use or disclosure permitted or authorized by law.

- As part of a limited data set. The Plan may use and disclose a limited data set that meets the technical requirements of 45 Code of Federal Regulations, Section 1164.514(e), if the Plan has entered into a data-use agreement with the recipient of the limited data set.

- For fundraising. The Plan may use and disclose certain types of protected health information to a business or to an institutionally related foundation for the purpose of raising funds.

The types of information that may be disclosed under this exception to the authorization requirement are: (1) demographic information relating to an individual; and (2) dates of health care provided to an individual. The fundraising materials must also inform you of how you may elect to opt out of the receiving further fundraising communications that are healthcare operations. The entity that sends you such communications must treat your request to opt out as a revocation of your authorization to receive any such communications.

Absent your written permission, Plan employees will only use or disclose your PHI as described in this HIPAA section. Plan employees will not access your PHI for reasons unrelated to Plan administration without your express written authorization.

If an applicable state law provides greater health information about privacy protections than the federal law, we will comply with the stricter state law.

Other Uses And Disclosures Of Your PHI

Before we use or disclose your PHI for any purpose other than those listed above, we must obtain your written authorization. You may revoke your authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI except as described above (or as permitted by any other authorizations that have not been revoked). However, please understand that we cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization.

In no event will the Plan use or disclose your PHI that is "genetic information" for "underwriting" purposes, as such terms are defined by the Genetic Information Nondiscrimination Act of 2008.

Your Rights

Federal law provides you with certain rights regarding your PHI. Parents of minor children and other individuals with legal authority to make health decisions for a Plan participant may exercise these rights on behalf of the participant, consistent with state law.

Right to request restrictions. You have the right to request a restriction or limitation on the Plan's use or disclosure of your PHI. For example, you may ask us to limit the scope of your PHI disclosures to a case manager who is assigned to you for monitoring a chronic condition. Because we use your PHI to the extent necessary to pay Plan benefits, to administer the Plan, and to comply with the law, it may not be possible to agree to your request. Except in the limited circumstances described below, the law does not require the Plan to agree to your request for restriction. Except as otherwise required by law (and excluding disclosures for treatment

purposes), the Plan is obligated, upon your request, to refrain from sharing your PHI with another health plan for purposes of payment or carrying out health care operations if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. The Plan will not agree to any restriction, which will cause it to violate or be noncompliant with any legal requirement. If we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify you that we are terminating the restriction with respect to PHI created or received by the Plan in the future.

You may make a request for restriction on the use and disclosure of your PHI by completing the appropriate request form available from the Plan.

Right to receive confidential communications. You have the right to request that the Plan communicate with you about your PHI at an alternative address or by alternative means if you believe that communications through normal business practices could endanger you. For example, you may request that the Plan contact you only at work and not at home.

You may request confidential communication of your PHI by completing an appropriate form available from the Plan. We will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure in another way could endanger your safety.

Right to inspect and obtain a copy of your PHI. You have the right to inspect and obtain a copy of your PHI that is contained in records that the Plan maintains for enrollment, payment, claims determination, or case for medical management activities. If the Plan uses or maintains an electronic health record with respect to your PHI, you may request such PHI in an electronic format and direct that such PHI be sent to another person or entity.

However, this right does not extend to: (1) psychotherapy notes, (2) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (3) any information, including PHI, as to which the law does not permit access. We will also deny your request to inspect and obtain a copy of your PHI if a licensed health care professional hired by the Plan has determined that giving you the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to cause substantial harm to you or another individual, or that the record makes references to another person (other than a health care provider), and that the requested access would likely cause substantial harm to the other person.

In the event that your request to inspect or obtain a copy of your PHI is denied, you may have that decision reviewed. A different licensed health care professional chosen by the Plan will review the request and denial, and we will comply with the health care professional's decision.

You may make a request to inspect or obtain a copy of your PHI by completing the appropriate form available from the Plan. We may charge you a fee to cover the costs of copying, mailing or of other supplies directly associated with your request. You will be notified of any costs before you incur any expenses.

Right to amend your PHI. You have the right to request an amendment of your PHI if you believe the information the Plan has about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Plan in a designated record set. We will correct any mistakes if we created the PHI or if the person or entity that originally created the PHI is no longer available to make the amendment. However, we cannot amend PHI that we believe to be accurate and complete.

You may request amendments of your PHI by completing the appropriate form available from the Plan.

Right to receive an accounting of disclosures of PHI. You have the right to request a list of certain disclosures of your PHI by the Plan. The accounting will not include:

1. Disclosures to carry out treatment, payment and health care operations,
2. Disclosures to you,
3. Disclosures incidental to a use or disclosure permitted or required by law,
4. Disclosures pursuant to an authorization provided by you,
5. Disclosures for directories or to people involved in your care or other notification purposes as permitted by law,
6. Disclosures for national security or intelligence purposes,
7. Disclosures to correctional institutions or law enforcement officials,
8. Disclosures that are part of a limited data set, or
9. Disclosures that occurred more than six years before your request.

Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accountings. We will notify you in advance of any costs, and you may choose to withdraw or modify your request before you incur any expenses.

You may make a request for an accounting by completing the appropriate request form available from the Plan.

Right to Receive Notice. If your "Unsecured" PHI is accessed, acquired, used or disclosed in a manner that is impermissible under the HIPAA privacy rules and that poses a significant risk of financial, reputational or other harm to you, the Plan must notify you within 60 days of discovery of such "Breach" (as such terms are defined in the HIPAA privacy rules).

Right to file a complaint. If you believe your rights have been violated, you should let us know immediately. We will take steps to remedy any violations of the Plan's privacy or of this HIPAA section.

You may file a formal complaint with our Privacy Officer and/or with the United States Department of Health and Human Services at the addresses below. You should attach any evidence or documents that support your belief that your privacy rights have been violated. We take your complaints very seriously.

The Plan prohibits retaliation against any person for filing such a complaint.

Complaints should be sent to:

Privacy Officer Laborers Health and Welfare Trust for Southern California 4399 Santa Anita Avenue, Suite 200 El Monte, CA 91731	Region IX, Office for Civil Rights U.S. Department of Health and Human Services 90 7th Street, Suite 4-100 San Francisco, CA 94103 Fax: 415-437-8329 TDD: 415-437-8311

Additional Information About This Section

Changes to this Section

We reserve the right to change the Plan's privacy practices as described in this section. Any change may affect the use and disclosure of your PHI already maintained by the Plan, as well as any of your PHI that the Plan may receive or create in the future. If there is a material change to the terms of this section, you will receive a revised notice.

How to obtain a copy of your Notice of Privacy Practices

You can obtain a copy of the current Notice by contacting the Privacy Office at the address listed on page 31.

No change to Plan benefit

This section explains your privacy rights as a current or former participant in the Plan. The Plan is bound by the terms of this section as they relate to the privacy of your PHI. However, this Notice does not change any other rights or obligations you may have under the Plan. You must refer to the Summary Plan Description for additional information regarding your Plan benefits.

Special Enrollment Periods

Under the provisions of HIPAA eligible individuals and eligible Dependents may be enrolled during special enrollment periods.

A special enrollment period applies when an eligible individual or an eligible Dependent loses other health coverage or when an eligible individual acquires a new eligible Dependent through marriage, birth, adoption or placement for adoption. The eligible individual or the eligible Dependents enrolling during a special enrollment period will not be subject to late enrollment provisions.

An eligible individual or an eligible Dependent that loses other health coverage may be enrolled during a special enrollment period if all of the following requirements are met:

1. The eligible individual or the eligible Dependent was covered under another group health plan or other health insurance coverage when otherwise initially eligible for coverage under this Plan; and
2. Coverage in this Plan was declined; and
3. Coverage under the other group health plan or health insurance coverage was lost for one of the following reasons:
   a. The other group health coverage is COBRA continuation coverage and the coverage has been exhausted; or
   b. The other coverage is a group health plan or other health insurance coverage and has been terminated as a result of loss of eligibility, or
   c. Employer contributions towards the other coverage have been terminated.

Loss of eligibility includes a loss of coverage as a result of:

- Legal separation,
- Divorce,
- Death,
- Termination of employment,

- Reduction in the number of hours of employment, and
- Any loss of eligibility after a period that is measured by reference to any of the foregoing.

Note: Loss of eligibility does not include a loss due to failure of the individual or the Participant to pay premiums on a timely basis or due to termination of coverage for cause and the eligible individual or eligible Dependent enrolls within 30 days of the loss of coverage.

If you have been eligible but not otherwise enrolled and if you acquire a Dependent through marriage, birth, adoption or placement for adoption, you and the new eligible Dependents may enroll during a special enrollment period.

The special enrollment period is 30 days, beginning on the date of the marriage, birth, adoption or placement for adoption. If a completed request for enrollment is made during the 30-day period, the effective date of coverage will be:

- **in the case of marriage**, the first day of the first calendar month following the date the completed request for enrollment is received; or
- **in the case of a Dependent's birth**, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

Pre-existing Condition Exclusions

This Plan does not have pre-existing conditions limitations or exclusions.

Certificate of Creditable Coverage

Under HIPAA, if your coverage has been terminated, your former group health plan or any insurance company or HMO providing such coverage is required to provide you with a statement of prior health coverage, commonly referred to as a "Certificate of Creditable Coverage."

The certificate must be provided automatically to you when you lose coverage under the Plan or otherwise become entitled to elect COBRA continuation coverage. You must also be furnished a certificate when COBRA continuation coverage ceases.

Plans and insurers must generally provide a certificate to you if you request one or someone requests one on your behalf with your permission.

Certificates must be furnished by this Plan free of charge up to 24 months following the date you were last covered.

You will need the certificate if you leave this Plan and enroll in a subsequent plan that applies a pre-existing condition exclusion period or if you purchase an individual health insurance policy from an insurance company.

STATEMENT OF YOUR ERISA RIGHTS

As a Participant in the Laborers Health and Welfare Trust for Southern California, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

Receive Information About The Plan and Benefits

You may examine, without charge, at the Trust Fund Office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. You may obtain, upon written request to the Trust Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The administrator may make a reasonable charge for the copies for some of these documents. You may receive a summary of the Plan's annual financial report. The Trust Fund Office is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

If you lose coverage under the Plan because of what is known as a Qualifying Event, you may be able to continue health coverage for yourself, Spouse or Dependents. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

If there is an exclusionary period of coverage due to pre-existing conditions under this plan, there may be a reduction or elimination of the exclusionary period if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you:

- lose coverage under the plan;
- when you become entitled to elect COBRA continuation coverage; and
- when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to any preexisting condition exclusion in your coverage for 12 months (18 months for late enrollees) after your enrollment date.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a health and welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty days, you may file suit in a federal court. In such a case, the court may require the Trust Fund Office to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court, but only after you first exhaust the claims and appeals procedures described earlier. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a qualified medical child support order, you may file suit in federal court, but only after you first exhaust the claims and appeals procedures described earlier.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Trust Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Fund Office, 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, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline of the Employee Benefits Security Administration. The toll-free telephone number is 1-866-444-3272.

SECTION 12. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

If you enter the Armed Forces of the United States, you may elect to continue your coverage and that of your eligible Dependents pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Under the terms of this Plan, your coverage will terminate on the date you begin military service and the coverage of your Dependents will also terminate.

If the period of your military service is thirty days or less, your coverage and your Dependents' coverage will continue during the period of military service. If the period of military service exceeds thirty days, you and your Dependents can elect continuation and you are required to pay the applicable USERRA continuation coverage premium. If you elect to continue your health coverage during your military service, it can be continued until the earlier of 24 months or the end of the period in which you must apply for reemployment upon the termination of your military service. Whether or not you elected to continue coverage, provided that you are honorably discharged and meet other requirements as set out in USERRA, you will be entitled to have your coverage reinstated on the date you return to Covered Employment with a Contributing Employer. You must notify the Contributing Employer of your intent to return to Covered Employment within the time period specified in USERRA.

SECTION 13. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

A Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to an Employee's child even if the Employee does not have custody of the child. A QMCSO is a judgment, decree, or order issued by a court of competent jurisdiction or by a state administrative body that has the force of a court judgment, decree or order. A QMCSO requires a child to be enrolled in the Plan as a form of child support or health benefit coverage pursuant to a state domestic relations law or to enforce a state law relating to medical child support.

The order must include the following information:

- The name of the Trust: *Laborers Health & Welfare Trust for Southern California;*
- The name and last known address (if any) of the Participant and the name and address of each child covered by the order;
- A reasonable description of the type of coverage to be provided by the Plan; and
- The period of coverage to which the order pertains.

Upon receipt of an order, the Plan will notify, in writing, the Participant and each child covered by the order of the Plan's procedures for determining whether the order is qualified. The Plan will also notify the Participant and each affected child in writing of its determination as to whether an order is a QMCSO.

A copy of the QMCSO procedures adopted by the Plan may be obtained without charge from the Fund Office. If you have any questions about QMCSOs or think you might have received one, you should contact the Fund Office. All QMCSOs must be submitted to the Fund Office for review and approval.

SECTION 14. IMPORTANT NOTICES

Women's Health And Cancer Rights Act Of 1998

Under the Women's Health and Cancer Rights Act of 1998 (WHCRA), a group health plan participant or beneficiary who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with the mastectomy, is entitled to coverage for the following:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of mastectomy, including lymphedema.

Treatment for these benefits or services will be provided in a manner determined in consultation with the Participant's or Beneficiary's attending physician.

If you are a Participant in the Plan and you are currently receiving, or in the future receive benefits under the Plan in connection with a mastectomy, you are entitled to coverage for the benefits and services described above in the event that you elect breast reconstruction. Your eligible Dependents are also entitled to coverage for these benefits or services on the same terms.

Coverage for the mastectomy-related services or benefits required under WHCRA will be subject to the same Deductibles and coinsurance or co-payments provisions, if any, that apply to any other medical or surgical benefits provided under the terms of the Plan.

Newborns' And Mothers' Health Protection Act Of 1996

Group health plans and health insurance carriers offering group health coverage, generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a normal vaginal delivery, or 96 hours following a caesarian section.

Current law prohibits a plan from requiring a health practitioner to obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending physician from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable) if the attending physician in consultation with the mother makes the decision.

The Plan may still require pre-certification or pre-authorization from the Plan or the insurer for prescribing a length of stay in excess of 48 hours (or 96 hours).

SECTION 15. MEDICARE COVERAGE AND ENROLLMENT

Retiree Welfare Plan Coverage Terminates When Eligible For Medicare

When any retired participant or a Dependent of a retired participant becomes eligible for Medicare coverage, medical, dental and vision coverage in the Trust will be terminated. Retirees and Medicare eligible Dependents should, therefore, be sure to timely enroll in the Medicare program.

Some General Information About Medicare

Medicare is a federal health insurance program for people 65 years of age or older and certain younger people with disabilities or end-stage renal disease (permanent kidney failure).

Medicare pays for much of your health care, but not all of it. You have to pay some costs yourself, unless you buy insurance designed to cover the Medicare deductibles and co-insurance amounts.

The Three Parts Of Medicare

Medicare has three parts:

Part A – Hospital Insurance
Part B – Medical Insurance and
Part D – Prescription Drug Program

Medicare refers to their Hospital coverage as Part A. You are not required to make any payments for Part A coverage.

Part B of your Medicare coverage is for services of doctors and other medical providers. You must pay a portion of the cost of Part B Medicare coverage and that amount is usually deducted from your monthly Social Security benefit.

Part D of Medicare covers prescription drugs. All individuals eligible for Medicare will have access to Medicare-endorsed drug discount cards that will provide discounts on drugs. Additionally, anyone meeting certain low income requirements may be entitled to receive a subsidy from the federal government to help cover their prescription drug needs.

Enrollment In The Medicare Program

If you are approaching age 65, you are not automatically enrolled in Medicare unless you have already filed an application and established your eligibility for a Social Security benefit. You can sign up for Medicare coverage at any time in the seven-month period that starts three months before your 65th birthday.

If you have not applied for Social Security benefits, you must file a separate Medicare application during the three-month period prior to the month in which you will become age 65 to assure that coverage will start in the month you become age 65.

If you do not apply for Medicare coverage within the initial seven-month enrollment period, you will have to wait for the next open enrollment and that will delay the start of your Medicare coverage until the next July 1.

Enrolling late for Medicare coverage will also cause your Part B and Part D premiums to be higher. Your Medicare Part B premium will cost you 10 percent more each year you delay enrollment. A delayed enrollment, which delays the start of your Medicare coverage, increases your risk of having to pay for medical expenses out of pocket.

Each person must file a separate Medicare application. Visit your local Social Security Office or call the Social Security Administration at 1-800-772-1213 to sign up for Medicare. For more information about the Medicare Advantage Plans, Medigap coverage or any other Medicare coverage issue, call 1-800-633-4227 toll free. TTY users should call 1-877-486-2048. You can also visit Medicare's website at http://www.medicare.gov.

Medicare Secondary Payer Provisions

If you are still active at work and your Medicare coverage begins, Medicare will not be the primary payer of your claims.

If you are covered by the Plan as an active-at-work Employee or if you are the Dependent of an active-at-work Employee and also eligible for Medicare, the Plan is the primary payer of your claims and Medicare is the secondary payer.

Medicare refers to these rules as the Medicare Secondary Payer Program. This means that the Plan will pay first for any of your covered health services claims and Medicare will then review what the Plan paid for the Medicare covered health care services. Medicare will then process any of the allowed additional costs up to the Medicare-approved amount.

For more information about the Medicare Secondary Payer Program, contact Medicare and ask for publications about it. You can also call the Medicare Coordination of Benefits Contractor at 1-800-999-1118.

SECTION 16. HOSPITAL AND OTHER MEDICAL BENEFITS

The PPO and EPO Plans are self-funded. Benefit payments are made from the assets of the Fund. Benefits paid under this part of the Plan's coverage are subject to the maximum annual benefits limits on essential health benefits per person. Please refer to the schedules of benefits for the maximum annual benefits applicable to your Plan.

Coverage Terminates When Maximum Annual Benefits Have Been Paid

When the maximum annual benefits have been paid to any person, medical coverage for that person will terminate for that year. If coverage of an eligible Employee, Retiree or Dependent is terminated under these provisions, the coverage of otherwise eligible family members will not be terminated.

The Annual Deductible and Co-insurance

An individual must satisfy the Deductible once each Calendar Year. The Deductible is the first out-of-pocket eligible expense incurred by each covered person during a Calendar Year. Your Plan also has a family maximum Deductible.

When the family maximum Deductible has been met, no additional family members are required to satisfy a Deductible. Refer to the "Summary of Benefits," a separate booklet, to find the Deductible amount and family maximum for your plan of benefits. A new Deductible will apply each Calendar Year.

After each covered individual has satisfied the Deductible within a calendar year or the family maximum Deductible has been met, the Plan will pay a percentage of all eligible expenses incurred. The percentage of payment varies among the different plans of benefits provided by the Trust. Refer to the Summary of Benefits for your plan for more information.

When the out-of-pocket expenses of a covered individual reach a specified dollar amount during a calendar year, the Plan's rate of payment will increase to 100 percent of allowed charges and that rate of payment will continue to apply to eligible expenses incurred during the remainder of the year. Refer to the Summary of Benefits to find the maximum out-of-pocket expense for your plan of benefits.

The Provider Network

One of the ways in which coverage is provided by the Plan for Participants, Retirees and eligible Dependents is through networks of providers.

The Plan has contracted with Anthem Blue Cross to provide a large number of Hospitals and other medical care providers that have agreed to provide certain services at discounted rates. If you use the network providers, you will reduce the amount of your out-of-pocket expense.

If you use one of the EPO or PPO Hospitals and also follow the procedures for Hospital pre-admission review, the Plan will pay a greater percentage of the covered charges. If you are enrolled in the PPO and receive any medical care from a non-network provider, your out-of-pocket expenses will usually be higher. And, if you are enrolled in the EPO Plan and receive medical care from a non-network provider, your claim will be completely denied (except for certain emergency conditions and authorized referrals).

How To Use The Network

The PPO and EPO programs allow you to choose from among the many hospitals, physicians, laboratories and X-ray facilities listed in the Anthem Blue Cross Provider directory. The Anthem online directory is the most current and is available at www.anthem.com/ca. If you wish to use a network Hospital, physician or other provider, simply follow these steps:

1. Check the provider directory for a convenient network provider. The directory lists physicians and other network providers according to location and type of practice.
2. Call the provider and identify yourself as an eligible Participant in the Laborers Health & Welfare Trust of Southern California, which uses the Anthem Blue Cross Prudent Buyer Network.
3. Make sure the provider is still contracted with Anthem and make sure the types of service provided are covered by the Plan.
4. Have the following information available when you call:
   a. Your Member's group number;
   b. Your Social Security number or your Anthem Blue Cross ID number and the name and relationship of the patient to the member;
   c. The telephone number you are calling from (or where you may be reached); and
   d. The name, address, telephone number and specialty of the doctor, Hospital or laboratory you have selected from the directory.

You should continue to check the participation status of your provider each time you have a need for medical services. It is your responsibility to make sure that a provider is in the network. You cannot assume, for example, that a network doctor will use a network laboratory or network X-ray facility or refer you to other network providers.

Note: Even if a provider is participating in the network, there is no guarantee that the services of the provider are covered by the Plan.

If you enrolled in the PPO and you do not use a contracted provider,

- the Plan's allowed charges may be less than the provider's fees; and
- you will be responsible for payment of a balance after the Trust processes your claim.

If you are enrolled in the EPO and you do not use a contracted provider,

- your claim for services of an out-of-network provider will not be covered at all; and
- you could be responsible for the entire amounts charged, except for certain emergency conditions.

Non-contracted, non-participating, or out-of-network providers are not limited as to amounts they can charge for any given service. Any amount of charges billed by non-panel providers that is over and above the Plan's payment will be the responsibility of the patient.

The Plan covers medically necessary services you receive from certain licensed health care providers. Providers' services must be within the scope of their license.

The Plan provides benefits for the following services:

- Inpatient and outpatient Hospital expenses;
- Skilled nursing facility or extended care facility charges;
- Home health care;

- Hospice care;
- Doctors' visits either in your home or in the doctor's office when related to an illness or injury;
- Surgical services for treatment of an illness or injury (except for Certified Nurse Assistants);
- Services of a surgical or physician's assistant, who helps the surgeon, when all of the following conditions apply:

  - The operation is performed in a Hospital;
  - The surgical or physician's assistant is not a Hospital employee;
  - The surgical or physician's assistant is supervised by a contracted physician;
  - The surgical or physician's assistant bills through the tax identification number of contracting physician;
  - The Hospital has no employee doctor available to help the surgeon; and
  - Medical visits by your attending physician during hospitalization when not related to surgery.

- Maternity-care benefits for the Member, if female, or Spouse of Member only, including pregnancy and routine pregnancy related conditions before and after delivery;
- Local ambulance service;
- Anesthetics and their administration;
- X-ray and radium treatments and other radioactive substances treatments;
- Physiotherapy;
- Dialysis;
- Blood and blood products not related by or for the patient;
- Surgical dressings;
- Casts, splints trusses, braces, crutches;
- Durable medical equipment;
- Non-dental prosthetic appliances, such as artificial limbs, larynx and eyes;
- Dental prostheses replacing accidentally injured sound natural teeth within twelve months of the accident;
- Diagnostic X-rays and other imaging services (including interpretation and report);
- Laboratory services, non-automated panel interpretation and reports (if you go to a non-PPO physician, you can ask your doctor to refer you to a PPO laboratory);
- Chemotherapy services;
- Directed second opinion on proposed surgery when your doctor recommends surgery at a Hospital inpatient or in an ambulatory surgery center (and the specialist who provides the second opinion does not perform the surgery. If the second opinion consultation does not confirm the need for surgery, benefits are available for a third opinion consultation);
- Consultation services when requested by the attending doctor for advice on an illness or injury;
- Physical therapy when prescribed by a doctor (The therapy must seek to improve or to restore bodily functions within a reasonable period.);
- Occupational therapy when prescribed by a doctor;
- Speech therapy to restore lost ability to speak when prescribed by a doctor;
- Prosthetic and certain orthotic appliances that support or replace part or all of a body function or organ when prescribed by a doctor. (Appliances must be medically necessary and the coverage includes replacing, repairing, fitting, and adjusting such devices. For orthotics to be medically necessary under the EPO Plan, the patient must be diabetic. Covered orthotics are rigid or semi-rigid braces, which are used to support a weak or deformed body part or to restrict or eliminate motion.); and
- Chiropractic services.

Note: Not all services may be covered in some of the plans of benefits. Coverage for some services is limited.

Hospital Pre-Admission Certification

All of the inpatient Hospital benefits provided by the Plan are subject to the provisions of the Anthem Blue Cross Utilization Review (UR) Program. You and your covered family members must follow the Plan's pre-admission certification procedures. Your share of the cost of your Hospital bill will be higher if the pre-admission procedures are not followed. Your inpatient care may not be covered at all if it is not medically necessary.

Failure to obtain pre-admission certification for an otherwise covered Hospital service will result in a penalty. You will be responsible for personal payment of an additional 10 percent of the amount of payment the Plan would otherwise pay to the facility. This could result in out-of-pocket costs to you of thousands of dollars.

A pre-admission certification should be obtained for each admission that is planned. Any time that your doctor recommends a non-emergency Hospital stay, you must ask your doctor to contact the Anthem UR Program to get authorization before you are admitted to the Hospital. Also, if your doctor is not a network doctor, show your doctor the listing of network Hospitals so that you and he can select one from the list.

The Pre-Admission Review Department will review the medical reasons for admission and the length of stay and may also discuss the case with your doctor. Once approved, if your Hospital stay must be extended beyond the number of days already authorized, your doctor or the Hospital must call the Pre-Admission Review Department to obtain authorization for the additional days of stay. The Pre-Admission Review Department will remain in contact with your doctor during your period of hospitalization.

In the case of an emergency or urgent care, you or a family member should call within 72 hours of the admission. If you do not obtain authorization within 72 hours or the first working day of admission, the Plan will pay a lower percentage of the allowable charges. For pre-admission certification, call Anthem at 1-800-274-7767.

The pre-admission certification requirements apply if this Plan is the primary payer of the claim. Primary payer means that this Plan is responsible for paying for health benefits first before any other group or HMO. Refer to the Coordination of Benefits section of this Summary Plan Description for more information.

If you will be admitted to a medical center or Hospital operated by the U.S. Department of Veterans' Affairs, and if you will be using your Plan benefits, you must comply with the pre-admission certification requirements.

Certification does not guarantee coverage. Certification of a Hospital admission only means that a Hospital admission is the appropriate setting for the procedure or procedures that have been scheduled. Although a Hospital admission may be certified, benefits cannot be paid if, for example, your coverage has been terminated, is not medically necessary, or if surgery is performed that is later determined to be a cosmetic, experimental or investigative procedure or if sufficient information is not provided to fully and accurately describe your condition.

Hospital Cost Is Not Paid In Full

For each covered stay to a Hospital, the patient must pay a portion of the cost. For all hospital stays, a patient co-payment of $200 is required.

After the co-payment requirement has been met, the Plan pays a percentage of the covered amount of charges. The percentages vary from plan to plan. A payment penalty of 10 percent may be applicable for failure to obtain pre-certification.

For covered stays to network and non-network Hospitals, the Plan pays a percentage of the contracted amount or allowed charge after the patient co-payment has been paid. The percentage payment varies from plan to plan and the percentage of payment by the Plan may be reduced if pre-authorization has not been obtained.

Private Room Accommodations

If you occupy a private room (single) during any Hospital stay, the Plan will base its allowance on a daily rate, which is equal to the Hospital's average semiprivate (double occupancy) daily room charge for bed, board and general nursing care.

Covered Hospital Services

The following services are covered by the Plan during a Hospital stay, regardless of the class of accommodations occupied, if they are medically necessary for the diagnosis and treatment of the condition for which you are hospitalized:

- Use of operating room and recovery rooms and equipment;
- Use of intensive care or special care units and equipment;
- X-ray, laboratory and pathological examinations;
- Use of cardio-graphic or endoscopic equipment and supplies;
- Drugs and medicines for use in the Hospital;
- Blood, use of blood transfusion equipment and administration of blood or blood derivatives when given by a Hospital employee;
- Sera, biological, vaccines and intravenous preparations;
- Anesthesia supplies and use of anesthesia equipment;
- Oxygen and other inhalation therapeutic services and supplies;
- Dressings and plaster casts;
- Physical and occupational therapy and rehabilitation services and supplies;
- Radiation therapy in a facility approved by the appropriate governmental authorities; and
- Any additional medical services and supplies customarily provided by Hospitals unless specifically excluded by this Plan.
- Benefits for your newborn child also include, at a minimum, coverage for at least 48 hours following a normal delivery birth or 96 hours following a caesarean section birth;
- Chemotherapy treatment for cancer (including medication);
- Hemodialysis or peritoneal dialysis while the covered individual is a registered bed patient in a Hospital;
- Outpatient dialysis in the home, including the cost of all appropriate and necessary supplies required for home dialysis treatment as well as the reasonable rental cost of the required equipment; and
- Outpatient dialysis in a Hospital or free-standing facility, including the cost of necessary treatment if the governmental authorities approve the facility's dialysis program. Dialysis benefits are available until the patient becomes eligible for Medicare coverage.

Outpatient Services

Coverage is provided for the same services that you would receive as a "Hospital bed patient" in the case of outpatient care provided for emergency medical treatment or for treatment of accidental injury or for a covered surgical operation. Whenever possible, make sure you use an outpatient facility that is part of the Anthem Blue Cross network or there could be substantial out-of-pocket expenses to you.

This coverage includes all services, supplies and equipment given by the Hospital as part of its regular inpatient care.

Patients are responsible for a co-payment of $75 per visit for Hospital emergency room that is provided. The $75 co-payment will be waived if the patient is directly admitted to the Hospital. The authorization must be obtained within 72 hours of the emergency admission.

Emergency Room Tips

If you have been injured or you have any questions about a health situation or emergency, you should call your personal physician for advice. Your personal physician will direct you to the appropriate care setting.

If you have been seriously injured and you cannot call your personal physician in advance, call an ambulance or go directly to an emergency room. If possible, go to the emergency room of the Hospital where your network personal physician is affiliated. Non-contracted hospitals may charge fees well in excess of charges covered by this Plan and should be avoided when possible.

Medical Emergency

The Plan defines an "emergency" as a medical or behavioral condition, the onset of which is sudden. It manifests itself by symptoms of such severity, including severe pain, which a prudent layperson with an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention would:

- place the health or life of the afflicted person in serious jeopardy;
- place the health or life of an individual with a behavioral health condition or others in serious jeopardy;
- cause serious impairment to the individual's bodily functions;
- cause serious dysfunction of any bodily organ or part; or
- cause serious disfigurement of the afflicted individual.

Pre-Surgical Testing

The Plan provides coverage for diagnostic tests performed in a Hospital if the tests are prescribed by your doctor and are preliminary to scheduled surgery, provided the surgery is performed within seven (7) days in the same Hospital.

Benefits will not be paid for tests done on an inpatient basis that are preliminary to surgery that could be performed in a doctor's office, surgical-center or outpatient facility.

The testing will be a covered expense even if surgery or admission does not occur but only for one or more of the following reasons:

- If the tests show a condition that requires medical treatment before admission;
- A medical condition develops that delays the admission; or
- The tests show that admission is not necessary.

Extended Care, Skilled Nursing Facilities, Or Residential Treatment Facilities

The Plan pays for eligible expenses incurred during a covered skilled nursing facility or a residential treatment facility stay after a Hospital stay of at least three (3) consecutive days. The skilled nursing facility stay must start within 14 days after the patient's release from the Hospital and must be recommended by a physician for the non-work-related condition causing the hospitalization.

The patient must be under continuous care of a physician and require 24-hour nursing care. The physician must initially certify, and re-certify at least once during each succeeding thirty-one (31)-day period of stay, that such nursing care is or was required to be given on an inpatient basis. If all of the requirements are met, the Plan will cover allowable room, board, other services, and supplies furnished by the facility for necessary care (other than personal items and professional services).

In the PPO Plan, active Employees are limited to a maximum stay of 70 days and dependents are limited to a maximum stay of 31 days, including the preceding days during the Hospital. In the EPO Plan, active Employees and their dependents are limited to a maximum stay of 100 days, including the preceding days during the Hospital. In the PPO Plan, Retirees (other than those in the Special Retiree Plans) are limited to a maximum stay of 70 days and dependents are limited to a maximum stay of 31 days, including the days during the Hospital. In the EPO Plan, Retirees (other than those in the Special Retiree Plans) and their dependents are limited to a maximum stay of 100 days, including days during the Hospital. Under any of these plans (other than the Special Retiree Plans), the maximum benefit period shall be reduced by one day for each day of Hospital stay during the same "Continuous Period of Disability" on page 73.

The percentage of payment varies from plan to plan and the percentage of payment may be reduced if pre-authorization has not been obtained. A co-payment is required if not discharged directly from an inpatient hospital stay.

Extended Care or Skilled Nursing Facilities are not covered in the Special Retiree Plans. (Refer to page 73 for specific exclusion number 38 regarding this benefit.)"

Home Health Care Benefits

Home health care benefits are available under a physician-approved plan of treatment when the necessary services are provided through a State-certified home health agency. Benefits will be provided only if hospitalization or stay in a Skilled Nursing Facility or a Residential Treatment Facility would otherwise have been required.

Coverage is provided for eligible charges for care furnished by a home health care agency, as follows:

- Part-time or intermittent nursing provided or supervised by a Registered Nurse;
- Part-time or intermittent home health aide services, primarily for the patient's care;
- Physical, occupational or speech therapy by a qualified therapist; and
- Medical supplies and laboratory services by or on behalf of a home health care agency, to the extent these services or supplies would have been covered if furnished by a Hospital or a Skilled Nursing Facility or a Residential Treatment Facility to an inpatient.
- When home health care is provided through an agency that participates in an agreement with the Plan to provide the care, these additional services are covered:
- X-ray and EKG services; and
- Ambulance to the Hospital for needed care.

Benefits for covered services are provided for up to 100 home health care visits per calendar year when care is provided by a Participating agency and the care begins within seven (7) days of discharge from a Hospital.

Coverage for home health care expenses is subject to the following conditions:

- Pre-authorization must be obtained;
- The patient must be under the care of a physician; and
- The physician must submit a home health care plan (a written program for care and treatment in the patient's home and certification that inpatient stay in a Hospital, convalescent nursing home or a Skilled Nursing Facility would be required if the home health care plan were not available).

Not more than 100 home health care visits will be included in the eligible expenses for any one person in a calendar year. Each visit by each member of a home health care team other than a home health aide is counted as one visit. Each four hours served by a home health aide is considered one visit.

For covered periods of Home Health Care, the Plan pays a percentage of the contracted or allowed amount. The percentage of payment varies from plan to plan; and the percentage of payment may be reduced if pre-authorization has not been obtained. Home Health Care is not covered in the Special Retiree Plans.

> The Home Health Care coverage is summarized in the "Summary of Benefits," a separate booklet, explaining the benefit.

Hospice Benefits

This Plan provides coverage for up to 210 inpatient days of Hospice Care in a hospice and outpatient services delivered by the hospice. The primary attending physician must certify that the patient has a life expectancy of six months or less. The hospice must be certified by the state in which it is located.

Covered hospice and outpatient services include:

- Bed patient care, either in a designated hospice unit or in a regular Hospital bed;
- Day care services provided by the hospice organization; and
- Home care and outpatient services provided and billed by the hospice, which may include the following:

- Intermittent care by an RN, LPN, or Home Health Aide;
- Physical therapy, speech therapy and occupational therapy;
- Respiratory therapy;
- Social services and nutritional services;
- Laboratory examinations, X-rays, chemotherapy, and radiation therapy when required for control or symptoms;
- Medical supplies;
- Drugs and medications prescribed by a physician and which are considered approved under the U.S. Pharmacopoeia and or national formulary (not covered when the drug or medication is of an experimental nature);
- Medical care provided by the hospice physician;
- Five visits for bereavement counseling for the covered person's family, either before or after the covered person's death;
- Durable medical equipment (rental only); and
- Transportation between home and Hospital or hospice organization when medically necessary.

The following charges will not be covered for hospice expenses:

- Services of a social worker or a clinical social worker;
- Hospice care services by volunteers or individuals who do not regularly charge for their services and
- Hospice care by a pastoral counselor or a bereavement counselor.

For covered periods of Hospice Care, the Plan pays a percentage of the contracted or allowed amount. No patient co-payment is required. The percentage of payment varies from plan to plan and the percentage of payment may be reduced if pre-authorization has not been obtained. Hospice Care is not covered in the Special Retiree Plans.

The Hospice Care coverage is summarized in the Summary of Benefit Chart.

(See separate booklet explaining the benefit.)

The Plan also provides coverage for the following services:

Other Health Care Services

The benefit summaries described the extent of coverage for the services of physicians and other health care professionals. This coverage is summarized in the charts section. (See separate booklet explaining the benefit.)

Directed Second Surgical Opinion

When you have to make a decision about a complicated matter, it helps to find out as much as you possibly can about the pros and cons. The same is true if a doctor tells you that you have to undergo surgery, especially if it is an elective procedure. You should get a second opinion any time a doctor suggests a non-emergency surgery. It is recommended that you get a second opinion or predetermination of benefits whenever elective, non-emergency surgery is suggested for you or your covered Dependent or if the cost of a treatment or procedure will exceed $2,000. First, make sure that a short delay will not be harmful and make sure that you have as much information as possible about the benefits and risks of surgery.

The term elective procedure means that the recommended surgery is a non-emergency nature. In the event of an emergency, you should seek medical attention immediately.

There are risks with any surgery and you should know what they are. You should also know what the surgery will do for you and whether other medical treatment might be used instead of surgery.

There is a $20 copayment to participants in the EPO Plan for a second opinion from another surgeon before you have elective, non-emergency surgery, including the costs for necessary X-rays or tests. The PPO Plan will pay 100 percent of the contracted rate to participating providers and 100 percent of the usual, customary and reasonable charges to non-participating providers for a second opinion from another surgeon before you have elective, non-emergency surgery, including the costs for necessary X-rays or tests.

When surgery is recommended that is non-emergency, you or your doctor should call the Pre-Admission Review Department at 1-800-274-7767. Information will be obtained from your doctor to help determine if alternative treatments or procedures would be appropriate and covered by the Plan. Also, it will be determined as to what extent the proposed surgery, treatment or procedure will be reimbursed or excluded from coverage by the Plan. Some procedures or treatments are not covered by the Plan. Before having expensive treatment done, you must verify with the Trust Fund Office as to whether the Plan will cover the treatment or procedure.

When it is not an emergency, you should take the time to explore and think about your options. For example, often there are differences of opinion about medical problems. One doctor may recommend surgery and another may tell you to wait awhile and another doctor may suggest another kind of treatment such as drug therapy or physical therapy, for example.

When there is time, a second opinion should give you additional information to help you decide if surgery is the best thing for you. You have every right to that information. You will find out if there are other methods of treatment available to you and weigh the benefits and risks of having the operation against the benefits and risks of not having it.

Here are some things you should know before you make a decision:

- What does the doctor say is your health concern?
- What surgical procedure does the doctor plan to do?
- What are the likely benefits to you?
- What are the risks of the surgery and how likely is a problem to occur?
- How long will the recovery period be and what will be involved?
- What is the cost of the surgery, and the Hospital and other services such as anesthesia?
- Will your benefit plan cover the costs?
- What will happen if you don't have the surgery?
- Are there other ways to treat your condition that could be tried first?

The more you know, the better prepared you'll be to make a decision.

If the second opinion does not confirm the advisability of the proposed surgery, with the Trustees' prior approval, a third opinion may be arranged and will be paid for in the same manner as the second opinion.

The following services should have a second opinion or predetermination of benefits in order to help you understand what will be covered:

- Allergy testing and therapy;
- Caesarean birth (initial or elective);
- Cataract surgery;
- Pteryqium excision;
- Gall bladder surgery (elective)
- Hernia repair;
- Hysterectomy;
- Immunomodulater therapy (for example, interferon, Bacillus Calmette-Guerin [BCG], interleukin);
- Jaw surgery for problems related to chewing;
- Knee or hip replacement;
- Nasal and sinus surgery;
- Orthognathic surgery;
- Outpatient parenteral nutrition;
- Podiatric treatments or surgery;
- Removal of hemorrhoids;
- Removal of tonsils;
- Temporomandibular joint disorder (TMJ) surgery;
- Varicose vein ligation and excision;
- Reduction mammoplasty;
- Acne therapy;
- Blepharoplasty; and
- Treatment of morbid obesity.

What Is Not Covered?

While your Plan will pay for second surgical opinions for many procedures and surgeries, it will not pay for a second opinion for:

- Emergency surgery;
- Cosmetic, dental or other surgery not covered under the Plan;
- Minor surgery which may be done in a doctor's office, such as incision and draining of an abscess;
- Elective abortions and normal vaginal deliveries;
- Second opinion consultation obtained more than six months after the date surgery was recommended;
- Consultation with any medical doctor related to or affiliated in any way with the doctor who originally recommended the surgery;
- Consultation with any physician who is, has been, or agrees to become the treating physician, or who agrees to assist or in any way participate in the proposed surgery.
- In every event, you and your medical provider make the final decisions about your medical treatment. This Plan only determines the amount of reimbursement for covered health care services. Neither the Trust nor its employees or agents participate in providing medical services, treatment or recommendations or medical services or treatment.

SECTION 17. GROUP LIFE AND ACCIDENTAL, DEATH AND DISMEMBERMENT INSURANCE

(For Active Employees and Their Dependents Only)

Note: The coverage and rules regarding Group Life Insurance and Accidental Death and Dismemberment are the same whether you choose the PPO Plan, the EPO Plan or the Kaiser Permanente HMO Plan.

Benefits

Benefits described in this section are insured by Aetna Life Insurance Company of Hartford Connecticut (Aetna).

Group Life Insurance coverage is provided by the Plan for Active Employees and their eligible Dependents that are enrolled in the PPO Plan, the EPO Plan, and the Kaiser Permanente HMO Plan. Retirees, their surviving Spouses, and other Dependents of Retirees are not eligible for group life insurance coverage.

Accidental Death and Dismemberment coverage is provided for Active Employees only. Dependents of Active Employees, Retirees, surviving Spouses of Retirees and other Dependents of Retirees are not eligible for Accidental Death and Dismemberment coverage through the Trust.

Initial eligibility for Group Life Insurance and Accidental Death and Dismemberment coverage is delayed for participants who are dispatched as trainees until they have completed 4,000 hours of Covered Employment.

Beneficiary Cards

You may also complete a beneficiary designation card and submit it to the Trust Fund Office. The beneficiary designation is used to determine your beneficiary for Life Insurance and Accidental Death and Dismemberment Insurance.

You may obtain beneficiary designation cards from your Local Union Office or the Trust Fund Office. You may change your beneficiary as you wish by completing a new card and delivering it to the Trust Fund Office. Any payment of benefits may be delayed if a beneficiary card is not on file in the Trust Fund Office.

Beneficiary

When completing your Enrollment/Change Form, be sure that you designated a beneficiary. Your beneficiary is the person or persons named by you on the most recent beneficiary designation form, which you have provided to the Trust Fund Office. If two or more persons are named as beneficiaries, they will share equally in the benefit unless you have designated otherwise. If you do not name a beneficiary or if your designated beneficiary does not outlive you, your beneficiary will be surviving person(s) in the order listed:

- Your Spouse;
- Your children, including your biological children, any legally adopted children, stepchildren, or grandchildren for whom you have legal custody, and any children who have been placed with you for adoption;

- Your parents;
- Your brothers and sisters; or
- Your executor or administrator

Life Insurance Schedule of Benefits
for Active Employees and Eligible Dependents

Employee	$10,000.00
Spouse	$ 5,000.00
Dependent	$ 5,000.00

Your Eligible Dependents Are Your Spouse And Your Eligible Dependent Children

In the event of your death, the full amount of Group Life Insurance as shown in the schedule of benefits will be paid to your designated beneficiary, either as a lump sum or in installments.

This Life Insurance benefit is payable regardless of the cause of death (including an on-the-job accident) and will be paid in addition to any death benefit that may be payable by Workers' Compensation.

In the event of the death of your eligible Dependent, the amount of Life Insurance shown in the schedule of benefits is payable to you. This benefit is payable regardless of the cause of death.

Filing A Claim

When there is a claim for Life Insurance benefits, the beneficiary should immediately send a letter and a certified copy of the death certificate to the Trust Fund Office. The Trust Fund Office will send the necessary information to Aetna and the benefit payment will be made by Aetna.

Conversion Privilege

Within 31 days of loss of eligibility under this Plan, you or your Dependent may convert the Group Life Insurance coverage to an Individual Life Insurance policy or any regular Aetna Whole Life or Endowment Plan. To do this, an application and the first premium payment must be made by you to "Aetna Life Insurance Company" within the 31-day period.

An individual policy will then be issued without medical examination at the insurance company's regular rates. If death occurs within the 31-day conversion period, the death benefit will be payable.

Death Benefits For Retirees Only

For Retirees who are eligible for or enrolled in retiree health and welfare coverage, and even if suspended, their designated beneficiary is eligible for a $1,000 death benefit, which will be paid by this Plan to that designated beneficiary. A beneficiary card must be completed and filed with the Trust Fund Office as described on page 52.

Dependents of Retirees, surviving Spouses of Retirees and other Dependents of Retirees are not eligible for Accidental Death and Dismemberment coverage through the Trust.

Accidental Death and Dismemberment Insurance (Active Employees Only)

The Accidental Death and Dismemberment Insurance coverage provides benefits for your loss, while insured, of life, limbs or the entire and irrecoverable loss of sight, but excluding losses resulting from work-related accidents.

Benefits are payable only if the loss results directly from bodily injuries sustained solely through accidental means and occurs within 90 days after the date of the accident causing the loss.

The Accidental Death Benefit payable is in addition to the Life Insurance benefit. The beneficiary will be the same as you have designated for the Group Life Insurance. A beneficiary designation card must be on file with the Trust Fund Office.

Accidental Death and Dismemberment Benefit

The full principal sum of $10,000 will be paid for loss of:

- Life
- Both hands
- Both feet
- One hand and one foot
- One hand and sight of one eye
- One foot and sight of one eye
- Sight of both eyes.

One half the principal sum ($5,000) will be paid for loss of one hand, one foot or the sight of one eye. In no case will more than the full principal sum be paid for all losses resulting from one accident.

Definition of Loss

Loss means, with regard to a hand or foot, actual severance through or above the wrist or ankle joint. With regard to loss of eyesight, loss means the entire and irrecoverable loss of sight of such eye.

Since this is coverage for losses due to accidents, no benefits are payable on account of a loss caused or contributed to by bodily or mental infirmity, ptomaine, bacterial infections, disease, medical or surgical treatment not made necessary by injury covered under the Plan, war, suicide or work-related accidents.

SECTION 18. PRESCRIPTION DRUG BENEFITS

Prescription Drug Plan

The Fund has made arrangements with a pharmacy benefit manager to administer this benefit. The manager is OptumRx, 3515 Harbor Boulevard, Costa Mesa, California 92626.

The Plan provides this prescription drug plan for Active Employees and their eligible Dependents that are enrolled in the PPO Plan and the EPO Plan. The prescription drug plan through OptumRx does not cover Actives and Dependents that are enrolled in the Kaiser Permanente (Kaiser) HMO. Kaiser provides that coverage for its members.

The Prescription Drug Plan also covers retirees, their surviving Spouses and other Dependents of Retirees, who are eligible in the Laborers' PPO Plan, the Laborers' EPO Plan or the Laborers' Special Retiree Plans I or II. The coverage of Retirees and Dependents is subject to different co-payments than those of the Active Employees' plan of benefits. The Prescription Drug Plan does not cover Retirees and Dependents who are enrolled in the Kaiser HMO.

Retirees eligible for Medicare and their Spouses eligible for Medicare and eligible for Health and Welfare coverage are eligible for prescription drug coverage. Retirees and their spouses eligible for Medicare are not eligible for medical, dental, vision or life and dismemberment insurance.

Initial eligibility for prescription drug benefits is delayed for participants who are dispatched as trainees. A trainee must complete 2,000 hours of Covered Employment to be eligible for prescription drug coverage for himself and his Dependents.

OptumRx has established a network of pharmacies where you may have your prescriptions filled. The list of network pharmacies is provided to all Participants without charge.

To have a prescription filled, you must present your OptumRx's identification card and the doctor's prescription to the pharmacist at a Participating pharmacy. At that time the pharmacist will verify your eligibility under the Plan. If you are eligible, the pharmacist will then fill your prescription. Retirees must pay for the prescription at the time it is filled and submit a claim for reimbursement afterwards.

You must pay a co-payment and/or Deductible and the prescription drug will be dispensed to you. Refer to the Summary of Benefits booklet for information about the limitations, co-payments, and Deductibles that apply to your particular prescription drug benefit schedule. (See Summary of Prescription Drug schedule in a separate booklet.)

Your Prescription Drug Plan covers medications (which require compounding) as well as prescriptions for legend drugs, and insulin (which is prescribed with specific dosage). A legend drug is one that may not be legally dispensed without the written prescription of a doctor.

In addition to covering insulin (by prescription), the Prescription Drug Plan will cover the following items when prescribed in writing by a doctor:

- Diabetic supplies, including insulin syringes, needles, sugar test tablets, sugar test tape, acetone test tablets, benedicts solution or equivalent (monitoring equipment is covered by the medical plan);
- Compound dermatological preparations, including ointments and lotions prepared by a pharmacist under a doctor's prescription; and
- Colostomy supplies.

General information About Generic Drugs

When a drug company develops a new drug, it has a patent for 17 years. The patent protects the drug company's right to be the only manufacturer of that drug. After the patent expires, other companies can then manufacture and sell the drug under either a different brand name or the generic name. The new product is usually sold at a lower price than the original brand-name product.

Because generic drug prices will cost less than brand-name drugs, you should urge your doctor to write your prescriptions for generic drugs when available. By law, generic and brand-name drugs must meet the same government standards for safety, purity, strength and effectiveness. To attain FDA approval, a generic drug must have the same effect on the body as the brand-name product. This means that the generic product must have the same active ingredient and must be the same strength. Sometimes, the generic drug may have a different color or shape than the brand-name drug. This has no effect on the medical or clinical effectiveness of the drug. When authorized by your doctor, generic drugs save you and your Plan money, which will help to maintain your current Prescription Drug Benefit Plan.

Closed Formulary Program – Retirees and Eligible Dependents

The Prescription Drug Plan for all Retirees and eligible Dependents of Retirees is a closed formulary program. A formulary is a comprehensive list of preferred brand-name and generic drugs that are covered under your prescription drug benefit plan and are available to your health care providers to use in your treatment. Only the specific drugs that are included in the formulary will be covered by the Plan.

Formularies list those medications that offer the best value without sacrificing the quality of care. Before prescribing a medication for you, your physician should consult the OptumRx formulary listing. If your particular medication is not among those listed on the formulary, an alternative medication will be listed which is designed to be equally safe and clinically effective. You should ask your doctor to prescribe an alternative medication that can be covered by the Plan.

Many Hospitals have used these medication lists for years to control costs while still providing quality medications. Pharmacy Benefit Managers, health plans, and even some large medical covered medications offer the best value without sacrificing the quality of your care. You can find out what drugs are on the formulary by visiting OptumRx's website or by calling the customer service toll-free telephone number at 1-800-797-9791. For OptumRx's mail order customer service, call 1-800-562-6223. (See formulary link in the box below.) The hours are from 6:00 a.m. to 9:00 p.m., Pacific Standard Time (PST), Monday through Friday. On Saturday and Sunday, the hours are from 7:00 a.m. to 7:00 p.m., PST.

To view the formulary list of the prescription drugs available, go to:

Active Formulary Link:
https://www.optumrx.com/clientformulary/formulary.asp?var=LSCRET2631&infoid=LSCRET2631&page=&par=

Retiree Formulary Link:
https://www.optumrx.com/clientformulary/formulary.asp?var=LSCRET&infoid=LSCRET&page=&par=

Prescription drug benefits are not payable (except as required to be provided as Covered Preventive Services) for:

- Medications that you can legally obtain without a prescription, except insulin (patent medicines or over-the-counter drugs such as, but not limited to, antacids, vitamins, dietary supplements, cough preparations, health and beauty aids, and appetite suppressants);
- Charges for administration or injection of any drug;
- Therapeutic devices or appliances, support garments or other non-medicinal substances;
- Investigative or experimental drugs;
- Unauthorized refills;
- Medications for cosmetic purposes;
- Drugs related to the treatment of sexual dysfunction, such as Viagra, Cialis, and other sexual dysfunctional medications;
- Contraceptives;
- Minoxidil (Rogaine) and other hair growth medications for treatment of alopecia;
- Immunization agents;
- Biological sera;
- Durable medical devices;
- Health foods and other herbal treatment when used as medical treatment;
- Nicorette and transdermal regulators for smoking cessation;
- Prescriptions covered under federal, state or local programs, including Workers' Compensation;
- Medication that is to be taken by or administered to an individual, in whole or in part, while a patient in a Hospital, rest home, sanitarium, convalescent hospital, nursing home, skilled nursing facility; residential treatment facility; and
- Expenses otherwise excluded or limited by the Plan.

Other limitations or exclusions apply. Please refer to the Limitations and Exclusions section of this Summary Plan Description.

The prescription drug benefits are subject to the Coordination of Benefits provisions.

Deductibles and Required Co-payments under the Prescription Drug Plan for Active and Retired Employees and their Eligible Dependents are summarized in the respective Summary of Benefits booklets. (See separate booklets explaining the benefit.)

SECTION 19. CHOOSING YOUR DENTAL PLAN

The dental plan has two options:

1. Delta Care USA and
2. Laborers' Dental Plan.

When you first become eligible for benefits under the Plan, you will have up to 30 days to make a decision about which plan to choose. If you make your choice and complete the appropriate enrollment form prior to establishing initial eligibility, you will be enrolled in the plan of your choice on the effective date of your initial eligibility. If your enrollment form is received after your initial effective date but within 30 days of your initial effective date, you will be enrolled in the plan of your choice, effective the first day of the month following your initial eligibility date.

If you do not choose a dental plan at the time your eligibility begins, you will automatically be enrolled in the Laborers' Dental Plan by default. The enrollment period will last a minimum of 12 months.

Changing Dental Options

After your initial enrollment and you have been in the plan 12 consecutive months, you will have the opportunity to change plans. Upon request, you will receive all of the information to help you make this choice approximately one month prior to the date you must make your choice.

Accessing Your Benefits

DeltaCare USA Plan. To access your benefits through the DeltaCare USA Plan, you will simply need to complete the enrollment process as directed by the Trust Fund Office. Call the Trust Fund Office to request an enrollment form. At the time you enrolled in the DeltaCare USA Plan, a provider will be assigned to you based on your home address. Your contracted dentist will take care of your dental needs, including referrals for treatment from a specialist if needed.

You can change your selected network dentists by telephone at 1-800-422-4234 or through DeltaCare's website at www.deltadentalins.com. Changes received by DeltaCare by the 21st of the month will be effective the first day of the following month.

If you need specialty care services, your contracted dentist will coordinate your specialty care needs for oral surgery, endodontics, periodontics or pediatric dentistry with an approved contracted specialist. If there is no contracted specialist within your service area, a referral to an out-of-network specialist will be authorized at no extra cost, other than the applicable co-payment, if any. If the dental patient is assigned to a dental school clinic for specialty services, a dentist, a dental student, a clinician or a dental instructor may provide those services.

You must receive all services from DeltaCare USA's contracted dentists. Under the DeltaCare USA Plan, many services are covered at no cost to you and your eligible family members. There is no Deductible and no annual maximum. The DeltaCare USA Plan does, however, require specific predetermined co-payments for some procedures. Services received outside of the DeltaCare network are not covered by Delta or by the Trust. For a list of covered services and co-pays, see the separate booklet of the "Summary of Benefits booklet" for DeltaCare's Schedule of Benefits and copayments.

DeltaCare USA Plan's Provisions for Emergency Care

Under your DeltaCare USA Plan, you and your eligible Dependents are covered for out-of-area dental emergencies (35 or more miles from your contract dentist).

The DeltaCare USA Plan will pay up to $100 for out-of-area emergency dental expenses incurred in each 12-month period.

You are expected to receive follow-up care for the emergency from your regular dentist. (See the separate booklet of the "Summary of Benefits.")

Laborers' PPO Dental Plan

To access your benefits through the Laborers' PPO Dental Plan, you will simply need to complete the enrollment process as directed by the Trust Fund Office. The Laborers' Plan uses Anthem Blue Cross Prudent Buyer PPO Dental as your PPO dental plan network. If you select the Laborers' PPO Dental Plan, to obtain maximum benefits, you will also need to select a dentist from the list of the Prudent Buyer PPO Dental providers or facilities. Although a dental directory is available, participants should always verify if a dental provider or facility is currently part of the Laborer's PPO Dental Plan's network before obtaining dental services.

When using the Laborers' PPO Dental Plan, you will be responsible for some payments. The fees you will have to pay depend on the circumstances. You may have to pay a co-payment or a Deductible, as well as amounts that exceed the plan's schedule of allowances. You will also have to pay for optional services that are not covered by the Plan. (See the separate booklet of the "Summary of Benefit Chart," for a description of the benefits and copayments.)

The annual Deductible is $25 per person per year. The maximum family annual Deductible is $75 per year. For individuals age 19 and over, the annual maximum payment for covered services is $2,500 per person per year.

Orthodontia

For orthodontia services for individuals under age 19, the Plan pays 80 percent of Anthem Blue Cross' contract rates for orthodontia up to the Plan's annual limit. For individuals age 19 or over, the Plan pays 80 percent of Anthem Blue Cross' contract rates up to a lifetime maximum $3,000 for orthodontia.

Network Providers Cost Less

Participants in the Plan will benefit the most when they go to their respective plan's network of providers. Non-participating dental providers are not limited as to amounts they can charge for dental services. When services are received from non-contracted PPO providers, any fees or charges that are over and above the allowable amount for services will be at the expense of the dental patient.

Limitations and Exclusions

The Laborers' PPO Dental Program is subject to the general limitations and exclusions of the Trust.

The DeltaCare USA Plan has its own list of exclusions. In addition to the general limitations and exclusions, no dental benefits will be payable under the Laborers' PPO Dental Plan for:

- Charges for treatment by other than a licensed dentist or physician, except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of a dentist;
- Charges incurred for more than one cleaning and oral examination in any six consecutive months;
- Charges incurred for services and appliances involving full or partial dentures, including fixed bridgework, if the prosthetic service or appliance was started before the eligibility date of the covered individual;
- Orthodontic services when rendered by a dentist other than a board eligible or board certified orthodontist or by a general dentist with approved qualifications;
- The replacement of an existing prosthodontic appliance unless the existing appliance is at least five years old. If evidence is submitted that the prosthodontics purchased within the five-year period cannot be made serviceable due to extensive loss of remaining teeth or change in supportive tissues, replacement benefits may be considered.
- Charges incurred for dentures involving special techniques such as attachment dentures, personalization or characterization in excess of the schedule maximum for complete or partial dentures;
- Charges for any lost or stolen appliances;
- Cosmetic treatment;
- Gold inlays, onlays and crowns when the tooth can be restored with an amalgam or composite resin restoration;
- Stress breakers;
- Charges for full mouth X-rays one set every 24 months;
- Charges for any procedure not specifically listed in the schedule of allowances;
- Charges for any procedure which is excluded under the Plan;
- Charges in excess of the Plan's maximum allowed charge; and
- Services that do not meet the standards of dental practice accepted by the American Dental Association.

All dental claims are subject to the Coordination of Benefits provisions of this Plan.

Specialty Dental Care

If you need specialty care services, your contracted dentist will coordinate your specialty care needs for oral surgery, endodontics, periodontics or pediatric dentistry with an approved contracted specialist. If there is no contracted specialist within your service area, a referral to an out-of-network specialist will be authorized at no extra cost, other than the applicable co-payment, if any. If the dental patient is assigned to a dental school clinic for specialty services, a dentist, a dental student, a clinician or dental instructor may provide those services.

SECTION 20. CHOOSING YOUR VISION BENEFITS

Vision Benefits

Vision care benefits are provided by the Plan for Active Employees and their eligible Dependents. The vision care program does not cover Retirees, their surviving Spouses and other Dependents of Retirees.

Initial eligibility for vision care coverage is delayed for participants who are dispatched as trainees. Coverage does not begin for these Employees and their Dependents until 4,000 hours of Covered Employment have been completed.

Exam benefits are not available to eligible participants and their Dependents who are enrolled in the Kaiser Permanente HMO Plan but the plan will cover the other benefits listed below.

> If you are a PPO or EPO Plan participant or a Kaiser member and qualify for vision benefits, your benefits are listed in the Anthem Blue View Vision Chart and Exclusions in the separate booklet, "Summary of Benefits, which explains the benefit.
>
> If you are a Kaiser member, your vision exam for refraction is listed in Kaiser Permanente's Summary of Benefits, which is in that separate booklet.

For all eligible Employees and Dependent who are enrolled in the EPO Plan or the PPO Plan, the Plan will pay 100 percent of the charges for covered services when using a contracted provider furnished once every 24 months for the following, except when specified otherwise:

- Complete visual analysis (eye examination) including case history and refraction and exam by a legally qualified ophthalmologist or optometrist (once every 12 months);
- Lenses (including contact lenses) when eyeglasses are first acquired or when they are required by a change in prescription resulting from a visual analysis;
- Replacement of broken lenses (visual analysis not required); and
- Frames when eyeglasses are first acquired or when frames must be replaced to accommodate new lenses.

Limitations and Exclusions

The Vision Care Program is subject to the general Limitations and Exclusions of the Trust and the Limitations and Exclusions of the Blue View Vision Plan. In addition to the general Limitations and Exclusions, no vision care benefits will be payable for:

- Expenses for any services or supplies covered by another part of the Plan;
- Orthoptics;
- Vision training;
- Subnormal vision aids;
- Plano sunglasses;
- Anti-reflective coatings
- Special vision testing except as provided by an ophthalmologist or optometrist;
- Charges in excess of the Plan's maximum allowable charge
- Medical or surgical treatment of the eyes (which may be covered under the medical plan); and
- Services or materials not listed as covered expenses.

Blue View Vision's Limitations and Exclusions:

- **Combined offers**. Not combined with any offer, coupon, or in-store advertisement;
- **Experimental or Investigative**. Any experimental or investigative services or materials;
- **Crime or Nuclear Energy**. Conditions that result from (1) insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available;
- **Uninsured**. Services received before insured person's effective date or after coverage ends;
- **Excess Amounts**. Any amounts in excess of covered vision expense;
- **Routine Exams or Tests**. Routine examinations required by an employer in connection with insured person's employment;
- **Work-Related**. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits;
- **Government Treatment**. Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free;
- **Services of Relatives**. Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage;
- **Voluntary Payment**. Services for which insured person is not legally obligated to pay. Services for which insured is not charged. Services for which no charge is made in the absence of insurance coverage;
- **Not Specifically Listed**. Services not specifically listed in this plan as covered services;
- **Private Contracts**. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act;
- **Eye Surgery**. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery;
- **Sunglasses**. Sunglasses and accompanying frames;
- **Safety Glasses**. Safety glasses and accompanying frames;
- **Hospital Care**. Inpatient or outpatient hospital vision care;

- **Orthoptics**. Orthoptics or vision training and any associated supplemental testing;
- **Non-Prescription Lenses**. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power;
- **Lost or Broken Lenses or Frames**. Any lost or broken lenses or frames, unless insured person has reached new benefit period; and
- **Frames:** Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.

Disclaimer. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's Policy, which shall conflict with this overview.

All vision care claims are subject to the Coordination of Benefits provisions of this Plan and must be completed and sent by the participant to Blue View Vision within one (1) year from the original date of service by the provider's office.

The Blue View VisionSM Reimbursement Form is available in the Summary of Benefits booklet. If you need additional forms, you may duplicate the form. Your completed Reimbursement Form may be faxed to 1-866-293-7373, or emailed to oonclaims@eyewearspecialoffers.com, or mailed to Blue View Vision, Attn: Vision Claims, PO Box 8504, Mason, OH 45040-7111 for processing.

SECTION 21. HOW TO FILE A MEDICAL OR DENTAL CLAIM FOR BENEFITS

Claim Filing Period

All claims must be filed within one year from the date of service in order to be covered and eligible for payment.

If you receive health care services at a network provider, you only have to present your network identification card. The Provider will send your claim to the Claims Administrator for processing.

Out-Of-Network Medical or Dental Claims

If you receive services from a provider that is not in the network, you may be required to file a claim form together with an itemized bill from the provider. All provider billings must be itemized, clearly identifying the employee, the patient, the diagnosis, the details of service provided, including procedure and diagnostic codes, the date of service, and the fee for each service. All billings must be original documents. Photocopies of billings, balance due billings, and cash register slips cannot be accepted. If you need claim forms, call the Trust Fund Office at 1-800-887-5679 or 1-626-279-3000.

Time Frame In Which You Will Be Notified Of The Plan's Decision On Your Claims

If you have an urgent claim, the Trust Fund Office or Utilization Review Firm will notify you of its initial determination within 72 hours from receipt of the claim. An urgent claim is a claim for medical care or treatment that would seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, subjecting you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A health care professional with knowledge of the claimant's medical condition may act as your authorized representative in claims involving urgent care. If the Trust Fund Office or Utilization Review Firm requires additional information from you, it will notify you of its need for additional information within 24 hours of receipt of your claim. Upon receipt of this notice you will have at least 48 hours to respond.

1. If you have a pre-service claim, the Trust Fund Office or Utilization Review Firm will notify you of its initial determination within 15 calendar days of receipt of the claim. A pre-service claim is any claim for a benefit under the Plan for which the Plan requires approval before medical care is obtained. The Trust Fund Office or Utilization Review Firm may have one 15-calendar day extension to respond to a pre-service claim if the Plan determines that such an extension is necessary due to matters beyond the control of the Plan. If the extension is necessary, the Trust Fund Office or Utilization Review Firm will notify you within the normal deadline. If the extension is necessary because you failed to provide necessary information, the notice of extension will specify the information needed. You will have at least 45 days to respond if additional information is requested.

2. If you have a post-service claim, the Trust Fund Office will notify you of its initial determination within 30 calendar days of receipt of the claim. A post-service claim is any claim for benefits under the Plan which is not an urgent claim or pre-service claim. The Trust Fund Office may have one 15-calendar day extension to respond to a post-service claim if the Trust Fund Office determines that such an extension is necessary due to matters beyond the control of the Trust Fund Office. If the extension is necessary, the Trust Fund Office will notify you within the normal deadline. If the extension is necessary because you failed to provide necessary information, the notice of extension will specify the information needed. You have at least 45 days to respond if additional information is requested.

3. A concurrent claim is a claim that is reconsidered after an initial approval was made and results in a reduced or terminated benefit. An example of this type of claim is an inpatient hospital stay that was originally certified for five days that is reviewed at three days to determine if the full five days is appropriate. The Plan will notify you of such a reconsideration early enough to have an appeal decided before the benefit is reduced or terminated. For approved urgent care treatment, any request by a claimant to extend that treatment will be acted on by the Plan within 24 hours after receipt of the claim, but only if the claim is received at least two hours prior to the expiration of the approved treatment.

Appeals Procedures

In the event that the Trust Fund Office makes an adverse benefit determination regarding your claim, you are entitled to certain appeal rights. An adverse benefit determination includes the following:

1. A denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;
2. A failure to cover an item or service because the Plan considers it to be experimental, investigational, not medically necessary or not medically appropriate; or
3. A decision that denies a benefit based on a determination that you are not eligible to participate in the Plan.

If the Plan makes an adverse benefit determination, you are entitled to a full and fair review of the determination. The Plan will include the following information in its notice of initial claim denials:

1. The specific reason or reasons for the adverse benefit determination;
2. The reference to the specific plan provisions on which the determination is based;
3. A description of any additional information or material necessary for the proper processing of the claim and an explanation of the reason it is needed; and
4. The notification of the right to appeal and time periods that you need to follow in order to appeal the claim, plus a statement that you can file a lawsuit under the Employee Rights Income Security Act of 1974 (ERISA) but only after first exhausting the claims and appeals procedures herein.

You will have 180 days from receipt of an adverse benefit determination to file an appeal with the Plan's Benefits Appeals Committee, by addressing it to:

Benefit Appeals Committee
Laborers Heath and Welfare Trust for Southern California
PO Box 8024
El Monte, CA 91734

Upon good cause shown, the Board of Trustees may permit the petition to be amended or supplemented. The failure to file an appeal within such 180-day period shall constitute a waiver of your right to a reconsideration of the decision on the basis of the information and evidence submitted prior to the decision.

The Board of Trustees is the Claims Fiduciary for the purpose of reviewing appeals. With the exception of urgent care appeals, which may be oral, all other appeals must be in writing. You, your representative or any provider to whom you have assigned your benefits can make the appeal. It must set out the reasons for the appeal and include any evidence or documentation, which supports your position. Upon written request, you may review pertinent documents that

pertain to your claim and denial and request a formal hearing before the Board of Trustees, which may be granted at the Board of Trustees' discretion. If the Board of Trustees exercise that discretion and grant such a hearing, they shall fix a date, time, and place for the hearing and advise you prior to the date of the hearing, by first class U.S. mail, of the time and place and date of such hearing. If a hearing is granted, it may be before the Board of Trustees, a committee of the Board of Trustees, or a hearing officer appointed by the Board of Trustees. You will also be advised of your right to be present; to present witnesses on your behalf and to proceedings of such formal hearing may be stenographically recorded, at the discretion of the Trustees.

If the appeal relates to an urgent claim, the Board of Trustees will notify you of its decision within 72 hours from receipt of the appeal. If the appeal relates to a pre-service claim, the Board of Trustees will notify you of the decision within 30 days of receipt of the appeal.

If the appeal relates to a post-service claim, the Board of Trustees decides on such claims at the next scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received in the Trust Fund Office within 30 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a consideration on review of your claim has been reached, you will be notified by the Trust Fund Office of the decision as soon as possible, but no later than five (5) days after the decision has been reached.

If the appeal relates to a concurrent claim, the Board of Trustees will notify you of its determination prior to termination of the benefit. For other claims involving death or accidental death and dismemberment benefits, they will be made in the same manner as for post-service claims.

Your failure to file an appeal within the periods stated above will be deemed a waiver of your right to appeal the denial of your claim.

In connection with an appeal of an adverse benefit determination, you may submit written comments, documents, records and other information for consideration by the Board of Trustees, whether or not such information was submitted or considered in the initial benefit determination.

Upon your request, you will have, free of charge, reasonable access to copies of all documents, records and other information relevant to the claimant's claims for benefits.

The Board of Trustees will promptly review your claim and appeal. The Board of Trustees will advise you of its decision in writing, giving specific reasons for the decision with specific reference to pertinent plan provisions on which the decision is based and informing you of your right to file suit under ERISA after having first exhausted the Plan's claims and appeals procedure. This written decision will be sent to you no later than five (5) days after the Board of Trustees decides the appeal, unless special circumstances require an extension of time for processing the appeal, any additional information is required or an investigation of the facts is necessary.

The Board of Trustees has the discretionary authority and power to make factual findings, to fix omissions, to resolve plan ambiguities, to construe the terms of the Plan, to make benefit eligibility determinations, and to resolve other disputes under the Plan. The decisions of the Board of Trustees shall be final and binding upon all parties hereto.

If you are an HMO member and have a dispute or complaint involving that HMO, the HMO's procedures for claims and appeals apply.

Coordination of Benefits

You and your Dependents are obligated under this Plan to notify the Trust Fund Office of the existence of any and all additional group coverage you, your Spouse or other Dependents may have which provides benefits similar to benefits provided by the Plan.

Under the terms of the Plan, you are not entitled to be paid more than 100 percent of your covered expenses from this Plan and any other plan combined. Payments from other sources to you or your Dependents may affect payments from this Fund. The Trust Fund Office will work with you or your Dependent's other health coverage to make sure you receive all of the benefits to which you are entitled.

When coverage is being provided to any person by two health plans, one plan is primary and other is secondary. The primary plan will pay benefits first and without consideration of the other plan(s). The secondary plan then makes up the difference up to the total allowable expenses. Medical, dental and vision plans providing benefits or service that will be coordinated with this Plan include any:

- Group, blanket or franchise insurance plan, whether insured or uninsured;
- Hospital or medical service plan or any group practice pre-payment plan;
- Union welfare or joint labor-management welfare plan;
- Coverage sponsored by, or provided through, a school or other educational institution;
- Plan which considers itself to be "excess";
- Government insurance plan or coverage required by law subject to the provisions of a Qualified Medical Child Support Order (medical assistance under a state plan or medical assistance approved under title XIX of the Social Security Act will not be taken into account); and
- Automobile coverage covering a Participant, including but not limited to, personal injury protection, or no-fault coverage.

When a plan is covering a person as an employee and the person is also covered in another plan as a Dependent, the plan providing Dependent coverage will be the secondary plan. If a Dependent child (whose parents are married) is covered under both parents' plans the plan of the parent whose date of birth (without regard to year of birth) occurs earlier in the calendar year will be the primary plan, and the plan of the other parent will be secondary. This is called the birthday rule.

When the parents are unmarried (whether by reason of divorce or otherwise) or legally separated, the order is:

1. The plan of the parent with sole legal custody is primary; and
2. The plan of the parent without custody is secondary.

When both parents, and neither parent, have legal custody, then the birthday rule shall apply. If the parent with custody of a child has remarried, the order of priority is:

1. The plan of the parent with custody;
2. The plan of the step-parent; and

3. The plan of the Parent without custody.

If there is a court decree, which states that one of the parents is responsible for the child's health care expenses, the plan of that parent will be primary. Refer to the section of this booklet entitled, "Qualified Medical Child Support Orders (QMCSOs)" for more information.

If a person is covered under more than one plan and the rules presented in this booklet do not resolve the order of priority, then the plan covering the person for the longer period will be primary. The exceptions to this rule are:

- A group plan that covers a person other than as a laid-off or retired employee, or Dependent of such person, will be primary;
- A group plan that covers a person as a laid-off or retired employee, or Dependent of such person will be secondary;
- A plan that contains no coordination of benefits rule is always primary; and
- A governmental plan is always primary, unless otherwise required by statute.

You have the responsibility to fully inform the Plan of any and all other health insurance coverage available to you and your eligible Dependents. You must fully disclose this information on the individual enrollment form that is filled out at the time you attain eligibility. You are also obligated to inform the Plan, at any time, that the information regarding other health insurance coverage changes.

For purpose of coordination of benefits, this Plan may:

- Release to or obtain from any insurance company or other organization or person any information and may require information to be furnished by any person claiming benefits under the terms of the Plan;
- Have the right to pay any organization any amount determined to be warranted, if payment should have been made by the Plan, but has been made by an other insurance company or organization; and
- Have the right, if overpayment is made, to recover such payment from any person or any insurance company or organization.

Claiming Filing Period

To avoid delay, do not initially submit your claims to both carriers at the same time. Submit claims to primary carrier and then to the secondary carrier after the primary carrier has acted on the claim. For example, if you and your Spouse are both covered through your respective employers, your Spouse must first submit his or her claims to that carrier. Once it has considered or paid any available benefit, you should then submit a copy of its determination along with a copy of the original billing to the Trust Fund Office. Claims should be submitted to the Trust Fund Office within 90 days of the date of service. Remember, under this Plan, you have a maximum of one year from the date of service to file claims with the Trust Fund Office or they will be denied.

SECTION 22. THIRD PARTY LIABILITY – EQUITABLE LIEN AND SUBROGATION RIGHTS

(Cases Involving A Third Party)

This Plan has reimbursement and subrogation rules that apply when you are injured or become ill and someone else is potentially responsible for your illness or injury. You must inform the Trust Fund Office if you are injured or become ill and a third party is potentially liable to you for the illness or injury.

In case of an accident, injury, sickness or condition (hereafter referred to as "Accident"), you or your dependent, must complete:

1. A questionnaire about it; and
2. The Acknowledgement of Equitable Lien and Subrogation Agreement ("Agreement"), which allows the Trust to recover the benefits it has or will pay relating to the Accident. The Agreement provides that you recognize the Trust's equitable lien or any money you recover (whether by settlement or judgment or otherwise) from a third party or from any other source because of that Accident. The Agreement also provides that you separately recognize the Trust's right of subrogation with respect to any legal right you or your dependents have against such third party, again in the amount of the benefits paid to you by the Trust. If any dependents were so injured or became ill because of the accident, each of them must also sign the Agreement. A parent or guardian may sign for a minor dependent.

Completion of the Agreement is a condition of eligibility for benefits under the Trust for you and your Dependents. Failure to do so or breach of such Agreement will be grounds for denying benefits or recovery under the Trust whether or not those benefits relate to an Accident involving a third party. You and your dependent are under a continuing obligation to advise the Trust and to have your attorney advise the Trust of the status of your claim against the third party or any related claim from time to time, upon the request of the of the Trust for such information.

The Trust has an equitable lien on any money from damages collected by you or your dependents, from that third party or from any recovery from any source up to the amount paid to you or your dependents, in benefits by the Trust because of the Accident. For example, if you or your dependent receive a third party recovery because of injuries from an auto accident, the Trust is entitled to a first right to reimbursement from full and partial recoveries even if you or your dependent are not made whole or do not receive the full damages claimed. That means that you or your dependent must reimburse the Trust 100 percent of the amount of the benefits the Trust paid on your behalf even if you or your dependent receive few or no monies out of any recovery from any source paid or payable to you.

The Trust shall also have the right of subrogation, that is to proceed in your name or that of your dependent, with or without you or your dependent's consent, in order to secure the right of first lien or reimbursement out of any recovery from any source which pays or may pay you or your dependent.

No attorney fees or costs may be deducted from the Trust's recovery without written consent of the Trust.

This provision shall not be interpreted as requiring the Plan to make payments of benefits contrary to any other provision of the Plan, which excludes payments of benefits.

Workers' Compensation Claim Rules

Additional rules apply to the procedures for subrogation of Workers' Compensation claims. Please review this section entitled, "Workers' Compensation Claim Rules." These special provisions apply only to Employees. No benefit payments will be made for Workers' Compensation claims submitted on behalf of your Spouse or Dependent Child.

Your Plan has been designated to provide coverage for you and your eligible Dependents for illness or injuries that are not work-related.

In today's world of rising medical costs, you must be extremely careful not to submit work-related claims for payment by the Plan. You also have to be careful not to use your prescription card to obtain medications for a work-related injury or illness.

By law, your Employer is required to provide you with medical coverage for all work-related illnesses or injuries. If your Spouse or your Dependent children are working full-time or part-time, the same regulations apply to their employer.

The Board of Trustees recognizes, however, that the appeal process, after the initial denial of a Workers' Compensation claim by your Employer's insurance carrier, may take a long time. Consequently, the Trustees have adopted provisions with respect to work-related injuries and illnesses so that you can, in appropriate cases, get some interim financial relief from the Plan while you go through the Workers' Compensation appeal process.

In accordance with these provisions, you must comply with the following procedures in order to obtain interim financial relief from the Plan for work-related injuries or illnesses:

1. If you suffer a work-related injury or illness, you must file a claim with your Employer's Workers' Compensation insurance carrier.
2. If your Employer's Workers' Compensation insurance carrier denies your claim for benefits, you must appeal this decision to the appropriate administrative authority.
3. You may file a claim for benefits under the Plan Fund after you appeal to the appropriate Workers' Compensation authority.
4. The Trustees will consider paying you benefits, according to the terms of the Plan, provided that you complete an Equitable Lien and Subrogation Agreement, assigning to the Plan any benefits you receive as a result of your Workers' Compensation appeal.
5. You and the attorney, if any, who represents you in your Workers' Compensation appeal, must complete the Equitable Lien and Subrogation Agreement.
6. The attorney must also confirm in writing that you are appealing the Workers' Compensation decision and provide the name of the jurisdiction in which the appeal has been filed and include the Workers' Compensation Appeals Board Case Number.
7. Your claim for benefits will be considered only after you and your attorney sign the Equitable Lien and Subrogation Agreement and provide the necessary information.
8. When the Workers' Compensation appeal authority makes its decision, you must forward a copy of this decision to the Trust Fund Office. If the decision is in your favor and grants you Workers' Compensation benefits, you must reimburse the Plan all benefits paid on account of the work-related injury or illness in accordance with the terms of the Equitable Lien and Subrogation Agreement that you and your attorney signed.

If the Workers' Compensation appeal authority's decision is not in your favor you still have the right to appeal the decision to the appropriate court in the jurisdiction involved. If you do so, the Equitable

Lien and Subrogation Agreement you and your lawyer signed will remain in effect and will continue to be binding.

If you do not appeal the decision, the Plan will recognize the claim you filed as a legitimate, non-work-related claim and will not require you or your attorney to reimburse the Plan for benefits that were paid on your behalf.

Misrepresentation And Fraud

In the event you or any Dependent receives benefits because of any misleading or fraudulent representations to the Plan, you will be liable to repay all amounts paid by the Fund.

Fraud includes failure to disclose any information regarding other group health coverage under the Plan's coordination-of-benefits provisions or failure to disclose information regarding no-fault automobile coverage, Workers' Compensation or third-party liability under the Fund's Equitable Lien and Subrogation provisions.

Furthermore, the Board of Trustees must ensure that all who benefit from the Plan do so appropriately and only as they are entitled. For example, if the Trustees determine that an Employee, his dependents, or health care provider has made any misrepresentation (whether or not intentional) in connection with claims for benefits or has committed any act or omission resulting in abuse or misuse of the Plan, the Board of Trustees reserves the right and authority to impose upon Employees and their Dependents restrictions with respect to their future rights to receive benefits from the Trust. The Trustees reserve the right to seek reimbursement and other damages, together with attorney's fees (to the extent provided by law) and other costs incurred in connection with recovering any benefits incorrectly paid, or not reimbursed, when reimbursement is required under the Plan. To be reimbursed for benefits improperly paid, the Trustees may also exercise a right of offset against future benefits payable on behalf of the Employee and his Dependents.

In addition to the specific circumstances set forth elsewhere in this document in which the Trustees may suspend the payment of benefits to a participant or a beneficiary, the Trustees shall also have the general power to withhold and offset such benefits for claims incurred on behalf of the any participant or beneficiary who:

1. owes money to the Trust because of any obligations imposed upon them by this Plan booklet or the rules and regulations of the Trust, or
2. owes money to the Trust because the Trust overpaid a participant or beneficiary, or
3. in any other circumstances in which a participant or beneficiary legally owes money to the Trust.

The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees deem necessary.

SECTION 23. LIMITATIONS AND EXCLUSIONS

All procedures and services not specifically listed in the Schedule of Coverage sections are to be considered as excluded under the Plan unless provided in accordance with accepted medical, dental and prescription drug treatment procedures and protocols.

The following Limitations and Exclusions are examples of the types of procedures and services that are limited or not covered by the Plan, but in no way constitute the only procedures/services that are subject to Limitations and Exclusions. In additional to any other limitations or specific exclusions described in this Summary Plan Description, there are Limitations and Exclusions that apply to all benefits.

List Of Limitations And Exclusions

No payments will be made for expenses incurred,
(except as required for Covered Preventive Services) for the:

1. Services, supplies or treatments which are not Medically Necessary, as defined in the Definitions section starting from page 70;
2. Services which were not recommended and approved by a Physician, or for which there is no legal obligation to pay, or for which no charge would be made in the absence of coverage under this Plan;
3. Charges which are not received by the Trust Fund Office, along with all required supporting information necessary to process the claim, within one year from the date services were provided;
4. Expense for any care provided by you, your Spouse, a child, brother, sister, your parent or your Spouse's parent or a person who normally lives with the Employee or Dependent;
5. Any Injury or Illness that is work-related or that is covered by Workers' Compensation Law or similar law;
6. Expenses for military service-related care in a veterans' facility or a Hospital operated by the United States, unless required by law;
7. Services for which there is no legally enforceable charge;
8. Services or supplies received as a result of an act of war (declared or undeclared) occurring while covered;
9. Charges incurred outside the United States, except for initial emergency treatment required before the condition permits transfer of the patient to treatment by providers within the United States;
10. Services beyond the scope of the license of the person performing them;
11. Fees for any Hospital, medical or surgical services that would otherwise be covered under the Plan, but that exceed the annual dollar limits or annual visit limits of this Plan;
12. Charges for Experimental or Investigational procedures, services and drugs as defined herein;
13. Expenses for the administration of local infiltration anesthesia or anesthetics by a physician performing or assisting in performing a surgical operation or procedure, or expenses for when the physician or anesthetist administering the anesthetics does not remain in constant attendance during the operation or procedure for the sole purpose of rendering the anesthetic service;
14. Infertility treatment or procedures;
15. Artificial insemination, in-vitro fertilization, or like procedures, and any services associated with such procedures;
16. Sterilization reversal;
17. Prenatal sex testing;

18. Expenses related to transsexual surgery, counseling (before and after surgery) or like services or treatment; cosmetic surgery unless required because of:
    a. Accidental bodily injury, provided that the surgery takes place within one year of the accident;
    b. Reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved part; or
    c. Reconstructive surgery, when required due to a congenital disease or anomaly has resulted in a functional defect;
19. Medical treatment of obesity (except morbid obesity);
20. Specialized medical weight reduction programs, diuretics and medications;
21. Membership in, or fees, dues or charges incurred with regard to recreational facilities, fitness centers, diet or nutritional centers, even though prescribed or recommended by a physician;
22. Lamaze classes;
23. Smoking cessation programs or products;
24. Services or supplies of common household use, including, but not limited to exercise equipment, air conditioners, air purifiers, water purifiers, allergenic mattresses, blood pressure kits, water beds, swimming pools, hot tubs, and any other clothing or equipment that could be used in the absence of an illness or injury, whether or not any such item is prescribed by any medical care provider;
25. Marriage counseling and services provided by a Marriage, Family, and Child Counselor;
26. Over-the-counter, non-legend or patent medicines, self-administered injectables, nutritional supplements, vitamins and appetite suppressants;
27. Routine physical examinations unrelated to either an illness or an injury, unless specifically included in the plan of benefits;
28. Chiropractic and physical therapy, occupational therapy and speech therapy services in excess of the maximum allowed visits within any calendar year, and fees that are in excess of the Plan's usual, customary, and reasonable charge limitations;
29. Any services or supplies for or in connection with acupuncture, unless administered by a medical doctor (MD);
30. Operation on or treatment of the teeth or gums other than as specifically described and limited elsewhere in this booklet;
31. Examinations to determine the need for or proper adjustment of glasses or a hearing aid, except as otherwise provided by the Plan;
32. Treatment, services, prosthetics or orthotic appliances which are not Medically Necessary or appropriate;
33. Routine foot care, except as specifically covered by the Plan;
34. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations) corns, calluses or toenails (except the removal of nail roots and necessary services in the treatment of metabolic or peripheral vascular disease);
35. Blood and blood plasma that is replaced by or for the patient;
36. Retirees and Dependents and Dependent children of active Employees are not covered for any services or treatments for the diagnosis or acute care, detoxification or rehabilitation and treatment of alcoholism and/or substance abuse;
37. Retirees and Dependents of Retirees, who are enrolled in Special Retiree Plans I and II, are not covered for services provided by an Extended Care or Skilled Nursing Facility Home Health Care services, Hospice Care, Mental Health Services, Directed Second Surgical Opinion and Durable Medical Equipment;
38. All services for treatment for developmental, learning, or perceptual disorders regardless of the type of treatment or the provider except to the extent medically required to restore speech that has been lost by reason of catastrophic illness or injury;
39. Medical expenses incurred for willfully self-inflicted injuries, unless such injury or disease results from a physical medical condition or a mental health condition;

40. Treatment of injuries resulting from assault, battery, or other misconduct for which civil action can be brought, unless it is shown to the satisfaction of the Plan that the claimant was neither the aggressor nor the instigator (However, benefits are payable for treatment of bodily injuries incurred during occurrences of misconduct where the covered person was a victim of domestic violence or where the occurrences of misconduct were committed as a result of a physical or mental condition.);
41. Meals, meal preparation, personal comfort or convenience items, housekeeping services, custodial care, and protective or companion services;
42. Charges incurred for handling fees, unless directly related to test results;
43. Charges for record keeping or completion of claim forms;
44. Charges for the copying of X-rays, charts or records;
45. Expenses incurred as a result of failure to keep a scheduled appointment;
46. Interest or other penalties;
47. Travel, except as specifically covered by this Plan;
48. Services or supplies for any injury or illness by a provider, who is not recognized by the Plan as an eligible provider;
49. The Board of Trustees reserves the right to determine that a provider is an ineligible provider and that no Plan benefits shall be payable for services or supplies provided by that provider on the basis that such provider has performed unnecessary services, billed in an inappropriate manner, or has engaged in any questionable, unethical or fraudulent billing practices as determined in the sole and absolute discretion of the Board of Trustees. The Board of Trustees also reserve the right to decide whether or not to accept or recognize any assignment of benefits from a participant or a beneficiary; and
50. Medical services, tests or supplies performed by any provider who solicits payments at public events and/or by advertising that it will accept whatever payments are made by the patients' insurance company or other organization which provides payments for health care, except that this exclusion shall not apply to a facility which has been approved by the Board of Trustees or is a Plan PPO Hospital.

SECTION 24. DEFINITIONS

These definitions are being provided to help you understand what the terms mean and how they are applied in the administration of your Plan.

The listed words, phrases, and acronyms have the following meaning:

Accidental Injury is physical harm or disability, which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Active Employee means one who is actively-at-work in the industry and for whom contributions are being paid into the Fund (other than Retiree co-payments) and who is not a Retiree.

Allowable Charge means the dollar amount determined by the Plan to be payable for a covered expense in any specific area. This amount is determined based on the dollar amount negotiated on behalf of the Plan by the Trustees or their agents or representatives and PPO/EPO providers as being an acceptable level of reimbursement less deductibles, co-insurance, and co-payment provisions. For non-PPO/EPO providers, the Plan will consider the allowable charge to be the amount it would have paid to a PPO/EPO provider for the same or similar services in the same county. For services rendered because of an emergency illness or accident or for services rendered more than 30 miles from the nearest PPO/EPO Hospital, the allowable charge shall be the usual, customary and reasonable amount for that service as determined by the Board of Trustees from time to time.

These scheduled amounts are not intended to dictate what a covered provider's charge will or should be, but are the maximum amounts the Plan allows. In no event will the total amount allowed be greater than the amount actually charged.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association for Ambulatory Health Care.

Where the licensure of such a facility is mandated by law, it has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Where the law does not mandate licensure of such facility, it meets all of the following requirements:

- It is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing surgical procedures;

- It is operated under the supervision of a licensed doctor of medicine (md) or doctor of osteopathy (do) who is devoting full time to such supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one hospital within the county in which the ambulatory surgical center is located;

- It requires, in all cases other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics and remain present through the surgical procedure;

- It provides at least two operating rooms and at least one post-anesthesia recovery room, is equipped to perform diagnostic x-ray and laboratory examinations and is available to handle foreseeable emergencies trained personnel and necessary equipment including, but not limited to, a defibrillator, a tracheotomy set and a blood bank or other blood supply;

- It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room;

- It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications or require post-operative stay;

- It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a pre-operative examination report, medical history and laboratory test and/or x-rays and operative report and discharge summary.

Approved Convalescent Facility means an institution (or distinct part of a Hospital or other institution) which meets all the standards for and has been certified to be an accredited extended care facility (not an intermediate care facility, domiciliary facility, or mental facility), by the Joint Commission on Accreditation of Hospitals or which has been approved by the Secretary of the United States Department of Health and Human Services for participation as an extended care facility under Title XVIII of the Federal Social Security Act.

In no event shall an approved convalescent facility include any institution or part thereof if that institution or part is used principally as a rest facility, a facility for the aged, a facility for the care of drug addiction or alcoholism, a facility for the care of pulmonary tuberculosis, a facility for the care of mental illness, a facility for the care of a mental disability or a facility for custodial care.

Authorized Referral occurs when you, because of your medical needs, are referred to a non-participating provider, but only when:

- There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 25-mile radius of your residence; or
- You are referred in writing to the non-participating provider by the physician who is a participating provider; and
- The referral has been authorized before services are rendered.

Average Wholesale Price is a term accepted in the pharmaceutical industry as a benchmark for pricing by pharmaceutical manufacturers.

Beneficiary is a person designated by a Participant or by the terms of this Plan, who is or may become entitled to a benefit.

Birthing Center means a licensed facility (not part of or directly connected to a Hospital) set up, equipped and operated solely as a setting for prenatal care, delivery and immediate postpartum care for patients with low-risk pregnancies. The facility must be directed by an M.D. or D.O. and

provide skilled nursing care under the direction of an R.N. in the delivery and recovery rooms. The center must have written agreement with a Hospital for immediate transfer in case of emergency.

Brand-Name Prescription Drug (brand-name drug) is a prescription drug that has been patented and is only produced by one manufacturer.

COBRA is the Consolidated Omnibus Reconciliation Act of 1985, which governs continuation of coverage.

Collective Bargaining Agreement means the labor agreements between Local Unions of the Laborers International Union of North America and participating Employers, or a Participation agreement that provides for the payment of contributions to the Fund.

Continuous Period of Disability. All stays in a Hospital or approved facility will be considered as having occurred during the same continuous period of disability:

- Unless evidence acceptable to the Trustees or Claims Administrator of the Plan is furnished that the Employee or Dependent concerned has not been confined in a Hospital or approved convalescent facility for a consecutive period of at least 90 calendar days, or
- Unless the later stay is due to causes entirely unrelated to the causes of the previous stay; or
- Unless separated by complete recovery; or
- As to the Employee, the Employee shall have returned to active work for at least one full day or shall have been physically able, available, and registered for active work for at least one full day.

Contracted rate is the amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Anthem Prudent Buyer Plan Participating Provider Agreements.

Cosmetic Surgery is defined as a procedure that is not medically necessary whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Includes but is not limited to ear piercing, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures such as mammoplasty, liposuction, keloid, rhinoplasty and surgery.

Cosmetic Surgery also includes non-medically necessary treatment relating to the consequences or because of Cosmetic Surgery. It does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly that has resulted in a functional defect.

Covered Employment means work for which an Employer is required to make contributions to the Fund under the terms of a Collective Bargaining Agreement or a Participation Agreement.

Covered Medical Expenses are the charges which are considered eligible for benefit payment according to the Plan and which are determined by the Plan to be reimbursable as medically necessary treatment of a non-work-related injury, illness or disease. To be covered expenses, such charges must be for treatment in the United States of America or for initial emergency treatment outside the United States.

Covered Preventive Services under our Plan are those services identified by the United States Preventive Services Task Force and which are required to be provided by non-grandfathered plans.

Custodial Care is defined as all services and supplies, including room and board, which is provided primarily to assist an eligible person in the activities of daily living and which do not require the continuous attention of trained medical or paramedical personnel. Custodial Care includes the preparation of special diets, supervision over medication that can be self-administered, assistance in getting in or out of bed, walking, bathing, dressing, and eating. Services and supplies may be deemed to be for Custodial Care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed.

Day Treatment Center is an outpatient psychiatric facility, which is licensed according to state and local laws to provide outpatient programs and treatment of mental or nervous disorders, severe mental disorders, or substance abuse under the supervision of physicians.

Deductible (also Annual Deductible) means the out-of-pocket expense that you must pay each year before a benefit is payable under the terms of the Plan.

Dentist means a person who is duly licensed to practice dentistry.

Drug Limited Fee Schedule represents the maximum amounts that the Plan will allow as prescription drug covered expense for prescriptions filled at non-participating pharmacies. These amounts are the lesser of billed charges or the average wholesale price.

Durable Medical Equipment is defined as equipment that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or injury;
- Suited for use while not confined as an inpatient;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation, sudden and unexpected severe pain), which the person reasonably perceives could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with the Board of Trustees.

Employee means a Person who is employed by an Employer and is covered by a Collective Bargaining Agreement between that Employer and a Local Union of the Laborers International Union of North America, in which such agreement requires employer contributions to be paid to provide for the benefits herein for such Employees.

Employer means an Employer whose Employees are covered by a Collective Bargaining Agreement between a Local Union of the Laborers International Union of North America, which agreements provide for the benefits herein for such Employees.

Employment and **Covered Employment** means employment of an Employee by an Employer.

ERISA means the Employee Retirement Income Security Act of 1974, as amended, which governs this Plan.

Experimental or **Investigational** is defined as any drug, device, procedure or treatment that is not of proven benefit for the particular diagnosis or treatment of the covered person's condition, or not generally recognized by the medical literature as effective or appropriate for the diagnosis or treatment of the covered person's particular condition.

Any or all of the following criteria may be applied in determining whether a technology is experimental, investigational, obsolete or ineffective:

- Medical devices, drugs, or biological products must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition;
- Provided that FDA approval has been granted for particular diagnosis or condition;
- Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes;
- Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, that is, the beneficial effects outweigh any harmful effects;
- Proof, as reflected in the published peer-reviewed medical literature, must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; or
- Proof, as reflected in the published peer-reviewed medical literature, must exist that improvement in health outcomes is possible in standard conditions of medical practice, outside clinical investigative settings.

Facility-Based Care is care provided in a Hospital, psychiatric health facility, residential treatment center or day treatment center for the treatment of mental or nervous disorders, severe mental disorders, or substance abuse.

FMLA means the Family Medical Leave Act of 1993.

Generic Prescription Drug (generic drug) is a pharmaceutical equivalent of one or more brand-name drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the brand-name drug.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Health Maintenance Organization (HMO) is a pre-paid benefit plan that the Trust has contracted with to provide benefits to eligible plan participants in lieu of the benefits provided through the PPO Plan or the EPO Plan, except for Group Life and Accidental Death and Dismemberment benefits.

Home Infusion Therapy Provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Home Health Agencies are home health care providers, which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Hospice is a licensed public or private health care organization primarily engaged in providing a coordinated program of home and inpatient care for a terminally ill individual, and which provides a coordinated set of services on a 24-hour basis as follows:

- Nursing care by or under the supervision of a registered nurse;
- Physical or occupational therapy or speech language pathology services;
- Medical social services under the direction of a physician;
- Home health care by a trained aide;
- Medical supplies, including drugs and biologicals and the use of medical appliances;
- Physician services;
- Short-term inpatient care for acute pain control, symptom management, or to provide respite periods for family members. Such respite care should only be provided on an intermittent, non-routine and occasional basis for a period of not longer than five (5) consecutive days; and
- Counseling, including dietary, with respect to care and adjustment to the patient's death.

Benefits are provided to terminally ill patients no longer receiving curative treatment, whose life expectancy is six (6) months or less, as certified by their attending Physician.

A hospice must be currently licensed as a hospice pursuant to section 1747 of the California Health and Safety Code or a licensed home health agency with federal Medicare certification pursuant to sections 1726 and 1747.1 of the same California code. A list of hospices meeting these criteria is available upon request.

Hospital is defined as an institution that:

- Is duly licensed as a Hospital (if licensing is required in the state);

- Operates primarily for the diagnosis, treatment and rehabilitation of sick, injured or disabled persons as in-patients;

- Provides 24-hour nursing services by registered or graduate nurses on duty or call; has a staff of one or more licensed physicians available at all times;

- Provides organized facilities for diagnosis and surgery either on its premises or at an institution with which the establishment has a formal arrangement for the provision of such facilities;

- Is not primarily a clinic, nursing, rest or convalescent home, an extended care facility, or a similar establishment and is not (other than incidentally) a place for treatment of alcoholism or drug addiction; and has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

Stay in a special unit of a Hospital used primarily as a nursing, rest or convalescent home or skilled nursing facility or residential treatment facility is deemed to be stay in an institution other than a Hospital.

Illness means a sickness, disease or disorder resulting in an unsound condition of the mind or body, including but not limited to pregnancy, childbirth and related conditions.

Infertility is: (1) the presence of a condition recognized by a physician as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Injury means a wound or damage sustained accidentally and or by external force.

Maintenance Drugs are those that are prescribed for an extended period of time and are necessary to maintain good health. Examples are drugs used to treat high blood pressure, diabetes and arthritis.

Medical Emergency is defined as the need for services to treat a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the afflicted person in serious jeopardy;
- In the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to the person's bodily functions;
- Serious dysfunctions of any bodily organ or part of such person; and
- Serious disfigurement.

Medically Necessary procedures, supplies equipment or services are those the Plan determines to be:

- Appropriate and necessary for the diagnosis or treatment of the medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;
- Within standards of good medical practice within the organized medical community;
- Not primarily for your convenience, or for the convenience of your physician or another provider; and
- The most appropriate procedure, supply, equipment or service which can safely be provided.

The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

- There must be valid scientific evidence demonstrating that the expected health benefits from the procedure a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives;
- Generally accepted forms of treatment that are less invasive or less costly have been tried and found to be ineffective or are otherwise unsuitable; and
- For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and you as an outpatient or in a less intensified medical setting cannot receive safe and adequate care.

Medicare means any health insurance benefits provided under Title XVIII of the Social Security Act of 1965, as amended, 42 U.S.C. § 1395 et seq.

Mental or **Nervous** or **Behavioral Disorder** is a condition, which manifests signs and/or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause. Mental or behavioral disorders and conditions include, but are not limited to, psychosis, effective disorders, anxiety disorders, personality disorders, obsessive-compulsive disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neuro hormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition, and not including alcoholism or drug addiction.

Non-Participating Provider is a provider, which does NOT have an Anthem Prudent Buyer Plan Participating Provider Agreement in effect with Anthem at the time services are rendered, and includes but is not limited to the following types of providers:

A hospital;
A physician;
An ambulatory surgical center;
A home health agency;
A facility, which provides diagnostic imaging services;
A durable medical equipment outlet;
A skilled nursing facility;
A clinical laboratory; or
A home infusion therapy provider.

Remember that only a portion of the amount, which a non-participating provider charges for services may be treated as covered expense under this plan.

Nurse-Midwife means a registered nurse who has gained the special knowledge and skills of child delivery in an educational program accredited by the American College of Nurse-Midwives and who is licensed in the state by the Board of Registered Nursing as Nurse-Midwife.

Office Visit means the consultation and evaluation service provided by a Physician and includes injections and immunizations, but shall not include any other services or procedures, which may be performed in conjunction with an office visit.

Participant is the active Laborer for whom contributions have been or are required to be made to this Plan and their eligible Dependents; Retirees who meet eligibility requirements, Spouses (who are not eligible for Medicare because they are under age 65) of Retirees who are not eligible under this Plan because they are age 65 or eligible for Medicare, but otherwise meet Retiree eligibility requirements; and, with the consent of the Trustees, employees of Local Unions and non-represented Employees of contributing Employers who participate under non-jobsite rules.

Participating Pharmacy is a pharmacy, which has a Participating Pharmacy Agreement in effect with OptumRx at the time services are rendered. Call your local pharmacy to determine whether it is a participating pharmacy or call the toll-free customer service telephone number 1-800-797-9791.

Participating Provider is a provider that has an Anthem Blue Cross Prudent Buyer Plan Participating Provider Agreement Plan with Anthem at the time services by reason of medical

or dental, vision care or prescriptions are rendered, or treatment, which benefits or services are provided by the following types of providers, which include but are not limited to:

- A hospital;
- A physician;
- An ambulatory surgical center;
- A home health agency;
- A facility, which provides diagnostic imaging services;
- A durable medical equipment outlet;
- A skilled nursing facility;
- A clinical laboratory or
- A home infusion therapy provides participating providers agree to accept the negotiated rate as payment for covered services. A directory of participating providers is available upon request.
- Participation Agreement means an agreement between the Fund and an Employer that provides for the payment of contributions to the Fund.

Physician means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided and renders a service within the scope of that license, including one of the following types of providers:

- A dentist (D.D.S.)
- An optometrist (O.D.)
- A dispensing optician
- A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
- A licensed clinical psychologist
- A chiropractor (D.C.)
- An acupuncturist (A.C.)
- A clinical social worker (L.C.S.W.)
- A physical therapist (P.T. OR R.P.T.)
- A speech pathologist *
- An audiologist*
- An occupational therapist (O.T.R.)*
- A physician's assistant
- A psychiatric mental health nurse (R.N.)*
- A nurse midwife**
- A registered dietitian (R.D.)* for the provision of diabetic medical nutritional therapy only and received by a person, group or entity for service.

* **Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in above.

** If there is no nurse midwife who is a participating provider in your area, you may call the Customer Service number on your ID card for a referral to an OB/GYN.

Preferred Provider Organization (PPO) means a group of select physicians, specialists, Hospitals, and other treatment centers that have agreed to provide their services to Fund Participants and Beneficiaries at a negotiated rate under the terms of an agreement. These medical providers are sometimes referred to as Network Providers or Panel Providers interchangeable throughout this booklet.

Prescription Drug or **legend drug** means a prescribed drug approved by the State of California Department of Health or the Food and Drug Administration for general use by the public. For the

purposes of this plan, insulin will be considered a prescription drug. A prescription drug or legend drug bears the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription."

Prosthetic Devices are appliances, which replace all, or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices that restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric Health Facility is an acute care 24-hour facility as defined in California Health and Safety Code 1250.2.

It must be:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to state law;
3. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
4. Staffed by an organized medical or professional staff, which includes a physician as medical director.

Psychiatric Mental Health Nurse is a registered nurse (R.N.) who has a master's degree in a psychiatric mental health nursing and is registered as a psychiatric mental health nurse with the state board of registered nurses.

Reasonable and Customary (R&C) and Usual, Customary and Reasonable (UCR) means the fee regularly charged for treatments or supplies covered under the Plan to the extent such fee does not exceed the general level of charges by others who render or furnish such services, treatments or supplies in the locality where the charge is incurred, for illness or injury comparable in nature and severity. The term "locality" means a county or such greater geographically significant area as is necessary to establish a representative cross section of providers regularly furnishing the type of treatment, services or supplies for which the charge was made.

A charge is Usual if it is the charge made by the health care provider to most private patients for the particular service.

A charge is Customary if it is within the normal range of charges made by most health care providers of similar training and experience for the same service in the geographical area involved.

A charge is Reasonable if it meets the above requirements or is justified in certain circumstances of a particular case and is within the amount of a provider's charge which could have been reasonably expected to have been paid by a person in the patient's income bracket.

If such health care provider's charge is in excess of that which would be payable under any insurance or benefit coverage or beyond a patient's personal ability to pay, this Plan then retains the right to limit its reimbursement to criteria in general usage in determining appropriate payment or to that which such provider has agreed to accept as payment in full, contractually or otherwise, from any other payment source providing the same or similar benefit coverage or insurance. The Plan determines UCR based on information acquired from third parties. If a UCR determination is contested, the Plan will consider additional information submitted to the Plan during the appeal process.

Registered Nurse means a registered graduate nurse (R.N.)

Residential Treatment Center is an inpatient or outpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental or nervous disorder, severe mental disorder, or substance abuse. The facility must be licensed to provide psychiatric treatment of mental or nervous disorders, severe mental disorders, or rehabilitative treatment of substance abuse according to state and local laws.

Retiree is a pensioner who is under the age of 65 years and not eligible for Medicare and who no longer is actively at work and who qualifies by reason of sufficient past qualified employment for coverage under this Plan and participation in the co-payment program, or a Retiree aged 65 or older or eligible for Medicare who makes a co-payment for prescription expense benefits or for medical and prescription benefits for a spouse who is still under age 65 and eligible for benefits under this Plan.

Second Surgical Opinion as used herein, is an opinion that may be obtained from another surgeon or doctor of internal medicine, or other specialist unassociated with the surgeon who first recommended surgery.

Skilled Nursing Facility is defined as the term defined by Medicare, which is qualified to participate and eligible to receive payment under Medicare, as an institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by the Board of Trustees to meet the reasonable standards applied by any of the aforesaid authorities. It is an institution, which meets all of the following tests:

- It is operated in accordance with the applicable laws of the jurisdiction in which it is located;
- It is under the supervision of a licensed physician, or registered graduate nurse (R.N.) who is devoting full time to such supervision;
- It is regularly engaged in providing room and board and continuously provides 24-hour-a-day skilled nursing care to sick and injured persons at the patient's expense during the convalescent state of an injury or sickness;
- it maintains a daily medical record of each patient who is under the care of a duly licensed physician;
- It is authorized to administer medication to patients on the order of a duly licensed physician; and
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or an institution for alcoholics or drug addicts or the mentally ill or is in whole or in part an institution to which a patent may be involuntarily committed by order of court.

Spouse means the lawful Spouse of the Active Employee or Retiree and whose marriage is legal in the State of California.

Total Disability and **Totally Disabled** means: 1) an employee other than a retired employee, who is prevented from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit; and 2) a retired employee or Dependent who is prevented solely because of non-work-related injury or non-work-related disease from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Trust Fund Office means the office of the Trust Fund Office of the Laborers Health and Welfare Trust for Southern California.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

Work-Related Injury or Disease means any illness or injury arising out of or during the course of employment.

You (or "Your") refer to the eligible participant and family members, who are enrolled for benefits under this Plan.

SECTION 25. REQUIRED INFORMATION BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

1. Name of Plan.

Laborers Health and Welfare Trust for Southern California.

2. Name and Address of Plan Sponsor.

The Board of Trustees of the Laborers Health and Welfare Trust for Southern California, c/o Associated Third Party Administrators (ATPA), 4399 Santa Anita Avenue, Suite 200, El Monte, California 91731.

A complete list of Employers and Employee organizations sponsoring the Plan may be obtained by Participants and Beneficiaries upon written request to the Trust Fund Office and is available for examination at the Trust Fund Office.

3. Fiscal Year.

The Fund's fiscal year begins on January 1 and ends on December 31.

4. Members of the Board of Trustees.

Union Trustees

Armando Esparza, Co-Chair
So. California District Council of Laborers
4399 Santa Anita Avenue, Suite 204
El Monte, CA 91731

Debra Baker
Local 802
540 N Marine Avenue
Wilmington, CA 90744

Val Macedo
Local 89
4161 Home Avenue, First Floor
San Diego, CA 92105

Manuel Monsibais
So. California District Council of Laborers
4399 Santa Anita Avenue, Suite 204
El Monte, CA 91731

Ed Padilla
Local 220
PO Box 301
Bakersfield, CA 93302

Sergio Rascon
Local 300
515 Shatto Place
Los Angeles, CA 90020

Peter Santillan
Local 507
3919 Paramount Boulevard
Lakewood, CA 90712-4116

John Smith
Local 1184
1128 E. La Cadena Drive
Riverside, CA 92507-8695

David Valenzuela
Local 585
21 S. Dos Caminos Avenue
Ventura, CA 93003

Employer Trustees

Robert Norling, Co-Chair
Associated General Contractors
1906 W. Garvey Avenue S., Suite 100
West Covina, CA 91790

Edward Ashton
E.R. Ashton Co.
13960 Cumpston Street
Sherman Oaks, CA 91401

Steve Blois
115 Valley Vista Drive
Camarillo, CA 93010

Gary Hand
BS Hand & Sons, Inc.
4450 Shopping Lane
Simi Valley, CA 93063

Walter Rados
Steve P. Rados, Inc.
PO Box 15128
Santa Ana, CA 92735

Roger M. Roddy
Southern California Contractors Association
6055 E Washington Boulevard, Suite 200
Los Angeles, CA 90040

Ian Rodriquez
High Light Electric, Inc.
PO Box 7339
Riverside, CA 92513

5. Employer Identification Number (EIN) of Plan Sponsor and Plan Number.

The Fund's employer identification number is 51-6146048 and its plan number is 501.

6. Type of Plan.

The Plan is a health and welfare plan, which provides hospital, medical, dental, optical, death benefits, accidental death and dismemberment benefits and prescription drug benefits.

7. Type of Administration.

The Plan is administered by a jointly trusteed, labor-management Board. The Plan is maintained pursuant to collective bargaining agreements and a jointly-trusteed labor-management trust. The collective bargaining agreements are available from the Trust Fund Office upon written request and are available for inspection at the Trust Fund Office. Third party contract administrative services are provided by ATPA, 4399 Santa Anita Avenue, Suite 200, El Monte, California 91731.

8. Source of Contributions to the Plan and the Funding Medium from Which Benefits are Provided.

Payments are made to the Trust Fund by individual Employers under the provisions of the collective bargaining and other agreements and by Retirees and surviving Spouses of Retirees under the co-payment program. All benefits are paid from the Fund or through the HMOs that you choose or your coverage.

A list of sponsoring employers who contribute to the Plan is available from the Trust Fund Office upon written request and is available for inspection at the Trust Fund Office.

Some medical, hospital and prescription drug benefits are provided through a contract with Kaiser Permanente. Some medical, hospital and prescription drug benefits are self-funded and paid both directly and through a contract with OptumRx. Some dental benefits are provided through a contract with Delta Dental, and some dental benefits are self-funded. Vision care benefits are self-funded and paid both directly and through a contract with Anthem Blue Cross of California.

Death benefits and Accidental Death and Dismemberment Benefits are paid under a contract with Aetna Life and Casualty.

The names, addresses and telephone numbers of the entities administering the benefits are on the following page.

Self-Funded PPO or EPO Medical Benefits	Associated Third Party Administrators 4399 Santa Anita Avenue, Suite 200 El Monte, CA 91731 626-279-3000
Health Maintenance Organization (HMO) Benefits	Kaiser Permanente 393 East Walnut Street Pasadena, CA 91107 1-800-464-4000 www.kp.org
Prescription Drug Benefits	OptumRx (formerly known as Prescription Solutions) 3515 Harbor Boulevard Costa Mesa, CA 1-800-797-9791 http://www.optumrx.com
Life Insurance/Accidental Death and Dismemberment Benefits	Aetna Life and Casualty 200 S Manchester Orange, CA 92668 714-648-3929
Vision Benefits	Blue Cross Life and Insurance Blue View Vision http://benefits.eyewearspecialoffers.com
Dental Benefits (DeltaCare USA)	Delta Dental PO Box 3370 Cerritos, CA 90703 http://www.deltadentalins.com 1-800-422-4234
Self-Funded PPO Dental Benefits	Associated Third Party Administrators 4399 Santa Anita Avenue, Suite 200 El Monte, CA 91731 626-279-3000 or 1-800-887-5679

Today's Date	Notes	Completed

Today's Date	Notes	Completed