We are pleased to provide you with this Summary Plan Description (SPD) which describes in detail the benefits available to you and your eligible dependents through the Connecticut Laborers' Health Fund as of August 1, 2005. The Booklet also describes the eligibility rules for obtaining these benefits and your right to continue your coverage if you exhaust your eligibility under the rules for active Participants.

Please insert this Booklet into your BENEFITS INFORMATION BINDER.

This Booklet also describes the conditions governing the payment of benefits and explains the procedures you must follow when filing a claim, as well as an appeal procedure if your claim is denied in full or in part.

We urge you to read this Booklet carefully in order to understand more fully the coverage available to you and your dependents. We also suggest that you keep the Booklet with your important papers so it will be readily available for future reference.

If you have any questions about your health benefits or would like assistance in filing a claim, please write or call the Fund Office. The staff will be pleased to assist you.

We wish you and your family the best of health in the years to come.

Sincerely,

Board of Trustees

IMPORTANT

The Board of Trustees of the Connecticut Laborers' Health Fund, acting as a body, has full authority and discretion to interpret and construe the terms of the Plan and the Trust, and to make factual determinations relating to any claim for benefits including such things as: interpreting provisions establishing eligibility for benefits; determining the manner in which hours of work are credited for eligibility; determining the status of any person as a covered or non-covered Participant; as well as all other matters. Nevertheless, the Board of Trustees has delegated to Aetna decision-making authority over whether a medical or dental claim is covered under the Plan, and if so, the amount covered, but not over decisions concerning eligibility to participate in the Plan. To the extent Aetna has been delegated such discretionary decision-making authority, it shall have full authority and discretion to interpret and construe the terms of the Plan and make factual determinations relating to any claim for benefits.

The Board of Trustees, acting as a body, and only the Board of Trustees, has the right to amend or terminate the Plan. The Board of Trustees has the right to establish eligibility requirements and the level and type of benefits offered under the Plan. Any discretionary action taken by the Board of Trustees and, where applicable, Aetna in determining any matter, including your rights or benefits under the Plan, will be decided in a nondiscriminatory manner, as required by law. Any determination made by the Board of Trustees and, where applicable, Aetna with respect to your rights or benefits will be entitled to the maximum deference permitted by law and will be conclusive upon all Participants unless the action of the Board of Trustees or Aetna can be shown to be discriminatory or to have been made arbitrarily or capriciously.

No local union, local union officer, business agent, local union employee, employer or employer representative, association or association representative, individual Trustee, fund administrative office personnel, consultant, attorney or any other person is authorized to speak for, or on behalf of this Fund, or to commit or to legally bind the Board of Trustees of this Fund in any matter whatsoever relating to the Fund, unless such person shall have been given express written authority from the Board of Trustees to act in such matter. All Participants are warned not to rely upon any opinion or interpretation expressed by any such individual. All inquiries, requests for rulings, interpretations, and decisions must be directed in writing to the full Board of Trustees in care of the Fund Office.

The Trustees have selected Aetna's Open Choice preferred provider network to provide an exclusive contracted panel of hospitals and physicians throughout your area ready to offer a complete continuum of care. Aetna represents that it selected these health care providers based on their demonstrated commitment to providing and maintaining the highest quality of care. Aetna and the physicians and providers in its network are independent and separate entities, not affiliated with or under the control of the Trustees of the Fund. The Trustees cannot take responsibility for the quality of care or treatment decisions received through Aetna providers nor will the Trustees interfere in this professional preferred provider organization (PPO) relationship.

You will receive separately information concerning the composition of the Aetna Open Choice preferred provider network, so that you can determine whether particular providers are participating in the network. Provider lists are furnished to you automatically and without charge.

No benefits or rules described in this Summary Plan Description (SPD) are guaranteed (vested) for any Participant, retiree, spouse or dependent. All benefits and rules may be changed, reduced or eliminated prospectively at any time by the Board of Trustees, at their discretion. All changes adopted by the Board of Trustees to the Plan of Benefits or the rules will be published in writing and circulated to the Participants, as required by law, so that the Participants may have up-to-date information concerning their rights, benefits, and privileges.

In reading this document, please remember that whenever a pronoun or other word describes a masculine person, the word also includes a feminine person, unless the context clearly indicates otherwise. In addition, the words used in the singular person also include plural persons, unless the context clearly indicates otherwise.

If you do not understand English and have a question about the benefits or the rules of the Plan, contact the Fund Office at the address or phone number on the following page to find out how to obtain help.

CONNECTICUT LABORERS' HEALTH FUND

435 Captain Thomas Boulevard
West Haven, Connecticut 06516-5896
Telephone (203) 934-7991
Toll Free (800) 922-3240
Fax (203) 933-1083

BOARD OF TRUSTEES

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CONSULTANTS AND ACTUARIES

The Segal Company

FUND COUNSEL

Murtha Cullina LLP

FUND AUDITORS

T.M. Byxbee Company, P.C.

FUND OFFICE

The Fund Office receives employer/Participant contributions, keeps eligibility records, coordinates processing and/or payment of claims, and provides information about the Plan

The Fund Office is located at:

435 Captain Thomas Boulevard
West Haven, Connecticut 06516-5896
Telephone: (203) 934-7991
Toll Free Number: (800) 922-3240
FAX: (203) 933-1083

The Plan Administrator is, collectively, the Board of Trustees. The Board of Trustees can be contacted at the following address:

Board of Trustees
Connecticut Laborers' Health Fund
435 Captain Thomas Boulevard
West Haven, Connecticut 06516-5896
Telephone (203) 934-7991
Toll Free Number (800) 922-3240
FAX: (203) 933-1083

The rules and regulations described in this Booklet apply to claims incurred on and after August 1, 2005. Your claims prior to August 1, 2005 shall be processed and reimbursed based on the rules and regulations including limitations and exclusions of the Plan of benefits in force when the claim was incurred.

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1 SCHEDULE OF BENEFITS

ACTIVE PLAN OF BENEFITS

LIFE INSURANCE (Member Only)	$10,000 (Aetna insures benefit).
ACCIDENTAL DEATH (Member Only)	$40,000 (Aetna insures benefit).
DISABILITY INCOME BENEFIT (Member Only)	$250 per week – 26 weeks maximum. Payable 1st day of disability due to injury, 8th day of disability due to illness (self-insured and administered by Fund Office through Aetna).

HOSPITAL AND MEDICAL BENEFITS

IN-NETWORK BENEFITS

The following hospital and medical benefits are the in-network benefits (Preferred Provider Network administered by Aetna).

PHYSICIAN OFFICE VISITS	$15 copayment – Plan pays balance in full. There are limits on the number of pediatric (well baby) visits and how frequently an adult can obtain a routine examination, including gynecological. There are no limits or restrictions on an individual where the physician indicates there is a diagnosis of a medical condition being treated.
ADULT ROUTINE PHYSICAL EXAM	$15 copayment – Plan pays balance in full.
ADULT IMMUNIZATIONS	$15 copayment – Plan pays balance in full. Covered as medical expense, except if required for travel.

WELL BABY AND CHILD VISITS	$15 copayment – Plan pays balance in full. Maximum number of exams by a participating and non-participating provider: • First year of life – 6 visits; • Second year of life – 2 visits; • Age two and older – annually. Immunizations are included as a covered expense based on American Pediatric Association Recommendations.
GYNECOLOGIST VISIT	$15 copayment – Plan pays balance in full. Limited to 1 well visit per calendar year; includes Pap Smears and covers children age 15 and older.
MAMMOGRAM	$15 copayment – Plan pays balance in full. One per calendar year.
CHIROPRACTIC VISITS	$15 copayment – Plan pays balance in full. Maximum 30 visits per calendar year.
ALLERGY VISITS	$15 copayment – Plan pays balance in full. Testing and treatment courses, including allergy shots.
PHYSICAL THERAPY (Occupational and Speech Therapy)	$15 copayment – Plan pays balance in full. Maximum of 60 treatments combined per calendar year.
DIAGNOSTIC LABORATORY	$15 copayment – Plan pays balance in full (blood tests, etc.).
X-RAY IMAGING	$15 copayment – Plan pays balance in full.
SURGERY	Plan pays 100% of covered services. Second opinion for non-emergency surgery is covered but not required. Oral surgery covered as medical expense.

MATERNITY	$15 copayment each office visit – Plan pays balance in full. Plan pays 100% delivery including birthing center and midwife, subject to a $250 copayment for the hospital admission.
INFERTILITY	Call Aetna for covered testing, diagnosis, treatment, and prescription drugs. Diagnostic service treated as any other medical expense. Prescription drugs $5,000 lifetime maximum per couple. Infertility treatment $10,000 lifetime maximum per couple.
ACUPUNCTURE	$15 copayment – Plan pays balance in full. Only covered when performed by a licensed medical doctor as an alternative to anesthesia.
EMERGENCY ROOM	$75 copayment – Plan pays balance in full. Copayment is waived if admitted to the hospital.
URGENT CARE CENTER	$75 copayment – Plan pays balance in full.
WALK-IN-CENTER	$15 copayment – Plan pays balance in full.
AMBULANCE	Plan pays 100% of covered expenses. Air ambulance maximum $5,000.
HOSPITALIZATION	$250 copayment per admission. Plan pays 100% of covered services after copayment regardless of length of hospital stay. (If a non-network provider makes charges, those charges are subject to deductible and coinsurance.) Room and board for semi-private room only, unless private room medically necessary. Prior approval required for non-emergency admissions. Please refer to Section 26.

OUTPATIENT HOSPITAL SERVICES	Plan pays 100% of covered services. Includes outpatient surgery, chemotherapy, diagnostic laboratory, imaging and pre-admission testing when billed by hospital.
HOSPICE	$250 copayment – Plan pays balance in full.
MENTAL/NERVOUS & ALCOHOL/SUBSTANCE ABUSE	
Physician (Office Visit):	$15 copayment – Plan pays balance in full. Maximum 25 visits per year. Requires prior approval by Health Management Center. Please refer to Section 20.
Inpatient:	$250 copayment per admission – Plan pays balance in full. Maximum 60 days per calendar year. Maximum 90 days per lifetime. Requires prior approval by Health Management Center. Please refer to Section 20.
HOME HEALTH CARE	Plan pays 100% of covered charges after hospitalization, subject to maximum of 120 visits per calendar year.
DURABLE MEDICAL EQUIPMENT	Plan pays 100% of covered expenses.
SKILLED NURSING FACILITY	$250 copayment per admission – Plan pays balance in full. Prior approval required. Maximum 120 days per confinement. Please refer to Section 26.

OUT-OF-NETWORK BENEFIT (NON-PARTICIPATING PHYSICIAN OR OTHER PROVIDER)

If a member (or dependent) receives services from a non-participating provider (physician, hospital or other laboratory facility), those charges are subject to a deductible, coinsurance and limited to reasonable and customary allowances.

Each calendar year:

- ✦ Deductible of $200 per individual;
- ✦ Plan pays 80% of next $5,000 of covered expenses;
- ✦ After first $5,000, Plan pays 100% of covered expenses:
  - Maximum out-of-pocket expense per calendar year for one person is $1,200;
  - Maximum family out-of-pocket expense per calendar year is $2,400;
  - Out-of-pocket expenses do not include expenses that exceed the maximum allowance recognized by Aetna and expenses not covered by the Plan.

LIFETIME MAXIMUM BENEFIT

There is a $500,000 lifetime maximum benefit payable by the Plan, which applies, to the combination of in-network and out-of-network hospital and medical benefits per illness or disability. This maximum applies on a cumulative basis to all Hospital and Medical Benefits under the Active and Retired Plans (Medicare Supplement and Non-Medicare).

PRESCRIPTION DRUG BENEFIT

(Administered by Aetna)

RETAIL PHARMACY:

Generic Drug:	10% coinsurance subject to $5 minimum and $10 maximum copayment for a 30 day supply.
Brand-Name Drug:	20% coinsurance subject to $10 minimum and $20 maximum copayment for a 30 day supply.

MAIL-ORDER PROGRAM:

Generic Drug:	$15 copayment for a 90 day supply.
Brand-Name Drug:	$30 copayment for a 90 day supply.

DENTAL BENEFIT

(Administered by Aetna)

Preventative Care:	Plan pays 100% of covered services.
Basic Services:	Plan pays 80% of covered services.
Major Services:	Plan pays 70% of covered services. Calendar year maximum of $2,000 per person applies to all dental benefits.

ORAL SURGERY — Covered as medical expense.

ORTHODONTIC BENEFIT — Only available to dependent child(ren) to age 19. 50% coinsurance. $3,000 lifetime maximum.

TMJ — 80% coinsurance. $500 lifetime maximum.

VISION BENEFIT — Exclusive benefit only provided through Davis Vision. Eye examination paid in full. Eligible Participant and dependent child(ren) age 19 and younger: one examination every 12 months paid in full; spouse and child(ren) older than age 19 once every 24 months. Basic eyeglasses and frames paid in full. Additional charges for specialty materials.

LASER EYE SURGERY	50% reimbursement. Subject to lifetime maximum of $1,250.
HEARING BENEFIT	Exclusive benefit provided through the UCONN Speech and Hearing Clinic. Plan pays 100% of charges for examination, fitting, and molds, along with 100% of the first $2,000 and 80% of the excess cost of hearing aids once every 3 years.

2 INTRODUCTION

This Plan is a self-funded plan maintained in accordance with the Employee Retirement Income Security Act of 1974, as amended (ERISA). This means that your health care claims are paid directly from Health Fund resources rather than by an outside insurance company with the exception of life and accidental death and dismemberment insurance. Contributions are made by your Contractor/ Employer to a Trust in accordance with the terms of a Collective Bargaining Agreement with the Connecticut Laborers. Because the Plan is self-funded, it is not subject to state insurance law. However, it is subject to federal laws. The life insurance and accidental death and dismemberment benefits are insured by Aetna.

Since the Plan is self-funded, you have a responsibility to be an informed, conscientious health care consumer. Your individual efforts to conserve Health Fund resources have a direct effect on the cost of health care benefits provided to you and your family and upon the ability of the Board of Trustees to maintain the current level of benefits and make future benefit improvements. To help conserve the Health Fund's assets and provide you with more efficient treatment, the Trustees contract with Aetna to review all hospital admissions and manage catastrophic claims. In addition, the Connecticut Laborers' Family Services Program must be contacted for all mental health and substance abuse services to assure that you and your family receive appropriate mental health, alcohol and substance abuse services.

The Fund Office handles the day to day administrative operations, including determining eligibility. Aetna processes medical and dental claims.

The Fund has a contractual agreement with Aetna to extend their Open Choice Network Preferred Provider Organization (PPO). The major advantage to you of using the network doctors and hospitals is that the Health Fund receives negotiated discounted fees and rates with the physicians and hospitals in the network. Your use of the network providers will also lower your out-of-pocket expenses as the network Plan of Benefits requires that you pay a co-payment with the balance of charges generally paid in full by the Fund. You will be provided with separate materials indicating the physicians and hospitals that are in the network, free of charge.

3 ELIGIBILITY PROVISIONS

COLLECTIVE BARGAINING EMPLOYEES

A. General Provisions

You are eligible for coverage if you are employed under the jurisdiction of one of the Local Unions affiliated with the Connecticut Laborers' District Council and sufficient contributions have been made on your behalf by Participating Employers. In addition, eligibility may be extended under a Participation Agreement. No medical examination is required to become covered under this Plan.

B. Effective Date of Insurance

You will become eligible for coverage on the first day of the second calendar month following the month in which you have earned at least 600 or more recorded hours of employment with one or more contributing employers (signatory contractor) for which contributions have been received by the Fund Office for work performed in the last ten (10) months. Hours worked in Covered Employment are not recognized until contributions from your Employer have been received by the Fund Office. These hours will be recognized and posted to the calendar month actually worked.

The qualifying period for accumulating 600 hours will not exceed 10 months and includes the 10 months plus a skip month prior to the month a claim is incurred.

For example:

You do not have to work 10 months before you become eligible for coverage. If you earn 600 hours from January through March, then you would become eligible for coverage on May 1st. You may, of course, verify your eligibility status at any time by contacting the Fund Office.

If you are credited with at least 600 hours in the following 10 months:	You will be eligible for benefits in the month of:
January through October	December
February through November	January
March through December	February
April through January	March
May through February	April
June through March	May
July through April	June
August through May	July
September through June	August
October through July	September
November through August	October
December through September	November

C. Eligibility While Disabled

If you become totally disabled while you are covered for benefits based on your prior work in Covered Employment, your eligibility for health coverage may be continued for up to a maximum of twelve (12) months. If you were totally disabled and the necessary certification supporting your disability is received in a timely manner, the months you were totally disabled (up to the maximum of twelve (12) months) will be omitted in computing your new eligibility, and any applicable work activity in the appropriate eligibility period prior to the disability will be recognized and counted towards maintaining or reestablishing your active coverage. If any applicable extension does not provide uninterrupted coverage to you, you will be notified by the Fund Office that you will be required to make COBRA self-payments to continue your coverage under the Plan. Once you are no longer totally disabled, if you lose coverage, you will be required to satisfy the eligibility rules of the Plan to regain eligibility for benefits. For the definition of "totally disabled", see Section 28.

If you become totally disabled while you are making COBRA self-payments, your eligibility for health coverage will be continued without payment from you for each month you remain totally disabled, up to a maximum of twelve (12) months, provided the necessary certification supporting your disability is received in a timely manner. Once you are no longer totally disabled, you will

be required to resume making COBRA self-payments for any balance of the COBRA period applicable to you. It is important to note that the period of time your COBRA premiums are suspended while you are totally disabled does not extend the total period of time you are eligible for COBRA Continuation Coverage. See Section 12 for more information. You will be required to satisfy the eligibility rules of the Plan to regain eligibility for benefits.

D. Termination of Coverage

Your eligibility for coverage under this Fund is determined each month based on contributions remitted for hours reported by your employer. Your eligibility will terminate as of the first day of any month shown in the right hand column of the table in Section B in which you did not accumulate at least 600 hours in the corresponding ten (10) month period shown in the left-hand column.

For example, if you accumulate only 570 hours in the months of August through May, you will lose your eligibility for benefits as of July 1st.

In the case of your death, your dependents will continue coverage as if you had remained a Participant until the end of the coverage period shown in Section B based on your credited work activity up to the date of your death. Thereafter, your dependents are permitted to elect COBRA coverage.

If your coverage terminates because you fail to accumulate sufficient hours, you will be offered the COBRA self-payment option to maintain benefits for a limited period of time. Regardless of whether you elect COBRA, you will be required to satisfy the eligibility requirements to reinstate your eligibility for coverage under the Plan.

When you terminate coverage, you will receive a Certificate of Coverage from the Fund Office. You should show this Certificate to your new employer to possibly reduce or eliminate any Pre-Existing Condition rules under another health insurance plan.

E. Family and Medical Leave Act

If you are on a leave of absence under the provisions of the Family and Medical Leave Act of 1993 (FMLA), your employer has an obligation to continue your medical coverage. In order to continue your coverage through this Fund, your employer must continue to remit hourly contributions on your behalf at forty (40) hours per week for each week you are on leave pursuant to the FMLA. Contact the Fund Office if you are planning to take FMLA leave so that the

Health Fund is aware of your employer's responsibility to make contributions during your absence. The Board of Trustees cannot enforce collection of contributions from your employer while you are out on leave.

F. Eligibility for Coverage During Military Service

If you are inducted into the Military Service of the Armed Forces of the United States of America, or if you enlist in the Military Service, including part-time National Guard service, or if, because of membership in a reserve component of the Armed Forces, you are called into active federal service, your health coverage will be continued by the Fund during your first 31 days of military service. During this 31 day period, the Health Fund will credit hours to your work record as if you worked in Covered Employment based upon a forty (40) hour work week. If you are eligible for benefits with the Health Fund at the time you enter military service and if you continue to serve in the military beyond thirty-one (31) days, you will have the following options regarding your health coverage:

1. You may continue to maintain coverage through the Health Fund based on the eligibility rules and your work activity prior to your active duty; or
2. You may have your coverage suspended and freeze the hours worked prior to your active military service and have them applied to reinstate your eligibility when you are discharged from active duty and return to work in Covered Employment; or
3. You may maintain coverage in the Fund for up to 24 months by making COBRA self-payments.

If you were not eligible for coverage with the Health Fund at the time you entered military service, these rules do not apply to you.

If you were eligible for health coverage based on your credited hours immediately before you entered military service, then you will be eligible immediately for coverage when you return, provided you were discharged under honorable conditions, and provided that you make yourself available for work in Covered Employment within the time period required by law after your date of discharge. That time period is generally one day if your military service is less than 31 days, although additional time is given to allow for safe transportation home; 14 days if the period of service was more than 30 but less than 181 days; and 90 days if the period of service was for more than 180 days. A longer period of time applies if you were hospitalized for or convalescing from an illness or

injury incurred in, or aggravated during, the performance of service in the uniformed services. **Therefore, it is imperative that you contact the Fund Office immediately if you enter military service, reserves, or active duty to ensure that your coverage continues and that you understand the rules that apply upon your return. You should also immediately notify the Fund upon your return.**

G. Surviving Spouse/Dependent Child(ren) Coverage

The surviving spouse and dependent child(ren) of an active Participant will continue to be eligible for the benefits of the Plan based on the deceased Participant's prior work history. Upon exhausting eligibility based on the deceased Participant's credited work history, a surviving spouse and/or dependent children may continue their benefits for up to three (3) years by making the necessary COBRA self-payments (see Section 12).

If the deceased active Participant could have otherwise retired as of the first day of the month of his death (accrued 30 Pension Credits or attained age 55 and accrued 10 Pension Credits in the Connecticut Laborers' Pension Fund or related Pension Fund) his widow will be eligible, after running out the Participant's active eligibility, to continue coverage for life under the Retiree Benefits Program by making the required monthly self-payment, provided the widow is eligible for benefits through the Health Fund on the effective date of pension benefits.

A spouse of a retiree covered under the Retiree Program may continue coverage under the Retiree Program for life, by continuing, without interruption, to make the appropriate monthly self-payment. However, benefits under the Retiree Program are subject to change or termination at any time; like all benefits under the Plan these benefits are not vested

NON-COLLECTIVE BARGAINING EMPLOYEES

H. Non-Jobsite Participation Eligibility Rules for Non-Collective Bargaining Employees

With the prior approval of the Board of Trustees, a contributing employer who routinely and regularly employs laborers may include its non-bargaining, regular

full-time employees (excludes part-time or summer help, etc.) who do not work in Covered Employment and are not represented by another union. The Board of Trustees may permit these employees to be included as Non-jobsite Participants in the Health Fund, subject to such additional requirements as the Board of Trustees may prescribe from time to time. In addition, the Board of Trustees will permit employees of the Connecticut Laborers' Funds, Connecticut Laborers' Legal Services Fund, Connecticut Laborers' District Council, the New England Laborers Training Trust Fund, and the Connecticut Laborers' Local Unions to participate in the Fund as Non-jobsite Participants.

A contributing employer in good standing, who routinely and regularly employs laborers, must submit a request to the Board of Trustees before contributions will be accepted on behalf of a non-collective bargaining employee. Contributing employers electing Non-jobsite Participation in the Plan may also be required to enter into a Participation Agreement with the Health Fund.

If you are a Non-jobsite employee and your employer has agreed to make contributions to the Fund on your behalf at the required monthly rate, you will become covered on the first day of the calendar month following at least one month of employment provided the Fund Office has received the monthly payment of contributions from your employer.

Monthly payments must be made in advance of the month for which eligibility for coverage is provided. If payment is not received by the Fund Office by the tenth day of the month, benefits will be cancelled for the Non-jobsite Participants as of the last day of the month for which payment was received. The monthly payments must be continuous to ensure continued eligibility for benefits. If there is a lapse or interruption in monthly payments, the Non-jobsite Participant will not be allowed to participate in the Connecticut Laborers' Health Fund as a Non-jobsite employee with the same employer for a period of twenty-four consecutive calendar months.

Eligibility for benefits as a Non-jobsite Participant will terminate at the end of the month following the earliest of:

1. The date you cease to be an employee of a contributing employer;
2. The date the employer ceases to participate in the Fund; or
3. The date the employer fails to make timely payments at the rate set forth by the Board of Trustees for Non-jobsite Participation.

In the event your coverage as a Non-jobsite Participant is terminated, you will be offered COBRA Continuation Coverage on a self-pay basis.

I. Special Eligibility Provisions for Laborers of Newly Organized Contractors Transferring Coverage from the Employer's Plan to the Connecticut Laborers' Health Fund

The Board of Trustees may extend special eligibility rules to newly organized contractors. When such a request is approved by the Board of Trustees, laborers of the newly organized contractor shall be eligible for benefits under the Plan on the first day of the month following receipt of a minimum of 125 hours of contributions for work activity during the prior month and subject to the following:

1. The newly organized contractor maintained comparable health benefits for its employees immediately prior to signing a bargaining agreement and the contractor paid the majority of the cost for such benefits; and
2. The laborers must have been employed by the contractor for at least 600 hours during the previous ten (10) month period; and
3. A minimum of 125 hours must be contributed each month on behalf of the laborer in order for coverage to be maintained. If 125 hours are not contributed, coverage will terminate at the end of the month in which the minimum contributions were not received and COBRA Continuation Coverage will be offered to the laborer. The laborer will then be subject to the standard eligibility rules of the Plan.
4. The Plan's normal eligibility provisions will not apply to a laborer extended the above provisions until 1,200 hours have been contributed to the Fund on the laborers' behalf.

The Board of Trustees has the right to review and determine the applicability of these eligibility provisions with respect to each newly participating contractor and its employees.

J. Pre-Existing Condition Limitations-Only Apply to Non-jobsite Participants

1. Definition of "Pre-Existing Condition"

A **"Pre-Existing Condition"** is any physical or mental condition, regardless of its cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the 90 day period ending on the date the individual commences coverage or, if earlier, the date the waiting period for coverage required by the Plan starts. Pregnancy is not a

Pre-Existing Condition for the purposes of this Plan. Newborns and adopted children covered within 30 days of birth or placement for adoption are not subject to Pre-Existing Conditions.

2. Maximum Period of Exclusion of Coverage for Pre-Existing Conditions After Initial Enrollment

If, after you and/or your eligible dependents become Participants in the Plan and the Fund Office or Aetna determines that you or any of your covered dependents has a Pre-Existing Condition, no expenses related to that Pre-Existing Condition incurred after the date of coverage will be covered before twelve months have elapsed since the date coverage begins or, if earlier, the date the waiting period for coverage under this Plan starts.

3. Credit for Previous Coverage

The Pre-Existing Condition limitations can be reduced or eliminated if you had health care coverage for hospital and medical expenses before you became enrolled under this Plan, provided you did not have a Break in Coverage of more than 63 days.

If there has been NO "Break in Previous Coverage," the 12-month period of exclusion of coverage for Pre-Existing Conditions described above shall be reduced by the period of time (up to the date coverage begins or, if earlier, the start of the waiting period) that you, your spouse, and/or any of your dependent children (whoever has the Pre-Existing Condition) were covered under any employer-sponsored group health plan, COBRA Continuation Coverage, or any group or individual health care plan or insurance policy, Medicare, Medicaid, military sponsored health care, state health benefits risk pools, the federal employees health benefit program, a public health plan, and/or any health benefit plan that provides hospital and medical coverage.

If there has been a Break in Previous Coverage, no such credit will be provided for any periods of coverage prior to the Break in Previous Coverage.

A **"Break in Previous Coverage"** means a period of 63 days or more between the date coverage ended under any other health care plan or insurance policy as described above and the date coverage under this Plan begins or, if earlier, the waiting period for coverage required by this Plan starts.

A leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act will not be counted as a Break in Previous Coverage.

This Plan will require you to submit certification for the period of creditable coverage under any other health care plan or insurance policy in order to prove that you are entitled to credit for the time you were covered under that plan or policy to reduce the maximum period of exclusion of coverage for this Plan's Pre-Existing Conditions Exclusion. You may request such a Certificate from your previous Employer, insurer or plan and they are required by law to provide such a Certificate to you on request. The Fund Office will assist you in obtaining a Certificate from a prior insurer or plan, if necessary.

The Plan will not cover, at any time, a condition previously attributable to an injury or illness covered by Workers' Compensation, regardless of the time of such injury or illness.

No Medical Examination or Age Restriction

No medical examination is required of any member to secure his eligibility for coverage, and all new members will be covered regardless of age. However, Participants not working under the terms of a collective bargaining agreement (Non-jobsite Participation) are subject to the Pre-Existing Condition limitations described under the Eligibility provisions of this Plan.

4 DEPENDENT ELIGIBILITY

A. Effective Date of Coverage for Eligible Dependents

- Any of your dependents (who meet the eligibility rules of the Plan) on the date you become covered under the Plan shall become covered on the same date as well.
- If you marry after the date you initially became covered under the Plan, your spouse will become covered on the first day of the month after your marriage.
- If you have a newborn biological child, an adopted child, step child for whom you are legally responsible by a court order or state order or a child placed for adoption with you, or a foster child, such child will become covered on the date of birth (for a newborn biological child), or for adopted or foster children the date the child is adopted or placed in your home.

You must notify the Fund Office within 31 days after you acquire a new dependent through marriage, birth, foster placement, or adoption to ensure coverage for your dependent.

B. Definition of Eligible Dependent

Your eligible dependents are:

Your lawful spouse of the opposite sex, legally married pursuant to federal law and the laws of the State of Connecticut, to the last day of the month in which divorce, dissolution of marriage, annulment, or legal separation is obtained. If your marriage occurred outside of the State of Connecticut, it will be recognized if the State of Connecticut would recognize the marriage. Nevertheless, in no event will the Fund recognize common law marriages or same sex marriages, even if the State of Connecticut would recognize those marriages.

Your unmarried biological children, foster children, children placed with you for adoption, adopted children, or stepchildren for whom no other insurance coverage is provided by a divorce decree, acknowledgment, paternity court order, state order, or for which a biological parent is otherwise responsible for the child's health insurance, until the last day of the month in which the child marries or attains the age of 19, whichever is earlier. An unmarried dependent child will be extended health coverage from age 19 through age 22, if attending

an accredited school, college, or university on a full-time basis. An unmarried child attending school, as described above, will be considered a dependent until the earlier of the first day of the month following the month in which the child ceases to be a full-time student, or the first day of the month following the month in which the child attains age 23. An unmarried child enrolled and attending school during a spring semester will be considered a covered dependent until the beginning of the fall semester unless the student graduates. The Trustees may request, at any time, evidence of continued full-time student status.

The Health Fund does not provide coverage for a child who is not the biological or legally adopted child of a Participant unless evidence is provided that the stepchild, grandchild, or foster child resides in the Participant's household (unless the stepchild, grandchild, or foster child meets the full-time student requirements described earlier) and is legally and financially dependent on the Participant for support. In addition, the Health Fund requires that the natural parents provide a copy of any and all documentation, including paternity papers, court order, state order, and/or divorce decree setting forth the responsibilities of the natural parents in providing support and care for the child. Generally, divorce decrees, child support orders or other agreements may require a biological parent to provide health insurance coverage for the child. In the event no such documentation exists, the Health Fund may approve coverage for the stepchild or foster child provided the following documentation demonstrates that the Participant supports the child and no one else has legal responsibility to do so:

- A copy of the child's birth certificate;
- If your spouse was previously married, a copy of the divorce decree;
- If your spouse was not previously married, a copy of any paternity order or child support order;
- For all stepchildren, grandchildren and foster children, the Participant, in addition to the above documentation, must sign an affidavit to the Health Fund acknowledging that the child resides in your household (unless he or she meets the full-time student requirements) and that you are financially responsible for the support of that child.

The Trustees may grant coverage on a provisional basis for a period of six months. You will be requested to submit documentation listed above before the

end of the six month period. If appropriate documentation is not received, no coverage will be extended to that stepchild, grandchild, or foster child.

The Health Fund will not provide coverage for other relatives living in your household (e.g., mother or father) regardless of whether they are dependent upon you financially, or for non-biological children living in your household for whom you are not legally responsible.

C. Dependent Eligibility Rules

In order for the Health Fund to consider the child an eligible dependent, the child must be unmarried and reside in your household (unless he or she meets the full-time student requirements) and be financially dependent on you for 51% or more of their support. If your unmarried dependent child is employed and becomes eligible for other group health coverage, then the plan under which he or she is considered an employee will be the primary plan for coverage and this Plan will be secondary. In order for a child to be deemed primarily dependent upon you for support and maintenance, proof of dependency must be furnished to the Health Fund upon request. The Health Fund reserves the right to review both the Participant's and the dependent's tax returns, along with any other documentation deemed by the Board of Trustees as relevant, to assure that the child satisfies the definition of a dependent.

If an unmarried dependent child (including stepchildren, grandchildren, or foster children who otherwise qualify) is incapable of self-sustaining employment because of a mental or physical disability and is dependent upon you for support and maintenance, the child's coverage will be continued under this Plan provided the incapacity began prior to attaining age 19 (or 23 if a full-time student). You must submit proof (medical records) of your unmarried dependent child's incapacity to the Fund Office no later than 31 days after the child attains age 19 or if attending school on a full-time basis, no later than 31 days following graduation. Proof of the continued existence of such incapacity is required by the Fund Office.

In order for foster children, children placed for adoption, adopted children, grandchildren, or stepchildren to be considered eligible dependents, you must provide the Fund with documentation, such as adoption papers or a court order appointing you as the legal guardian or foster parent for the child. An illegitimate child of a male or female Participant will not be recognized as an eligible dependent, unless legal papers are provided to the Fund Office that

establishes the Participant has legal responsibility for the child and requires at least 51% of the financial support for the child's care.

If an unmarried dependent child is eligible for benefits under this Plan as an active employee, he will not be considered an eligible dependent. However, if a dependent spouse is eligible for benefits under this Plan as an active employee, benefits will be payable first as a Participant, then as a dependent. In no event will benefits exceed 100% of the network fees or reasonable and customary covered charges incurred.

An unmarried dependent child that loses dependent eligibility status may only regain eligibility by becoming a full-time student and satisfying all the requirements included in the Plan's definition of an eligible dependent.

The Trustees reserve the right to require the Participant to provide documentation substantiating an individual's right to dependency status. Some examples of this documentation include, but are not limited to, marriage certificates, birth certificates, tax returns, notarized affidavits, and acknowledgment of paternity.

D. Change in Family Status

After your coverage becomes effective, it is necessary to notify the Fund Office in writing of any change in your family status by reason of marriage, birth of a child, a child being married, a child attaining age 19, a child age 19 through age 23 ceasing to be a full-time student at an accredited college, university or recognized educational institution, death, divorce, or legal separation. **This is very important because the COBRA election period to continue coverage by self-payment is for a limited time and the failure of you or your dependent to notify the Health Fund of such a change when the change occurs may result in a loss of COBRA rights for which you and/or your dependent could have been eligible. See Section 12 for more information on COBRA rights.**

In addition, failure to file the required information may delay payment of any benefits to you or on behalf of you or your dependents.

E. Qualified Medical Child Support Order "QMCSOs"

The Plan is required to recognize Qualified Medical Child Support Orders ("QMCSOs"). Health plans are required to recognize state court orders, and certain other orders made pursuant to laws relating to medical child support, that

the Plan finds to be Qualified Medical Child Support Orders. The Plan has procedures in place that govern the determination of whether an order qualifies as a QMCSO. QMCSOs require a Participant to provide health benefit coverage for children, even if the Participant does not have custody of the children or if the child would not otherwise be eligible for coverage as a dependent of the Participant under the definition of "dependent" provided by the Plan. If you have questions about QMCSOs, or would like to obtain a copy of this Plan's QMCSO procedures, you should contact the Fund Office. The procedures will be provided to you free of charge.

F. Termination of Dependent Coverage

Your dependent's coverage under the Plan will terminate on the earliest of the following dates:

1. The date your coverage under the Plan ends; or
2. The last day of the month during which your dependent no longer meets the definition of an eligible dependent; or
3. The last day of the month that you voluntarily request that the coverage of an otherwise eligible dependent be terminated.

As noted above, however, your dependent does have rights to be covered under COBRA following the time his or her coverage ceases due to loss of status as a dependent.

5 RECIPROCAL AGREEMENTS

Reciprocal Agreements with other Laborers Funds

The Board of Trustees has entered into reciprocal agreements with other Laborers' Funds outside of Connecticut which provide for the transfer of contributions for hours you work in the jurisdiction of another fund while you are participating in this Health Fund. Contributions received from a reciprocating Fund are divided by the hourly contribution rate in the Collective Bargaining Agreement payable to the Connecticut Laborers' Health Fund at the time the work was performed. This result will determine the number of hours, that will be credited to your work record based on when you worked, to establish or maintain eligibility.

Example:

Assume you work out of state and worked 300 hours at a contribution rate of $6.00 per hour. A reciprocal transfer of $1,800 is made on your behalf which is converted to 360 hours ($1,800.00 ÷ $5.00 = 360 hours) by dividing the contributions received by the contribution rate in effect for the Health Fund, assuming the contribution rate to this Fund at that time is $5.00 per hour. In this example, 360 hours would be added to your work record for the months you actually worked when the reciprocal payment is received. The contrary also applies if the hourly contribution rate payable to the Connecticut Laborers' Health Fund is greater than another Fund; you would receive less hours than those actually worked by dividing the hourly rate into contributions received.

The provisions that govern the transfer of contributions on your behalf to this Health Fund for work performed in the jurisdiction of another Laborers' Health Fund may be unique to each reciprocal agreement. Each agreement provides for an exchange of hours and contributions necessary in computing eligibility. Therefore, if you work in the jurisdiction of another local union not participating in this Health Fund, you should notify the Fund Office immediately to determine whether there is a reciprocal agreement in effect. This will permit the Fund Office to contact that Health Fund so that arrangements can be made to have contributions transferred to this Health Fund in an expeditious manner so you will receive credit for the hours you worked.

You should notify the Fund Office in writing anytime you work as a laborer outside the state of Connecticut. Please indicate when you begin working, your name, social security number, the local union number where you are working, and approximately how long you will be working in that jurisdiction.

Although the Board of Trustees will make every effort to collect amounts due from other Funds under reciprocal agreements, they cannot enforce collection from Employers who are not signatory to the Collective Bargaining Agreement with the Connecticut Laborers. Collection can only be enforced by the Fund in the jurisdiction where the work was performed.

6 FILING A CLAIM AND APPEAL PROCEDURES

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claims will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval is not a claim for benefit.

There are a number of different benefits provided under the Plan. The procedures involved in filing claims under the Plan differ depending upon the type of claim involved and are summarized below (a detailed explanation follows):

Medical/Dental Claims

Electronic Claim Submission – Submit to Aetna

Paper Claim Submission – Mail to Aetna
P.O. Box 981109
El Paso, TX 79998

Appeals (1st and 2nd level) – Submit to Aetna

Voluntary 3rd Appeal – Submit to Fund Office

Weekly Disability Income Benefits

Electronic Claim Submission – Not Applicable

Paper Claim Submission – Submit to Fund Office

Appeals (1st and 2nd level) – Submit to Fund Office

Prescription Drug Benefits

Retail – Obtain at Participating Pharmacy

Mail Order – Submit to AetnaRx Home Delivery

Paper Claim Submission – Submit to Fund Office

Appeals (1st and 2nd level) – Submit to Aetna

Voluntary 3rd Appeal – Submit to Fund Office

Vision Benefits

All Benefit Claims – Contact Davis Vision directly

Paper Claim Submission – Not Applicable

Appeals (1st and 2nd level) – Submit to Davis Vision

Voluntary 3rd Appeal – Submit to Fund Office

Hearing Benefit Claims

Contact the Fund Office to start the process to receive an appointment at the Clinic

All claims with the Clinic are processed directly with Fund Office

Appeals – Submit to Fund Office

Life and Accidental Death/Dismemberment Claims

Claim – Submit to Fund Office

Appeals – Submit to Fund Office

A. When Claims Must be Filed

All claims for benefits should be made within 60 days after the date of the services or treatment received. However, stricter rules apply to pre-service claims and urgent care claims, which are described in Paragraph B on the following page.

The incurred date for a Life Insurance claim is the date of death; for a Disability Income Benefits claim, it is the first (1st) day of disability due to injury or the eighth (8th) day of disability due to an illness measured from the date you first lose time from work and are treated by a physician because of the disability; for an inpatient hospital claim, it is the admission date; and for all other medical and vision claims, it is the date treatment is received.

It is suggested that you submit your claim within 60 days of the date of treatment to ensure the accurate and timely processing of your claim. In no event will a claim be paid if submitted more than fifteen (15) months from the date services were provided. This fifteen (15) month rule does not apply to life insurance claims.

B. Filing Health and Dental Claims under the Plan

You may file claims for health and dental Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. Often times, the provider will make the claim on your behalf directly to Aetna. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf, such as your spouse. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. A form can be obtained from the Fund Office to designate an authorized representative.

Generally, health and dental benefit claims are handled directly by Aetna. However, as described on page 6-7, after you have exhausted your standard appeal process, you are permitted but not required to appeal directly to the Board of Trustees. In addition, although Aetna is the claims fiduciary responsible for determining health and dental benefit claims, the Board of Trustees has the exclusive authority to determine all questions of eligibility to participate under the Plan, including the health and dental portions of the Plan.

Urgent Care Claims – Submit Directly to Aetna

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received. The decision will be made by Aetna unless the decision relates to your eligibility to participate, in which case it will be made by the Fund Office, acting on behalf of the Board of Trustees.

A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Health and Dental Claims (Pre-Service and Post-Service) Submit Directly to Aetna

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim. For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period.

For example:

They may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information.

You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for

the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Notice of Decisions

If your claim is denied, you will be provided with written notice of denial of a claim (whether denied in whole or in part). This notice will be provided by the Fund Office on behalf of the Trustees, if the decision relates to Plan eligibility; otherwise, it will be provided by Aetna. This notice will state:

1. The specific reason(s) for the determination.
2. The specific Plan provision(s) on which the determination is based.
3. A description of any additional material or information necessary to perfect or decide the claim, and an explanation of why the material or information is necessary.
4. A description of the appeal procedures (including the voluntary appeal opportunity) and applicable time limits.
5. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
6. If an internal rule, guideline, or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that such a rule was relied upon in deciding the claim, and that a copy will be provided to you upon request at no charge.
7. If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
8. If the adverse benefit determination involves urgent care, a statement of the expedited review process applicable to such claims. An adverse determination involving urgent care may be provided orally, provided written notification is provided not later than 3 days after the oral notification.

Health and Dental Claims – Standard Appeals

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to Aetna or, if it relates to eligibility, the Board of Trustees. If the appeal is to Aetna, you will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. Urgent care appeal provisions are described later in this page. If you are appealing an adverse determination relating to eligibility to the Board of Trustees, the Board of Trustees will make a determination at the next scheduled meeting of the Board of Trustees following the Plan's receipt of the request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of a request for review. If special circumstances require a further extension of time, a determination shall be rendered not later than the third meeting of the Board of Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. Notice of the benefit determination and review by the Board of Trustees will be made as soon as possible, but not later than 5 days after the benefit determination is made.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the urgent care appeal is received.

If you are dissatisfied with the appeal decision, you may file a second level appeal within 60 days of receipt of the level one appeal decision. The appeal will be handled in the same time frames as the first level appeal and a notice will be sent to you explaining the decision.

Health and Dental Claims – Voluntary Appeals

You may file a voluntary appeal to the Board of Trustees of any final standard appeal determination made by Aetna. Subject to verification procedures that the Plan may establish, your authorized representative (cannot be a provider) may act on your behalf in filing and pursuing this appeal. All of the levels of standard appeal described above must be completed before you can file a voluntary appeal. The appeal must be filed for review within (60 days) after you receive the final denial notice under the standard appeal processes, described above.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of an appeal will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice. No fees or costs are imposed upon you as part of the voluntary level of appeal. The decision to submit a denial made by Aetna to the Board of Trustees will have no effect upon your rights to any other benefits under the Plan.

If you choose to appeal to the Fund following an adverse determination at the final level of standard appeals by Aetna, you must do so in writing, and you should send the following information:

1. The specific reason(s) for the appeal;
2. Copies of all past correspondence with the Health Fund and Aetna, including any Explanation of Benefits, (EOB's); and
3. Any applicable information that you have not yet sent to the Health Fund.

If you file a voluntary appeal, you will be deemed to authorize the Fund to obtain information from your Health Plan relevant to your claim.

Mail your written appeal directly to:

Board of Trustees Connecticut Laborers' Health Fund
435 Captain Thomas Boulevard
West Haven, CT 06516-5896

The Board of Trustees will review your appeal. The Board of Trustees will evaluate your claim within the time frames previously described, relating to appeals to the Board of Trustees involving eligibility decisions.

Appeal Process

The appeal process works as follows: You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon in deciding your claim); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person within Aetna will review your claim than the one who originally denied the claim. The reviewer will not be the subordinate of the person who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. That professional may not be an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Notice of Decision on Appeal

The decision of any review of your appeal will be given to you in writing, except in case of an urgent claim. The notice of a denial of an appeal will state:

1. The specific reason(s) for the determination.
2. The specific plan provision(s) on which the determination is based.
3. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
4. If an internal rule, guideline, or protocol was relied upon by the Plan, you will receive either a copy of the rule, or a statement that such a rule was relied upon in deciding the claim, and that a copy will be provided to you upon request at no charge.
5. If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
6. If the appeal is denied by Aetna, a statement describing the voluntary appeal procedures to the Board of Trustees, as set forth on page 6-7.
7. A claimant's right to bring an action suit under Section 502(a) of the Employee Retirement Income Security Act.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, excluding voluntary appeals, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. However, the law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow the claims and appeals procedures properly.

C. Vision, Hearing, Weekly Disability Income, and Life Insurance Claims

The following applies only to Vision, Hearing, Weekly Disability Income and Life Insurance Benefits. For claims and appeals procedures for your medical and dental benefits, please refer to the information in the previous Section B. The prior Section describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

How and Where to File a Claim – Vision, Hearing, Weekly Disability Income, and Life Insurance Benefits

Claims for Vision Benefits are made directly by participating optometrists to Davis Vision. Claims for hearing benefits are submitted by the University of Connecticut Speech and Hearing Clinic directly to the Fund Office. Claims for Weekly Disability Income Benefits and Life Insurance Benefits should be made by you or your beneficiary directly to the Fund Office.

Weekly Disability Income and Life Insurance Benefits

Your claim (or that of your beneficiary) will be considered filed as soon as it is received at the Fund Office. Claims should be filed and mailed to the Fund Office at the following address:

Connecticut Laborers' Health Fund
435 Captain Thomas Boulevard
West Haven, CT 06516-5896

Hearing Benefits

When you utilize the University of Connecticut Speech and Hearing Clinic, your claim will automatically be submitted by the Clinic directly to the Fund Office. There are no claim forms for you to complete.

Vision Benefits

When you utilize a Davis Vision network provider, your claim will automatically be sent to Davis Vision by the optometrist. There are no claim forms for you to complete. No benefits are provided by the Fund when you receive services at other than a Davis Vision provider.

Information regarding Davis Vision can be obtained from the Fund Office. In addition, you can call Davis Vision at 1-800-999-5431 or access information on their web site at www.davisvision.com.

Hearing and Vision Claims

The following procedure applies to hearing and vision claims. As noted above, hearing and vision claims are automatically filed by the provider.

Ordinarily, you will be notified of the decision on your hearing or vision claim within 30 days from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a hearing or vision claim and notify you of the determination.

Life Insurance Claims

For life insurance claims, the Fund Office will make a decision on the claim and notify your beneficiary of the decision within 90 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. The extension will not exceed 90 days.

Weekly Disability Income Benefits Claims

For Weekly Disability Income Benefits (Disability Claims), the Plan will make a decision on the claim and notify you of the decision within 45 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45 day period. The period for making a decision may be delayed an additional 30 days, provided the Plan administrator notifies you, prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice for 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within 30 days.

All decisions on initial claims for the benefits described in this Section C, except for vision claims, will be made by the Fund Office, acting on behalf of the Board of Trustees. The information which you provide, if your claim is denied, the time frames within which you can appeal, your rights to receive and supply information, the time frame for a decision on appeal, and the information provided to you if the appeal is denied, is the same as described in the preceding Section B relating to decisions by the Fund Office and Board of Trustees with respect to claims involving eligibility to participate in the medical and dental portions of the Plan.

Additional Information

To avoid a delay in benefit payments, it is important that you (or the provider submitting the claim directly) provide the following information with each claim submitted:

1. If there is more than one group health plan involved, your claim must be submitted in accordance with the Coordination of Benefits procedures, described in Section 10 of this booklet.
2. A separate claim must be submitted for each individual family Participant who incurs covered expenses.
3. ALL questions must be completed and answered with a detailed explanation of all charges.

The maximum benefits, where applicable, and other payment provisions apply separately to each individual family Participant.

Payment of hospital bills and ambulance service charges will be made directly to the provider, unless different arrangements are required by law. In addition,

when utilizing network/participating physicians and/or other vendors, payment will be made directly to them by Aetna.

Payment of bills from nonparticipating/out-of-network doctors and other providers will normally be made directly to the provider unless evidence is received that the services have already been paid, unless otherwise required by law.

Even though the Fund may make payment of claims of a Participant or eligible dependent to the provider directly, no provider shall have any right, title or interest to payment from this Fund, and no provider shall have a right to any remedies or other procedures provided under the Plan for the benefit of a Participant or eligible dependent unless the provider qualifies as an authorized representative. Only the Participant or eligible dependent may exercise any rights provided under the Plan and any assignment, pledge or other agreement between the Participant or eligible dependent and any provider shall not create any right against the Plan and any such assignment, pledge or other agreement shall be null and void as to this Plan.

Payment of Weekly Disability Income Benefits are made weekly, including fractional parts of a week, and directly to you, the Participant, upon receipt by the Fund Office of the necessary information to process the claim, provided your claim is approved.

The Health Fund receives a discount on services provided when you utilize a network provider. The Health Fund's payment of your claim will recognize these discounted charges. Network providers are not permitted to balance bill you for the difference between their discounted charges and their normal charges. If this occurs, please notify the Fund Office.

Disputes about Hospital and/or Physicians' Bills

Occasionally, a claim processor will question the amount or the reasonableness of a billing.

For example:

A physician may charge for an office visit and also for two or three medical treatment procedures performed on the same day at his office. In such a case, Aetna may negotiate with the physician to revise the billing.

Whenever the amount or reasonableness of a charge is questioned, the claims processor may investigate the matter. If the dispute cannot be resolved by Aetna they will refer the claim to an External Review Program to determine the Health Fund's obligation under the Plan for those charges. The Health Fund will only reimburse covered expenses, to the extent that the External Review Program evaluation supports the charges and/or services as reasonable, customary, and proper. Claims denied in whole or in part on the basis of services and/or treatment not being medically necessary or if the proposed treatment is considered experimental or investigational will be reviewed by Aetna or may be reviewed by the Board of Trustees retaining an outside independent organization.

7 HIPAA PRIVACY PRACTICES

The following describes how medical information about you may be used and disclosed and how you can get access to this information

The Connecticut Laborers' Health Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI);
- Your rights to privacy with respect to your PHI;
- The Fund's duties with respect to your PHI;
- Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS); and
- The person or office you should contact for further information about the Fund's privacy practices.

Your Protected Health Information (PHI)

The term "Protected Health Information" (PHI) includes all individually identifiable health information relating to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

Under the law, the Fund may disclose your PHI without your consent or authorization, and without providing you an opportunity to agree or object, in the following situations:

1. If you request it – The Fund is required to give you access to certain PHI in order to allow you to inspect and/or copy it. You have additional rights explained in Section 6 and Section 32.
2. As required by HHS – The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.
3. For treatment, payment, or health care operation – The Fund and its business associates will use PHI in order to carry out: treatment, payment, or health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example:

The Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

For example:

The Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example:

The Fund may use information about your claims to refer you into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

4. Disclosure to the Fund's Trustees – The Fund will also disclose PHI to the Plan Sponsor, the Board of Trustees of the Connecticut Laborers' Health Fund, for purposes related to treatment, payment, and health care operations, and has amended the Trust Agreement to permit this use and disclosure as required by federal law. For example, we may disclose

information to the Board of Trustees to allow them to decide an appeal or review a request for a compromise of the Fund's lien in a third party liability or worker's compensation matter.

5. Disclosure to Other Benefit Plans – On certain occasions, it may be necessary to receive information from the Health Fund in order to process life insurance benefits, Weekly Disability Income Benefits or benefits from the Pension Fund. In those cases, we will request an authorization from you to release such information in order to continue processing your benefits.

Sharing Your PHI Requires Your Written Authorization

Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Fund will use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives, and your close personal friends is allowed under federal law if:

1. The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
2. You either have agreed to the disclosure or have been given an opportunity to object and have not objected.

You should note that under certain circumstances described below, federal law allows the use and disclosure of your PHI without your consent, authorization, or opportunity to object to such use or disclosure.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required

The Fund is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. When required by applicable law.

2. Public health purposes – To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. Domestic violence or abuse situations – When authorized by law to report information about abuse, neglect or domestic violence to public authorities, if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

4. Health oversight activities – To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).

5. Legal proceedings – When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

6. Law enforcement health purposes – When required for law enforcement purposes (for example, to report certain types of wounds).

7. Law enforcement emergency purposes – For certain law enforcement purposes, including: identifying or locating a suspect, fugitive, material witness or missing person, and disclosing information about an individual who is or is suspected to be a victim of a crime.

8. Determining cause of death and organ donation – We may give PHI to a coroner or medical examiner to identify a deceased person, determine a cause of death or perform other authorized duties. We may also disclose PHI for cadaveric organ, eye, or tissue donation purposes.

9. Funeral purposes – We may give PHI to funeral directors to carry out their duties with respect to the decedent.

10. Research – For research, subject to certain conditions.

11. Health or safety threats – When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. Workers' Compensation programs – When authorized by and to the extent necessary to comply with Workers' Compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

Other Uses or Disclosures

The Fund may disclose protected health information to the plan sponsor of the Fund for reviewing your appeal of a benefit claim or for other reasons regarding the administration of this Plan. The "plan sponsor" of this Fund is the Board of Trustees of the Connecticut Laborers' Health Fund.

Your Individual Privacy Rights

The following is a description of your individual privacy rights. It is important to note that while all requests should be directed to the Health Fund, the Fund contracts with numerous vendors, called "business associates," who provide services to the Fund and services and benefits to you on the Fund's behalf. Once the Fund is notified that you choose to invoke any of the individual rights listed below, it will notify the appropriate vendor on your behalf. Because some of your PHI is maintained and used by these business associates to provide or process your benefits, the Fund requires that they administer certain aspects of the individual privacy rights. **You may contact the Privacy Official at the address and phone number listed below:**

Richard F. Weiss, Privacy Official
Connecticut Laborers' Health Fund
435 Captain Thomas Boulevard
West Haven, CT 06516-5896
Phone: (800) 922-3240
Fax: (203) 933-1083

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations; or
2. Restrict uses and disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care.

The Fund, however, in accordance with regulations, may choose not to honor your request in certain circumstances.

You must contact the Fund to receive an application to make a request to restrict the use or disclosure of PHI. You may contact the Privacy Official at the address and telephone number previously listed.

You May Request Confidential Communications

The Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request alternative means and/or locations for communication of PHI. You may contact the Privacy Official at the address and telephone number previously listed.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," as long as the Fund maintains the PHI. However, you do not have a right to inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law(s) that otherwise prohibits access to PHI.

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30 day extension is allowed if the Fund is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable fee may be charged. You may contact the Privacy Official at the address and telephone number previously listed for additional information.

Under limited circumstances, access may be denied. If access is denied, you will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and HHS.

Designated Record Set includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a Health Fund or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

You have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set, subject to certain exceptions. You or your personal representative will be required to complete a form to request amendment of the PHI.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30 day extension if the Fund is unable to comply with the 60 day deadline. If the Fund denies your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You may contact the Privacy Official at the address and phone number previously listed on page 7-5. You or your personal representative will be required to complete a form to request amendment of your PHI.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. The Fund does not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing.

The Fund has 60 days to provide the accounting. The Fund is allowed a single 30 day extension if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12 month period, the Fund may charge a reasonable, cost-based fee for each subsequent accounting.

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, absent notice of restrictions under the Fund's Right to Request Restrictions on the Use and Disclosure Policy and Procedures, the Fund will automatically consider a spouse to be the personal representative of an individual covered by the Plan. In addition, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse or a parent may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Fund restrict access to PHI by family members.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative.

Maintaining Your Privacy

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

The Fund reserves the right to change its privacy practices. If a privacy practice is changed, Participants will be advised by U.S. Mail of any revised provisions within 60 days of the effective date of any material change to the uses or disclosures of PHI, your individual rights, the duties of the Plan, or other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations: disclosures to or requests by a health care provider for treatment, uses or disclosures made to you, uses or disclosures made pursuant to your authorization, disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA, uses or disclosures required by law, and uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

The PHI requirements do not apply to information that has been de-identified. De-identified information is information that: does not identify you, and with respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose "summary health information" to the Plan Sponsor for purposes of obtaining premium bids or modifying, amending or terminating the group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the following official:

Richard F. Weiss, Privacy Oficial
Connecticut Laborers' Health Fund
435 Captain Thomas Boulevard
West Haven, CT 06516-5896
Phone: (800) 922-3240
Fax: (203) 933-1083

You may also file a complaint with:

Secretary of the U.S. Depatment of Health and Human Serices
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Fund will not retaliate against you for filing a complaint.

All Other Uses & Disclosures of Your PHI

All other uses or disclosures of your PHI will only be made with your authorization or the authorization of a duly appointed personal representative pursuant to the Fund's Recognition of Personal Representative Policy and Procedures.

If you have any questions regarding this notice of HIPAA Privacy Practices or the subjects addressed in it, you may contact the Privacy Official at the address and telephone number previously.

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This description attempts to summarize the regulations. The regulations will supersede this description if there is any discrepancy between the information in this description and the regulations.

8 MISCELLANEOUS PROVISIONS

A. Misrepresentation and Fraud

In the event a Participant or dependent receives benefits, as a result of misleading representation or any type of false information or other fraudulent representations to the Fund, such person will be liable to repay all amounts paid by the Fund. Fraud includes such person's failure to disclose any other group health coverage to the Fund, including that charges are work-related and not disclosing that a third party is or may be responsible. The Participant or dependent will also be held liable for all costs of collection of the amounts, including interest and attorney's fees.

B. Overpayments and Erroneous Payments

If a claim payment is made to a Participant or assigned to a provider that is later determined to be an overpayment or an erroneous payment, the Board of Trustees may offset future claim payments or take any other action they deem appropriate in order to recover the overpayment or erroneous payment.

C. Notices Sent to Addresses of Participants

The Board of Trustees and/or the Fund Office will give notice by mail to Participants of actions taken with respect to eligibility, claims, and other important matters.

All such notices will be sent to your address, as it appears in the Health Fund's records. To protect yourself and your rights, you must be sure the Fund always has your current address.

If you fail to notify the Health Fund of your current address, you may miss receiving an important notice and might lose valuable rights or benefits. You may even lose coverage.

Any notice sent to you at the address in the Health Fund's records will be deemed to have been received by you. The time in which you must reply to such a notice will not be extended because you did not give the Fund Office your current address.

9 COST SAVING MEASURES

A. Physician's Fees and Treatment Plans

Whenever possible, you should use an in-network physician, hospital, laboratory or imaging provider. If you use an out-of-network provider, you should ask your physician about his treatment and medical fees, as it is important to know whether the Health Fund will recognize these fees as "reasonable and customary." Remember that coverage under this Plan for out-of-network services is limited to the reasonable and customary charges for the services in question. In addition, out-of-network deductibles and coinsurance apply. You are liable for charges above reasonable and customary charges billed by a physician or other provider and this amount will not count towards your annual out-of-pocket maximum. You do not have this risk of being billed above the allowance recognized by the Health Fund if you utilize a network provider.

B. Bills and Unnecessary Services

Review your medical bills thoroughly to assure correct calculations and payments. When deciding upon the methods for treatment, avoid requesting unnecessary services. For example, you may reduce your expenses by:

1. Periodically having a routine physical examination and maintaining a medical history with a physician;
2. Avoiding weekend hospital admissions;
3. Obtaining a second surgical opinion;
4. Taking advantage of outpatient surgery;
5. Making use of this Plan's utilization review program (refer to Section 26); and
6. Requesting generic drugs when available.

By adhering to these suggestions, you may utilize your benefit to its fullest, while simultaneously cutting medical costs.

C. Reliance on Coverage Advice

If you contact Aetna to determine if a particular service, procedure, or medication is a covered expense, including eligibility and other advice, unless you receive written confirmation, the Plan is not necessarily responsible for these representations. If there is any question about eligibility or coverage of a specific service, procedure, or prescription drug **you should <u>not</u> rely on any verbal representation** from Aetna or the Fund Office, but request confirmation in writing to assure that there will be no misunderstandings.

⑩ COORDINATION OF BENEFITS

A. Duplicate Coverage of Medical and Dental Expenses

This Section describes the circumstances when you or your covered dependents may be entitled to medical and/or dental benefits under this Plan and may also be entitled to recover all or part of your medical and/or dental expenses from some other source. It also describes the rules that apply when this happens.

There are several circumstances that may result in you and/or your covered dependents being reimbursed for your medical and/or dental expenses not only from this Plan but also from some other source. This can occur if you or a covered dependent is also covered by:

1. Another group or individual health care plan; or
2. Medicare or some other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, or any coverage either provided by a federal, state or local government or agency, or any coverage required by federal, state or local law, including, but not limited to, any motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law; or
3. Workers' Compensation.

Duplicate recovery of medical and/or dental expenses can also occur if a third party is financially responsible for your medical and/or dental expenses, such as in the case of negligence or an intentionally wrongful action committed by another person or entity against you.

This Plan operates under rules that prevent it from paying benefits which, together with the benefits from any other source described above, would allow you to recover more than 100% of the reasonable and customary medical and/or dental expenses you incur. In many instances, you may recover less than 100% of those medical and/or dental expenses from the duplicate sources of coverage or recovery. In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered dependent actually recover some or all of your losses from a third party.

Furthermore, under the Coordination of Benefits provisions, an eligible dependent also covered under another group plan which includes programs such as a Utilization Review Program and/or Hospital Pre-Admission Certification and Continued Stay Review requirements, will not receive any payment or compensation from this Health Fund for reductions in benefits paid by the "other plan" because of the failure of your dependent to utilize the "other plan's" mandatory programs.

For example:

If the "other plan" requires that your dependent call them before a scheduled surgery or hospital stay, and your dependent fails to do this which results in a reduction in benefits or no benefits from the "other plan", this Plan will not reimburse you or your dependent for what the "other plan" failed to pay.

These reductions or penalties may be, for example, flat dollar reductions or a lower percentage of the benefit paid. In addition, if your dependents are covered under an HMO or similar type program which is considered the "Primary Plan," they must utilize the facilities listed in their Plan before the Health Fund will consider secondary payment.

Important:

In the event that an employer offers group health insurance coverage for your spouse and your spouse elects other compensation from the employer (e.g., bonuses, vacation time, or other benefits) instead of health insurance coverage, then benefits payable under this Plan will be coordinated with the other available health insurance coverage, even though your dependent spouse elected not to be covered by the employer's plan. This means that the Connecticut Laborers' Health Fund will only assume secondary liability for the payment of any claims your dependent spouse incurs and your spouse's employer's group health insurance plan will be considered the primary payor, although such coverage was not elected and your spouse will receive limited, if any benefits under this Plan.

If another plan is primary under this Plan's rules, and the other plan contains a provision capping its benefits for you or your eligible dependents because you or your eligible dependents has coverage under this Plan, and that provision has the effect of shifting coverage liability to this Plan in a manner which the Trustees determine to be designed to avoid the usual operation of this Plan's

coordination of benefits rules, then this Plan shall not be liable to provide benefits unless and until the other plan provides as the primary plan its customary benefits, determined without regard to such a cap.

The important thing to remember is that Coordination of Benefits is designed for just one purpose-to conserve your health care dollars. This protects the entire Plan from unnecessary increases in cost, which will help protect you and your fellow workers.

B. Coordination of Benefits (COB) Definitions

It is important to review the following definitions so you will understand the concept of Coordination of Benefits:

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is provided by any one of the plans that cover the person for whom a claim is made. When the benefits from a plan are in the form of services, not cash payments, the reasonable cash value of each service is both an allowable expense and a benefit paid.

Plan refers to any of the following plans, which provide full or partial health benefits for services on an insured or self-funded basis:

1. group, blanket, or franchise insurance;
2. group Blue Cross, group Blue Shield, and any other group HMO or prepayment plans;
3. union welfare plans, employer organization plans, or labor-management trustee plans;
4. governmental programs or coverage required or provided by law. However, "plan" does not include any governmental program coverage which is not allowed by law to coordinate;
5. Medicare, Title XVII of the Social Security Act of 1965, as amended, to the extent permitted by law.

"Plan" will apply separately:

1. to each policy, contract, agreement, or other plan for benefits or services; and
2. to that part of such policy, contract, agreement, or plan which reserves the right to consider the benefits or services of other plans in determining its benefits and to that part which does not.

Primary Plan If a plan is considered "primary," it is responsible for paying first, according to its benefits schedule, all claims for a covered person.

Secondary Plan If a plan is "secondary," it is responsible to pay benefits, if any remain, after the primary plan has paid its share.

C. Coverage Under More Than One Group Health Plan

When and How Coordination of Benefits (COB) Applies – For the purposes of this Coordination of Benefits Subsection, the word "plan" refers to any group or individual medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits for medical or dental services incurred by the covered person or that provides medical or dental services to the covered person. A "group plan" provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage. An "individual plan" provides its benefits or services to individuals or families who have purchased coverage.

Many families that have more than one family member working outside the home are often covered by more than one medical or dental plan. If this is the case with your family, **you must let this Plan know about all your coverage when you submit a claim**.

Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the reasonable and customary medical or dental expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First: Order of Benefit Determination Rules – An individual plan (that is, a plan purchased by an individual), whether provided through a policy, subscriber contract, health care network plan, or group practice or individual practice plan, pays first; and this Plan pays second.

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are

commonly used by insured and self-insured plans. Any group plan that does not use these same rules will be deemed to be the primary plan by this Plan.

If the first rule does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The rules are:

Rule 1: Non-Dependent/Dependent

The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.

There is one exception to this rule. If the person is also a Medicare beneficiary, Medicare is:

1. Secondary to the plan covering the person as a dependent. However, if the dependent is the retiree's spouse and the retiree's spouse is covered under the Medicare Supplement Benefit, Medicare is primary; and
2. Primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee). However, if the Plan covers an individual as an employee, and not a retiree, the Plan is primary and Medicare is secondary.

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

1. The parents are married;
2. The parents are not separated (whether or not they ever have been married); or
3. A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for that child.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

The term **"birthday"** refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first.

If the parents are not married (whether or not they ever were married), or are separated, or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

1. The plan of the custodial parent pays first;
2. The plan of the spouse of the custodial parent pays second;
3. The plan of the non-custodial parent pays third; and
4. The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

The start of a new plan does **not** include a change:

1. In the amount or scope of a plan's benefits;
2. In the entity that pays, provides, or administers the plan; or
3. From one type of plan to another (such as from a single employer plan to a multiple employer plan).

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

D. How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, less whatever payments were actually made by the plan (or plans) that were primary. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid for the reasonable and customary charges for each claim, as it is submitted, had it been the plan that paid first. This has the effect of maintaining this Plan's deductibles, coinsurance and exclusions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the covered health care services.

E. Administration of COB

To administer COB, the Plan reserves the right to: (1) exchange information with other plans involved in paying claims; (2) require that you or your health care provider furnish any necessary information; (3) reimburse any plan that made payments this Plan should have made; or (4) recover any overpayment from your hospital, physician, dentist, other health care provider, other insurance company, you or your dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount that the Fund Office or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the medical and/or dental expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

If this Plan is secondary, this Plan will pay secondary medical benefits only when the coordinating primary plan pays medical benefits, and it will pay secondary dental benefits only when the primary plan pays dental benefits.

If this Plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the Allowable Expense and the benefits paid by the primary plan.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained outside of an exclusive network of providers, like an HMO, or otherwise reduced by a noncompliance penalty, this Plan will only consider such charges after reducing such charges by what the primary plan would have paid if not reduced by such realities.

If this Plan is secondary and the coordinating plan is also secondary because it provides by its terms that it is always secondary, applies the "gender rule" in lieu of the "birthday rule", or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan; this Plan may pay one-half of the benefits it would have paid had it been the primary plan, expecting the other plan to pay the other half of the expenses.

F. Coordination of Benefits With Medicare and Other Government Programs

Medicare Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

If you, your spouse and/or your dependent child are covered by this Plan and by Medicare while you remain actively employed, your health care coverage will continue to provide the same benefits, and this Plan pays first and Medicare will pay second.

If you become totally disabled and entitled to Medicare because of your disability, you will continue to maintain your active coverage until your eligibility for active benefits or extended benefits runs out. You will then have the option to either continue coverage under COBRA or, if eligible, under the retiree Medicare Supplement Program.

If you are covered under Medicare and elect the retiree Medicare Supplement Program, Medicare pays first and this Plan pays second.

If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of:

(1) The month in which Medicare ESRD coverage begins; or

(2) The first month in which the individual receives a kidney transplant.

Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Medicare Risk or Medicare Replacement Programs. Participation in a Medicare Replacement Private Insurance Program is in lieu of the Connecticut Laborers' Retiree Medicare Supplement Program. Those private contracts are in lieu of benefits provided under the Medicare Supplement Program. There is no coordination of benefits between this Plan and a Medicare Risk or Medicare Replacement Plan.

Medicaid. If a covered individual is covered by both this Plan and Medicaid, Medicaid pays first and this Plan pays second.

Military Insurance Coverage. If a covered individual is covered by both this Plan and Military Insurance, Military Insurance pays first and this Plan pays second.

Veterans Affairs Facility Services. If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are medically necessary and the charges are reasonable and customary. For a Medicare eligible retiree, VA charges will be considered as if Medicare had paid on a primary basis.

Other Coverage Provided by State or Federal Law. If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

G. Motor Vehicle No-fault Coverage Required by Law

If you or your dependent is involved in a motor vehicle accident and you have or are required by state law to have basic reparation coverage, your insurance carrier will be primarily liable for lost wages, medical surgical, hospital, and related charges.

Regardless of whether this Plan is primary or secondary, you or your dependent (if an adult) may be required to sign a Reimbursement Agreement and Consent to Lien (see Section 11) before any claims relating to the accident will be paid. The Reimbursement Agreement permits the Fund to receive reimbursement for expenses paid by the Fund that you recover through litigation or settlement with another party or insurance company.

H. Coordination of Benefits with Medicare for Active Employees

If you or your spouse are age 65 or older, you are eligible for insurance benefits under Title XVIII of the Social Security Act of 1965 (Medicare). You do not have to be retired to receive these benefits. Medicare includes hospital insurance benefits (Part "A"), as well as supplementary medical insurance (Part "B"). While you remain eligible for active insurance coverage, regardless of your age, you will receive the same benefits from the Health Fund as an eligible Participant under age 65. Medicare will provide secondary coverage for some care, if the Fund does not pay the full cost. In technical terms, the Fund is

"primary" (pays first) for your covered medical and hospital expenses, while Medicare is "secondary" (pays second).

If a claim is incurred by an eligible dependent covered by Medicare while you maintain active eligibility (an employee), the Health Fund is "primary" (pays first) and Medicare is "secondary" (pays second).

Coverage for Disabled Participants or Participants' Disabled Dependents – If you or one of your eligible dependents, while under age 65, are entitled to Medicare benefits: (1) solely because you or one of your eligible dependents are in the first 30 months of end stage renal disease (ESRD) care, or (2) solely on the basis of a total and permanent disability (except ESRD), as defined by the Social Security Administration, this Plan will be primary for meeting your medical expenses, provided you are insured under this Plan as an active Participant or as a dependent of an active Participant. Medicare will provide coverage on a secondary basis. Therefore, any covered charges should be submitted to this Plan for payment. Afterwards, any unpaid balance should be submitted to Medicare for their consideration.

Medicare Enrollment If you are actively employed, Part A coverage under Medicare is not automatic when you reach age 65 unless you have applied for Social Security Benefits. Since Part A coverage is not automatic, you and your spouse MUST register with Social Security for Part A when you reach age 65. You do not have to receive Social Security payments – that is, actually retire – but you must apply and establish your entitlement to such benefits in order to be covered by Medicare.

You should also enroll in Part B during the seven-month period beginning three months before and ending three months after your 65th birthday. Failure to apply for Medicare coverage under Part A and Part B, when you are eligible to do so, will result in a higher cost to you for Medicare coverage at the time you finally apply.

For retirees ages 65 and older who are entitled to Medicare benefits please disregard this Section and refer to Retiree Benefits in Section 29.

11 THIRD PARTY LIABILITY AND RIGHT OF REIMBURSEMENT

A. Payment Prior to Determination of Responsibility of a Third Party

The Plan does not cover nor is it liable for any charges or expenses incurred by a Participant or eligible dependent (the 'claimant") as a result of an accident or injury for which one or more third parties are or may be legally liable. The Plan is also not liable for any disability income payments if the disability is the result of an accident or injury for which one or more third parties may be legally liable. Also see Section 27 for General Limitations and Exclusions. However, subject to the terms and conditions of this Section, the Board of Trustees, in its discretion, may advance payment for some or all of a claimant's expenses, and may provide the Participant with disability income payments (if the Participant otherwise qualifies) after receipt of a properly executed Reimbursement Agreement and Consent to Lien. In addition, acknowledgment of the Agreement must be provided to the Fund Office by the claimant's attorney. The Reimbursement Agreement and Consent to Lien, and Acknowledgment must be executed without alteration or any other condition.

Where the Plan has made payments for an injury, irrespective of any signed, written agreement, the Plan shall have the right to recover from the claimant the full amount of benefits paid, without deductions or adjustments of any kind, if the claimant obtains any settlement, judgment, arbitration or recovery from a third party or from any insurance provider or other source. In such event, the Plan will have a first lien on any such recovery and must be promptly reimbursed in full within 30 days, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The claimant shall first reimburse the Fund out of any recovery before the claimant is entitled to any portion of the recovery and without regard to the extent of the recovery that has been or may be provided to the claimant.

As noted above, the Plan has the right to recover the full amount of benefits paid by the Plan, without deductions or adjustments of any kind. For example, there is no deduction or adjustment for attorney's fees incurred by the claimant in obtaining the settlement, judgment, arbitration or recovery. The Plan's lien is not reduced by any such attorney's fees. Regardless of the sufficiency of any recovery, the Plan is not subject to any state law doctrines, including, but not limited to the common fund doctrine, which would purport to require the Plan to

reduce its recovery by any portion of a claimant's attorney's fees and costs. The Plan is also not subject to the make whole doctrine, or other similar doctrines, which purport to subject the Plan's recovery to the claimant's full compensation for all of his or her injuries.

In the event the claimant fails to reimburse the Fund from proceeds received from a third party, the Fund will also have the right to withhold future benefits equal to the amount otherwise due the Fund, plus interest and the costs of collection, including attorneys' fees.

B. Reimbursement Agreement and Consent to Lien

As noted earlier, every claimant on whose behalf an advance may be payable must execute and deliver to the Fund a Reimbursement Agreement and Consent to Lien in a form without alteration provided by the Fund. Each such claimant must promptly notify the Health Fund if he or she makes a claim or brings an action against any third party or if he or she obtains any settlement, judgment, or other recovery from any source.

Nevertheless, if any claimant does not execute any such Reimbursement Agreement and Consent to Lien for any reason, it will not waive, compromise, diminish, release, or otherwise prejudice any of the Health Fund's reimbursement rights if the Health Fund, at its discretion, makes an advance or inadvertently pays benefits in the absence of a reimbursement agreement.

The Health Fund's standard administrative procedure will be to determine whether a third party might potentially be held liable in connection with an accident or injury. Claims will not be paid until this determination is made. If it is determined that the claim may be the result of a third-party's negligence or other misconduct, the Health Fund will not process any claims without a properly signed Reimbursement Agreement and Consent to Lien along with acknowledgment by the claimant's Attorney, both executed without alteration or other condition.

C. Cooperation with the Plan by All Covered Persons

By accepting an advance for related claim payments, every claimant agrees to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Health Fund's reimbursement rights.

This Health Fund is a self-insured employee welfare benefit plan, and therefore, ERISA preempts any state law purporting to restrict the Health Fund's rights under this provision. Furthermore, any state law directed at insurance companies shall not apply to the Health Fund since it is self-insured.

E. No Fault Insurance Coverage

Where the Participant or his dependent is involved in a motor vehicle accident covered by a No-Fault Insurance policy, whether or not required by state insurance law, the motor vehicle No-Fault Insurance carrier will initially be liable for lost wages, medical, surgical, hospital, and related charges and expenses up to the greater of:

- The maximum amount of basic reparation benefit required by applicable law; or
- The maximum amount of the applicable No-Fault Insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of the respective Plan in which you are provided health coverage. Before related claims will be paid through this Fund, the Participant or his dependent may be required to sign a Reimbursement Agreement and Consent to Lien.

If the Participant or his dependent fails to secure No-Fault Insurance if required by state law, the Participant or dependent is considered as being self-insured and must pay the amount of the basic medical reparation expenses for himself and/or his dependents arising out of the accident.

F. Refund of Overpayment of Benefits – Right of Recovery

If the Fund pays benefits for expenses incurred on account of you or your eligible dependent, you or any other person or organization that was paid must make a refund to the Fund if:

1. All or some of the expenses were not paid, or did not legally have to be paid, by you or your eligible dependents;
2. All or some of the payment made by the Fund exceeds the benefits under the Plan; or

By accepting an advance payment for claims related to an injury, every claimant agrees to notify and consult with the Board of Trustees, its Fund Office or designee, before:

1. Starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the claimant's injury that resulted in the Health Fund's advance payment of claims; or
2. Entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or contributed to the claimant's injury that resulted in the Health Fund's advance for claims related to such injury.

By accepting an advance in claim payments, every claimant agrees to keep the Board of Trustees, its Fund Office or designee, informed of all material developments with respect to all such claims, actions, or proceedings.

D. All Recovered Proceeds Are to Be Applied to Reimbursement of the Fund

By accepting an advance payment of claims for an injury, every claimant agrees to reimburse the Health Fund for all such advances, by applying any and all amounts paid or payable to them by any third party or that third party's insurer by way of settlement, judgment, arbitration or recovery, or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized as being paid on account of the medical expenses for which any advance has been made by the Health Fund. The Health Fund shall have the right to recover from the claimant the full amount of benefits paid, without deductions or adjustments of any kind, including attorney's fees. In such event the Health Fund must be fully reimbursed within 30 days of the date proceeds are received by the claimant or his/her attorney, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The Health Fund may offset future benefits in order to receive the full amount of benefits paid if full reimbursement is not made.

Furthermore, once the claim is settled, the Health Fund is not liable for and will not pay future benefits for claims related to that injury or accident.

3. All or some of the expenses were recovered from or paid by a source other than this Plan including another Plan to which this Plan has secondary liability under the Coordination of Benefits provisions. This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions.

The refund shall equal the amount the Fund paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Fund paid.

If you, or any person or organization that was paid, do not promptly repay the full amount, the Fund may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required repayment, plus interest. The Fund may have other rights in addition to the right to reduce future benefits.

⑫ COBRA CONTINUATION COVERAGE

You and your eligible dependents have the right to continue your benefit coverage under this Plan on a self-pay basis, upon no longer satisfying the eligibility rules of the Health Fund or if coverage would otherwise terminate due to a Qualifying Event. Additional information regarding COBRA is available from the Plan Administrator.

Qualifying event means one of the following occurrences which would otherwise terminate your or your eligible dependent's coverage in the absence of COBRA continuation availability:

1. Your loss of eligibility due to termination or reduction in hours;
2. Your death;
3. Your divorce or legal separation;
4. With respect to your dependent child, ceasing to satisfy the Health Fund's definition of an eligible dependent.

Address to Notify Plan Administrator (Fund Office) of a Qualifying Event and to Request Additional Information

Connecticut Laborers' Health Fund
435 Captain Thomas Boulevard
West Haven, CT 06516-5896
Attention: COBRA Administrator
Phone: (800) 922-3240
Fax: (203) 933-1083

A. Election Period

You and/or your eligible dependents must make a written election to continue coverage within 60 days of:

1. The date you and/or your eligible dependents would otherwise lose coverage due to the qualifying event; or
2. The date you and/or your eligible dependents are notified of your right to elect the continuation coverage.

WHEN THE PLAN MUST BE NOTIFIED OF A QUALIFYING EVENT – VERY IMPORTANT INFORMATION

As a covered employee or other qualified beneficiary, you are responsible for providing the Fund Office with timely notice of certain qualifying events. You must provide the Fund Office with notice of the following qualifying events:

1. The divorce or legal separation of a covered employee from his or her spouse.
2. A beneficiary ceasing to be covered under the plan as a dependent child of a Participant.
3. The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA with a maximum of 24 months. This second qualifying event could include an employee's death, entitlement to Medicare, divorce or legal separation or child losing dependent status.

In addition to these qualifying events, there are two other situations where a covered employee or other qualified beneficiary is responsible for providing the Fund Office with notice within the time frame noted in this Section:

4. When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 24 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time that an individual is disabled during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible to extend the 24 month maximum coverage period, until eligible for Medicare.
5. When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Fund Office is notified of any of these five occurrences listed above. Failure to provide notice within the time frames described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.

How Should A Notice Be Provided?

Notice of any of the five situations listed above must be provided in writing to the Fund Office. Contact the Fund Office and they will provide you with a COBRA election form. You may use the Fund's "COBRA Notice Form for Covered Employees and Other Qualified Beneficiaries" to provide notice to the Fund. You may obtain a copy of this form by contacting the COBRA

Administrator at the address previously listed in this Section. Alternatively, you may send a letter to the Fund containing the following information: your name, the identity for which of the five events listed above you are providing notice, and the date of the event.

To Whom Should the Notice Be Sent?

Notice should be sent to COBRA Administrator at Connecticut Laborers' Health Fund at the address previously listed in this Section. Notice may be sent by first class mail.

When Should the Notice Be Sent?

If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage or a second qualifying event, you must send the notice no later than **60 days after the later of:** (1) the date of the relevant qualifying event; or (2) the date upon which coverage would be lost under the Plan as a result of the qualifying event.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than **60 days after the later of:** (1) the date of the disability determination by the Social Security Administration; (2) the date of the qualifying event; or (3) the date on which the qualified beneficiary would lose coverage under the Plan due to the qualifying event.

If you are providing notice of a Social Security Administration determination that you are **no longer** disabled, notice must be sent no later than **30 days after** the date of the determination by the Social Security Administration that you are no longer disabled.

Who Can Provide a Notice

Notice may be provided by the covered employee or other qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or other qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if an employee, spouse and child are all covered by the Plan, and the child ceases to be a dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

Once the Fund Office receives notice of a qualifying event, it will then send you, your spouse and/or dependent child an election form and information about

continuation coverage. **Important: If you do not notify the Fund Office of a Qualifying Event within 60 days of the date of the event, you will lose your right to elect COBRA coverage entirely.**

In order to protect your family's rights, you should keep the Fund Office informed of any changes in address of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

How to Elect COBRA Continuation Coverage

Step 1. In order to elect COBRA Continuation Coverage, the Fund Office must be notified when you experience a Qualifying Event. You must notify the Fund Office within 60 days from the date that the Qualifying Event Occurs, or the date that you would lose coverage under the Fund because of the Qualifying Event, whichever is later.

Your Employer may notify the Fund Office in some cases, such as in the event of your termination of employment, reduction in hours, or retirement. In other cases, you or your dependent must notify the Fund Office, as described above.

Within 60 days of the event that would cause you to lose your health coverage, you must inform the Fund Office that you want continuation coverage. No evidence of insurability is required. If you do not choose continuation coverage, your group health insurance coverage will end.

Step 2. Once the Fund Office sends you your COBRA election materials, you have **60 days** to make an election.

Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA Continuation Coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. A parent or legal guardian may elect continuation coverage for a minor child.

Step 3. Once the Fund Office receives your election material, they will notify you of the amount of premium you owe. You will have 45 days from the date you made your COBRA election to pay all premiums owed for the period. If payment is not received, COBRA coverage will be cancelled retroactively to the date your coverage under the Plan terminated.

Step 4. Your monthly payments are due on the 1st day of each month. You will have a 30 day grace period in which to pay. Payments should be mailed to the

Fund Office. If you do not make payment by the end of the grace period, your coverage will be cancelled retroactively to the last day of the previous month, with no provision for reinstatement.

If you have any questions or need additional information about COBRA coverage, please contact the Connecticut Laborers' Health Fund Office at the address previously listed in this Section.

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 federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63 day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get 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 events 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.

Notice of Unavailability of Coverage

Where you or your dependents have provided notice to the Fund Office of a divorce or legal separation, a beneficiary ceasing to be covered under the Plan as a dependent, or a second qualifying event, but are not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within 15 days of your notification of the qualifying event.

Once you elect your Plan of Benefits described in paragraph F later in this Section of the booklet, you may <u>not</u> change your election. Once you elect single or family coverage, you are not allowed to change your election UNLESS you get married, your spouse dies, or you acquire a dependent child.

B. Continuation Period

Coverage may continue on a self-pay basis as follows:

Qualifying Events and Maximum Periods of Continuation of Coverage

Qualifying Event	Employee	Spouse	Dependent Child(ren)
a. Laborer loses eligibility	24 months*	24 months*	24 months*
b. Laborer dies	N/A	36 months	36 months
c. Laborer becomes divorced or legally separated	N/A	36 months	36 months
d. Laborer becomes entitled to Medicare	N/A	36 months	36 months
e. Dependent child ceases to have dependent status	N/A	N/A	36 months
f. Disability as certified by Social Security Administration of any COBRA covered beneficiary	29 months	29 months	29 months

* *COBRA regulations only require the Fund to offer COBRA coverage for an 18-month period. However, the Fund has elected to extend this period to 24 months.*

If the qualifying event elected in (a) above occurs, the COBRA coverage period is extended up to a total of 36 months if a second qualifying event listed in (b), (c), (d), or (e) occurs while the spouse or dependent is covered under COBRA due to the qualifying event described in (a). The COBRA coverage period described in (a) above also may be extended to a total of 29 months in the case of disability as described in paragraph D in this Section of the booklet.

C. Coverage Provided When COBRA Continuation Coverage Is Elected

If you and/or your dependent(s) choose COBRA Continuation Coverage, the Plan is required to provide coverage that is identical to the current coverage under the Plan that is provided for similarly situated employees or family members.

If, during the period of COBRA Continuation Coverage, you marry, have a newborn child, have a child placed with you for adoption, or become legally responsible for a stepchild or grandchild, that spouse or dependent child may be enrolled for coverage for the balance of the period of COBRA Continuation Coverage on the same plan of benefits previously elected. Enrollment must occur no later than 30 days after the marriage, birth, adoption, or legal responsibility for such child. The same rules about dependent status and qualifying changes in family status that apply to active employees will apply to those dependents. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

If, during the period of COBRA Continuation Coverage, the Plan's benefits change for active employees, the same changes will apply to you and/or your dependent(s).

D. Changes to Maximum Period of COBRA Continuation Coverage

Multiple Qualifying Events

If your continuation coverage is for a maximum period of 24 months, and during that period, another qualifying event takes place that would otherwise entitle a spouse or dependent child to a 36 month period of continuation coverage, the 24 month period will be extended for that spouse or dependent child. The total period of coverage for any spouse or dependent child will never exceed 36 months from the date of the first qualifying event.

For example:

If you terminated employment and elected COBRA Continuation Coverage for 24 months for you and your covered spouse and/or dependent child(ren), and died during that 24 month period, the continuation coverage for your spouse and/or dependent child(ren) could be extended for the balance of 36 months from the date your employment terminated.

However, if you become entitled to COBRA Continuation Coverage because of termination of employment or reduction in hours worked that occurred less than 24 months after the date you became entitled to Medicare (Part A, Part B or both), your spouse and/or dependent child(ren) would be entitled to a 36 month period of COBRA Continuation Coverage beginning on the date you became entitled to Medicare.

For example:

If termination of employment occurred less than 24 months after the date you become entitled to Medicare, your spouse and/or dependent child(ren) would be entitled to COBRA Continuation Coverage for a 36 month period beginning on the date you became entitled to Medicare.

E. Entitlement to Social Security Disability Income Benefits

If you, your spouse or any of your covered dependent child(ren) are entitled to COBRA Continuation Coverage for a 24 month period, that period can be extended for the covered individual who is determined to be entitled to Social Security disability income benefits and for any other covered family members, for up to 5 additional months if **all of the following conditions** are satisfied:

1. The disability occurred on or before the start of COBRA Continuation Coverage, or within the first 60 days of COBRA Continuation Coverage; and
2. The disabled covered individual receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration; and
3. The Plan is notified on a timely basis as previously described.

This extended period of COBRA Continuation Coverage will end at the earlier of the end of 29 months from the date of the qualifying event or the date the disabled individual becomes entitled to Medicare. Of course, coverage will also cease if premiums are not paid.

F. Benefit Options

If you choose to continue your coverage, the Health Fund will give you the option to elect either:

1. The same full plan of benefits called Core Plus Non-Core Benefits (Plan A) that is being provided to active Participants and eligible dependents, but excludes Weekly Disability Income Benefits; or
2. The same full plan of benefits called Core Plus Non-Core Benefits (Plan B) that is being provided to active Participants and eligible dependents, but excludes Life Insurance, AD&D and Weekly Disability Income

Benefits; or

3. A partial plan of benefits called the Core Only Benefits extending to you and/or your eligible dependents the Hospital/Medical and Prescription Drug Benefits only, Excluding Life Insurance, Accidental Death and Dismemberment, Weekly Disability Income Benefits, Dental, Orthodontic, TMJ, Hearing, and Vision Benefits.

You can only elect a continuation of the coverage you had previously as an active Participant. You cannot elect Non-Core benefits independently from basic Core Benefits (hospital/medical and prescription drug).

After an election is made regarding COBRA coverage, no change will be allowed in the level of coverage for the duration of the continuation period although transfers between "single" and "family" coverage will be permitted if warranted based upon changes in family status, as described above.

Self-Payment Plan of Benefits

The benefits listed below under the three COBRA plan options are the same benefits provided to active Participants and eligible dependents unless otherwise stated.

Plan A – Core Plus Non-Core Plus Life Benefits (Eligible Participants only)

Hospital/Medical Expense Benefits
Prescription Drug Benefit
Life Insurance/Accidental Death and Dismemberment Benefit
Dental Expense Benefits
Orthodontic Expense Benefit
Temporomandibular Joint Dysfunction Benefit
Vision Care Benefit
Hearing Care Benefit
Connecticut Laborers' Family Services Program

Plan B – Core Plus Non-Core Benefits

Hospital/Medical Expense Benefits
Prescription Drug Benefit
Dental Expense Benefits
Orthodontic Expense Benefit
Temporomandibular Joint Dysfunction Benefit
Vision Care Benefit
Hearing Care Benefit

Connecticut Laborers' Family Services Program
Plan C – Core Only Benefits

Hospital/Medical Expense Benefits
Prescription Drug Benefit
Connecticut Laborers' Family Services Program

G. Termination of COBRA Coverage

Coverage under COBRA will cease on the first of the following dates:

1. The date you or your eligible dependent becomes covered under another health plan, following an election to receive COBRA coverage under this Plan;
2. The date the Plan terminates;
3. The date the required premium is due and unpaid following the applicable grace period of 30 or 45 days;
4. The date you and/or your dependents become entitled to Medicare;
5. The date the applicable period of continuation is exhausted (24, 29, or 36 months);
6. The date you reestablish eligibility under the Health Fund; or
7. In the case of extended coverage due to disability, the Social Security Administration has made a final determination that the disabled individual is no longer disabled.

In addition, COBRA Continuation Coverage will cease if the employer that you worked for before the qualifying event stops contributing to the Plan, and that employer either establishes one or more group health plans covering a significant number of employees formerly covered under the Plan or that employer starts contributing to another multiemployer group health plan.

Continued coverage may also cease on the date you and/or your dependents become insured under another group plan, regardless of whether the new benefits are the same as your current benefits, with the exception of a Pre-Existing Condition exclusion in your new health plan. If the "other" plan does have a Pre-Existing Condition limitation that applies to you or one of your covered dependents, you may retain your COBRA coverage. Please contact the Fund Office for additional information when you and/or your dependents

become insured under another group plan.

Other Information About COBRA Continuation Coverage

If the coverage provided by the Plan is changed in any respect for active Plan Participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

If you retire and run out your active eligibility, you may elect, if eligible, retiree coverage (see Section 29) or you will be permitted to make COBRA self-payments upon the expiration of your active eligibility.

H. Monthly Self-Pay Rates

The Board of Trustees will set premium payments according to federal law which allows the monthly self-payment to be set at a level not to exceed the full expected average group cost of such benefits, plus administrative expenses (up to a maximum of 102% of the full expected group cost). If the cost changes, the Fund Office will revise the charge you are required to pay. In addition, if the benefits change for active Participants and those same benefits are provided to you under your specific COBRA coverage, your coverage will change as well.

I. Notice to Providers of Health Care Continuation Coverage

If you, your spouse or dependent child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect; and a health care provider requests confirmation of coverage, COBRA Continuation Coverage will be confirmed, but with notice to the provider that the cost of the COBRA Continuation Coverage has not been paid and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

J. Another Employer-Sponsored Health Plan

If you are or expect to be covered by another employer-sponsored health plan (including a plan of your spouse's employer), a recently passed federal law

guarantees you certain rights under that plan which you should consider when making your decision about COBRA Continuation Coverage.

Under the Health Insurance Portability and Accountability Act (HIPAA), the period during which a group health plan may exclude or limit coverage for Pre-Existing Conditions is reduced or eliminated for the individual who had previous health coverage under another group health plan. However, credit is not given for earlier coverage if it was allowed to lapse, without replacement, for at least 63 days. If there is a delay before you can enroll in a new plan, a break in health coverage may be avoided by maintaining COBRA Continuation Coverage in the meantime.

K. Electing COBRA Instead of Retiree Benefits

If you are eligible for Retiree Benefits from the Health Fund and elect COBRA Continuation benefits instead, you **will not** be permitted to enroll in the Retiree Plan in the future. If you are continuing your coverage by making COBRA self-payments and subsequently retire, you will be given the opportunity to participate in the Retiree Plan.

L. Additional COBRA Election Period and Tax Credit in Cases of Eligibility for Benefits Under the Trade Act of 1974

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your dependents did not elect COBRA during your election period, but are later certified by the DOL for Trade Act benefits or receive pensions managed by the Pension Benefit Guaranty Corporation (PBGC), you may be entitled to an additional 60 day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan.

Also under the Trade Act eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

13 WORKERS' COMPENSATION CLAIMS

Medical expenses covered by the Health Fund are for services and supplies received for the treatment of non-occupational bodily injuries and illnesses. If you incur a work related injury or illness (one which arises out of or in connection with your employment), your claim for any medical expenses arising out of or in connection with that injury or illness must be submitted through your employer for Workers' Compensation coverage. No benefits are payable by the Health Fund for such medical expenses, unless the Workers' Compensation Commissioner determines that the underlying injury or illness is not compensable. These Plan provisions will apply in all circumstances where Workers' Compensation insurance is required, including individuals that are self-employed.

However, if you have been notified that your employer is contesting liability for your Workers' Compensation claim and the Health Fund has received a formal Notice to Contest Liability from your employer or its Workers' Compensation insurance carrier, the Health Fund may, in its sole discretion, pay hospital and/or medical expenses connected to a claimed work-related injury or illness, pending a formal ruling of the Workers' Compensation Commissioner. (The Health Fund will not pay Weekly Disability Income Benefits.) In any event, before payment for medical expenses arising out of or in connection with a claimed Workers' Compensation injury will be advanced by the Health Fund, you will be required to sign a Reimbursement Agreement and Consent to Lien (see Section 11). In order for the Health Fund to consider exercising its discretion to advance payment for hospital or medical expenses connected to a claimed Workers' Compensation injury, the Notice to Contest Liability must challenge liability for the underlying illness or injury, and not just for particular hospital or medical expenses that are contested by your employer or its Workers' Compensation insurance carrier for one reason or another. In other words, the Health Fund will not advance payment for hospital or medical expenses connected to a work-related injury or illness simply because your employer or its Workers' Compensation carrier has contested certain specific hospital or medical expenses.

Although claims relating to an occupational injury or illness must be submitted through the state Workers' Compensation system, the Life Insurance and other health benefits will continue for yourself and your eligible dependents for charges incurred due to non-occupational accidental bodily injuries or illnesses, as long as you maintain eligibility.

Where a claim for Workers' Compensation is settled by stipulation or agreement, you cannot claim benefits for the same disability from the Health Fund. Therefore, if the Health Fund does advance payment for medical expenses connected to a claimed Workers' Compensation injury, and the Workers' Compensation claim is later settled, and/or it is later determined that the injury or illness giving rise to the contested medical expense is work-related, the Health Fund must be reimbursed for any payments to you or your dependents or providers, and for all costs of collection, including attorney's fees and court costs.

14 LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (ELIGIBLE EMPLOYEE ONLY)

A. Life Insurance

In the event of your death from any cause (on the job or off) while you are insured, the proceeds as shown in the Schedule of Benefits will be paid to your named beneficiary. Life Insurance is provided by an insurance company retained by the Board of Trustees on a fully insured basis. Currently, Aetna is that insurer.

B. Accidental Death and Dismemberment Benefit

Accidental Death and Dismemberment Benefits are payable, provided the insurance company retained by the Plan (currently, Aetna) receives written proof that the loss occurred as a result of an accidental bodily injury and independently of all other causes and occurrences.

If while you are insured, you suffer a bodily injury caused by an accident, within 365 days of that accident benefits are payable as follows:
The full Principal Sum is payable for loss of life.
The full Principal Sum is payable for loss of both hands, both feet, or both eyes.
The full Principal Sum is payable for loss of both hearing and speech.
The full Principal Sum is payable for quadriplegia.
The full Principal Sum is payable for third degree burns covering 75% or more of the body.
Half the full Principal Sum is payable for loss of either hearing or speech.
Half the full Principal Sum is payable for loss of a hand, loss of a foot, or loss of an eye.
Half the full Principal Sum is payable for paraplegia or for hemiplegia.
Half the full Principal Sum is payable for third degree burns covering 50% to74% of the body.
One quarter of the Principal Sum is payable for loss of the thumb and index finger of the same hand.
One quarter of the Principal Sum is payable for uniplegia.

Loss of limb means dismemberment or severance at or above the wrist or ankle joint. Loss of sight means the total and irrecoverable loss of sight.

A total loss of speech or hearing will be deemed permanent if the loss has been present for 12 consecutive months.

If more than one of the losses set forth above is suffered, as a result of any one accident, not more than the full amount of Accidental Death and Dismemberment Benefit will be payable.

C. Beneficiary

You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out the proper form and filing it with the Fund Office. If a beneficiary is designated, the beneficiary's consent is not required to change the beneficiary. If your beneficiary predeceases you, such beneficiary's interest will automatically terminate. If you name more than one beneficiary, but do not say how much each beneficiary should receive, the total amount will be shared equally by all surviving beneficiaries. If there is a court order that requires the Participant to name a specific beneficiary, such order shall only be recognized if on file at the Fund Office at the time of death. If there is no living designated beneficiary when you die, the insurance company will make the payment to your surviving spouse; if none, to your surviving children in equal shares; if none, to surviving parents in equal shares; and if none, to your surviving brothers and sisters in equal shares; and if none, to your estate.

D. Facility of Payment

If you die and your estate is the beneficiary, but no administrator of your estate has been appointed within a reasonable period of time following your death, the Health Fund and/or the insurance company in their sole discretion has the right to pay the party it believes is entitled to such payment by reason of having incurred funeral or other expenses incidental to your last illness or death. Once such a payment is made, the Health Fund and/or insurance company has no further obligation with respect to the amount paid.

E. Termination of Coverage

When your coverage terminates in accordance with the termination of eligibility rules of this Plan, your Life Insurance will cease. However, if your death occurs within 31 days after termination of coverage, the death benefit will be payable.

There is no cash value to either the Life Insurance benefit or the Accidental Death and Dismemberment benefit.

F. Assignment

You may not assign your Life Insurance benefit. This means you may not give or transfer your Life Insurance offered through this Plan to any other person.

G. Limitations and Exclusions

No payment will be made for death or any loss under the Accidental Death and Dismemberment benefit resulting from or caused directly, wholly, or partly by:

1. Bodily or mental infirmity, [ptomaines], bacterial infections (except infections caused by [pyogenic] organisms which occur with and through an accidental cut or wound), or disease or illness of any kind;
2. Services for which benefits are not payable according to the "General Plan Limitations and Exclusions" Section of this document;
3. Suicide or attempted suicide while sane or insane;
4. Intentionally self-inflicted injury while sane or insane;
5. Insurrection, riot, act of war for any country;
6. Injury or death during military service for 30 days or more;
7. Travel or flight in or on an experimental or military aircraft;
8. Participation in, or the result of participation in, a felony; or
9. Voluntary use of controlled substances as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a physician for the person.

⑮ WEEKLY DISABILITY INCOME BENEFIT (NON-WORK-RELATED) (ELIGIBLE EMPLOYEE ONLY)

A. In General

If, while covered under the Health Fund and working or available for work in Covered Employment, you become totally disabled, and you are under the continuous care of a physician legally licensed to practice medicine, you will receive the Weekly Disability Income Benefits shown in the Schedule of Benefits. Benefits are payable provided your total disability is not the result of:

1. Any injury arising out of or in the course of employment;
2. Any disease that may entitle you to benefits under any Workers' Compensation, occupational disease law, or similar legislation.

If you incur an accident or injury for which one or more third parties are or may be liable, you will be required to execute a Reimbursement Agreement and Consent to Lien (see Section 11) before Weekly Disability Income Benefits will be paid. **No benefits are payable during periods when the Participant is collecting unemployment benefits.**

These benefits will commence on the 1st day of disability due to injury and on the 8th day of disability due to an illness and will continue during total disability for a maximum of 26 weeks for any one continuous period of disability due to the same or related cause(s).

Once you begin collecting a pension from the Connecticut Laborers' Pension Fund or the Pension Plan for the Staff of the Connecticut Laborers' Funds, you are not eligible for, and therefore cannot collect, Weekly Disability Income Benefits, even though you may continue to be covered under the Health Fund as an active Participant until your eligibility runs out. If you receive both a monthly pension and Weekly Disability Income Benefits for the same time period, you are required to refund any such Weekly Disability Income Benefit payments to the Health Fund.

B. Successive Disabilities

Separate periods of disability, resulting from the same or related causes, will be deemed one period of disability, unless separated by your return to active Covered Employment for at least two (2) consecutive weeks (80 hours over consecutive work days). Separate periods of disability resulting from unrelated causes will be deemed one period of disability, unless separated by your return to active Covered Employment for at least one (1) full day. In addition, Weekly Disability Income Benefits are limited to a maximum of fifty-two (52) weeks in any period of one hundred and four (104) consecutive week periods.

C. Limitations and Exclusions

It is not necessary to be confined to your home to collect benefits, but you must be under the care of a physician. No benefits are payable for:

1. Any day you are not under the care of a physician. It is understood that no disability will be considered to have started until you have been treated personally by a physician;
2. Any day you are receiving compensation or performing work of any kind, anywhere, for compensation or profit;
3. Any day you are released by your physician to engage in work of any kind;
4. A disability due to accidental bodily injuries arising out of and in the course of your employment;
5. Those days for which you are receiving compensation for lost wages from motor vehicle reparation (no-fault) insurance or its equivalent, Workers' Compensation, Unemployment Compensation, or a Pension from the Connecticut Laborer's Pension Plan or the Pension Plan for the Staff of the Connecticut Laborers' Funds; or
6. Services for which benefits are not payable according to the "General Plan Limitations and Exclusions."

Note: Payments received under this benefit are considered as taxable income and must be reported on your federal, state or any other applicable income tax returns. The Fund Office will arrange to have taxes withheld from your disability payments, upon your request. The Health Fund will deduct the FICA tax on your behalf and pay it to the appropriate government agency.

The Health Fund reserves the right to request a second medical opinion of the nature and extent of your disability at any time as a condition of continued receipt of such benefits.

16 IN-NETWORK AND OUT-OF-NETWORK HOSPITAL AND MEDICAL BENEFITS

You and your eligible dependents may obtain health care services from in-network or out-of-network health care providers. The preferred provider network benefits are not available to retirees or their eligible dependents who are eligible for and/or receiving Medicare benefits. You can find a network physician, participating provider, facility, or hospital in your area by contacting the Fund Office, Aetna or accessing Aetna's website at Aetna.com. The first step in locating a network physician, participating provider, facility, or hospital on the website is to click on "members and consumers." The next step is to click on "services and tools." The menu will then reflect a selection "find a doctor." The next screen will allow you to determine the area and type of participating provider you wish to locate in Aetna's network. Contact the Fund Office if you need a copy of the network/participating provider list, and it will be furnished to you at no charge.

A. In-Network Benefits

The Health Fund has contracted with Aetna to utilize their Open Choice Preferred Provider Organization (PPO) of hospitals, physicians, and other providers to provide services at a favorable negotiated discounted fee arrangement. Participants who elect to utilize the Aetna PPO network of quality hospitals, physicians, medical laboratories and other providers receive enhanced benefits.

When you use the services of an in-network Aetna care provider for any medically necessary services, you are responsible only for paying the applicable co-payment. You do not need to meet the plan deductible or pay any additional coinsurance. The co-payment varies depending upon the type of care you receive. Any required co-payment will not be applied to your out-of-network deductible or out-of-pocket maximum. In addition, because Aetna has a contract with the network PPO participating providers, they are prohibited from balance billing you for covered services in excess of their contractual discounted fee.

B. Physician Office Visits, Laboratory, and X-ray services – $15 Co-payment

You are only required to pay a $15 co-payment for a physician office visit, and/or laboratory and x-ray services with a participating provider in the PPO network. The remaining cost of the charges covered will be paid for by the Fund. The $15 co-payment applies to any diagnosis customarily performed in a physician office setting.

C. Inpatient Hospital Admissions – $250 Co-payment

If you are admitted on an inpatient basis to a hospital participating in the Aetna Open Choice Network, you will be responsible for a $250 co-payment for each inpatient admission. (Note: As of August, 2005, all the general hospitals in Connecticut participate in Aetna's network.) For example, if you are admitted to the hospital for surgery regardless of the length of stay, you will only be responsible for the $250 co-payment. The balance of all covered expenses will be paid in full by the Health Fund. This assumes all services while hospitalized are provided by network providers.

In the case of a maternity admission, only one co-payment will be charged if both the mother and newborn are discharged on the same day.

For any hospital stay, please refer to the Utilization Review Program requirements. (See Section 26).

D. Outpatient Hospital and Specialty Services Care

If you are receiving care in a participating hospital or medical facility on an outpatient basis, covered charges will be paid in full. Outpatient hospital care includes, but is not limited to, outpatient surgery, dialysis, imaging services (MRI or CAT Scan, etc.), specialty treatment such as chemotherapy and radiation, special procedures and laboratory tests and x-rays that are performed in a participating hospital or other participating medical facility.

E. Emergency Room - $75 Co-payment

If you receive treatment for an emergency condition at a participating hospital or at a participating freestanding medical/urgent care facility, you will be responsible for a $75 co-payment and the Health Fund will pay the remaining

balance. A medical emergency is the sudden and unexpected onset of condition in which a delay in treatment would endanger your health or life. The following are considered medical emergencies by the Health Fund:

1. Difficulty breathing;
2. Severe burns;
3. Broken bones;
4. Unconsciousness;
5. Excessive bleeding;
6. Suspected heart attack;
7. Acute and sudden pain;
8. Shock; and
9. Any condition for which a physician advises you to seek treatment in an emergency room.

If using the Emergency Room for non-emergency care, a 50% coinsurance rate will apply along with the $75 co-payment.

The emergency room co-payment will be waived if you are admitted to the hospital; however, the inpatient hospital co-payment will apply.

F. Out-of-Network Services

Out-of-network health care providers have no contractual fee agreements with Aetna and/or the Health Fund and are generally free to set their own charges for the services or supplies they provide. The Health Fund through Aetna will reimburse the reasonable and customary charge for any medically necessary services or supplies, which are covered charges, subject to the Health Fund's deductibles, coinsurance, limitations and exclusions. You must submit a claim before any reimbursement will be made, and out-of-network health care providers may bill you for any balance that may be due in addition to the amount payable by the Health Fund.

G. Reasonable and Customary Charges

Benefits paid by the Health Fund to out-of-network providers are subject to reasonable and customary limits as determined by Aetna. Reasonable and customary charge limits only apply to out-of-network benefits and dental benefits. The use of this term may place a limit on the amount the Health Fund pays for the health or dental care you receive.

The **"Reasonable and Customary"** charge for medically necessary services or supplies will be determined by Aetna to be a percentage of the average usual charge by a health care provider for the same or similar service, surgical procedure, or supply in the geographic location where the provider practices; or the health care provider's actual charge.

The Health Fund will not pay more than the reasonable and customary charge for such benefit. The reasonable and customary charges may differ by area, so what is a reasonable and customary charge for a certain surgery in New Haven may differ from the reasonable and customary charge for the same surgery in Waterbury. For example, if your surgeon charges $3,000 for a certain surgery, and the reasonable and customary charge in your area is only $2,000, the Health Fund will consider and pay your claim on the basis of a $2,000 reasonable and customary charge only. **You will be liable for the excess amount.**

Before incurring medical expenses with an out-of-network physician, ask whether his charge for a particular procedure is within the reasonable and customary limits or would he accept as payment the allowance paid by the Health Fund. Otherwise, you may be liable to pay part of the expense out of your own pocket.

H. Out-of-Network Out-of-Pocket Maximum

Generally, the Health Fund will not reimburse you for all covered charges provided by a non-network (out-of-network) physician, hospital or other facility. Usually, you will have to satisfy a deductible or pay some coinsurance toward the amounts you incur that are covered charges. However, once you have met the annual out-of-pocket maximum, which includes your deductible and coinsurance ($200 individual deductible and 20% coinsurance up to the first $5,000 covered expenses; the maximum out-of-pocket cost of $1,200 per individual/$2,400 for family), no further coinsurance will be applied and the Fund will pay 100% of the reasonable and customary covered charges for the remainder of that calendar year.

I. Lifetime Maximum

There is a $500,000 lifetime maximum benefit per illness or injury (combined both in and out-of-network services), as well as certain calendar year maximums applicable to each Plan Participant with respect to certain expenses.

J. Cost Sharing - Services and Charges Not Paid for by the Health Fund

Deductible. The amount you must pay each calendar year before the Health Fund pays out-of-network hospital and medical benefits.

Individual and Family Deductibles. Each year, you are personally responsible for paying all of your covered medical expenses until you satisfy the annual deductible. Then, the Health Fund begins to pay a percentage of the covered charges. There are two types of deductibles applicable to out-of-network services: individual and family. The individual deductible is the maximum amount one covered person has to pay before Health Fund benefits begin. The **Plan's individual deductible is $200.** The family deductible is the maximum amount that a family of two or more is responsible for paying before Health Fund benefits begin. **The Plan's family deductible is $400.**

Carryover of Deductibles. So that your expenses will not be subject to a deductible late in one calendar year and soon again the following calendar year, any covered out-of-network charges incurred during the last 3 months of a calendar year that are applied to the deductible for that year will be applied toward the following year's deductible as well.

Coinsurance. The percentage amount you must pay of the covered services. Once you've met your annual deductible, the Health Fund generally pays 80% of out-of-network covered charges, and you (and not the Health Fund) are responsible for paying the rest. The part you pay (that is, 20%) is called your coinsurance.

Coinsurance When You Don't Comply With Aetna's Utilization Review Program. If you fail to follow the Plan's Utilization Review Program, the Health Fund benefit which would have been payable **will be reduced by 20%**, subject to a maximum reduction of $500 per occurrence.

For example:

If you incur a hospital bill of $2,000, the Health Fund would normally pay 80% or $1,600. However, if you do not comply with the Utilization Review Program, the Health Fund will reduce your benefit and only pay $1,280.

This 20% reduction (up to $500) in the amount of covered expenses also applies to network hospital charges.

For example:

For a $10,000 hospital charge at a network hospital, a Participant would generally only have to pay $250 with the Health Fund paying $9,750. If you do not follow the Plan's Utilization Review Program, you would be responsible for a $250 co-payment, plus, a $500 penalty.

Annual Out-of-Pocket Maximum. The amount of **out-of-pocket expenses** you are responsible for paying each year before the Health Fund pays 100% of most (but not necessarily all) of your covered charges.

Expenses Not Subject to the Out-of-Pocket Maximum. There are expenses for medical services and supplies that you are always responsible for paying yourself. Under the Plan, each year you will be responsible for paying out of your own pocket:

1. Your out-of-network individual or family deductible;
2. Any applicable coinsurance and co-payments, subject to the out-of-pocket maximum shown below;
3. All expenses for medical services or supplies that are not covered by the Health Fund;
4. All charges in excess of the reasonable and customary charge for out-of-network medical and dental services, determined by the Health Fund;
5. All charges in excess of the Health Fund's lifetime maximum benefit, limited overall, and/or annual maximum benefits or in excess of any other limitation of the Plan; and
6. Any additional coinsurance applicable because you failed to comply with the Health Fund's Utilization Review Program.

Out-of-Pocket Maximum Applies Only to Certain Co-payments, Out-of-Network Deductibles and Coinsurance Each calendar year, after an individual incurs maximum out-of-pocket expenses of $1,200 for any individual, or $2,400 out-of-pocket expenses for a family, your coinsurance of 20% for services will not apply to out-of-network charges. As a result, the Health Fund will pay 100% of all out-of-network covered reasonable and customary charges that are incurred during the remainder of the calendar year after the out-of-pocket maximum has been reached. The out-of-pocket maximum does not apply to in-network services. In addition, you will still be responsible for paying all of the expenses

described in the previous paragraph, entitled "Expenses Not Subject to the Out-of-Pocket Maximum." Once you or your family has incurred the annual out-of-pocket maximum, you still will be responsible for paying any applicable co-payments that are not subject to the out-of-pocket maximum.

Out-of-Pocket Maximum When You Do Not Comply With Utilization Review Program If you are required to pay a greater coinsurance amount because you or any of your covered dependents failed to comply with the Health Fund's Utilization Review Program, the excess coinsurance amount or non-compliance penalty you are required to pay will not count toward the annual out-of-pocket maximum.

Maximum Plan Benefit Per Illness or Injury The maximum the Health Fund will pay for all covered charges for an illness or injury is $500,000. This maximum applies whether or not any interruption in the individual's coverage has occurred.

Limited Overall Maximum The most the Health Fund will pay for in a lifetime for a particular Plan benefit. (For example, TMJ benefits are limited to $500 per lifetime.)

Annual Maximum The most the Plan will pay **each calendar year** for a particular Plan benefit. Generally, if you receive services or supplies from an in-network provider, your out-of-pocket costs will be limited to the required co-payment. (For example, chiropractic services are limited to 30 visits a calendar year.)

Finally, certain medical expenses are not covered by the Plan at all. See Section 18 "Medical Expenses Not Covered" and Section 27 "General Plan Limitations and Exclusions," for details about excluded expenses.

17 COVERED MEDICAL EXPENSES

A. Description of Benefits

Medical expenses, whether received from a network or out-of-network provider, are covered by the Health Fund to assist you and your eligible dependents in the payment of medical bills that result from serious or prolonged disabilities, as well as from ordinary injuries or diseases, regardless of the number of injuries or diseases.

B. Covered Medical Expense Benefits

Benefits are payable for the medically necessary charges incurred while you or your eligible dependent is covered under the Health Fund for treatment, services, and supplies ordered by a physician. These include charges as follows:

1. For **hospital expenses** incurred for inpatient treatment, except as otherwise indicated elsewhere in this booklet. Covered room and board charges may not exceed the hospital's average rate for semi-private rooms unless it is medically necessary to isolate the patient to prevent contagion as the result of any infectious disease. If a hospital does not have semi-private rooms, the covered charges will not exceed the average rate for such rooms charged by hospitals located in the surrounding geographic area (for hospital admissions, please refer to the Section on Utilization Review Program in Section 26);

2. For **hospital** charges for **services and supplies** other than room and board charges incurred during an inpatient confinement;

3. For diagnosis, treatment, and **surgery** performed by a physician or surgeon;

4. For rental of **durable medical equipment**, such as wheelchairs and hospital-type beds when accompanied by a prescription from a licensed qualified physician. The benefit limit for renting such equipment shall not exceed the purchase costs. The Fund may purchase such equipment. The Fund will not pay for the purchase or rental of durable medical equipment that is not approved by the Fund, regardless of medical necessity. The Health Fund will provide for the basic equipment required, and the cost of any enhancements for personal or convenience reasons shall be borne by the Participant. If the equipment has been purchased by the Health Fund,

the Health Fund will own the equipment, but has no responsibility for repair, upkeep or modifications of the equipment;

5. For **services of a licensed, qualified physician**, including a specialist for surgical and non-surgical care in a hospital, home, physician's office, or skilled nursing facility (for skilled nursing facility admissions, please refer to the requirements of this Plan's Utilization Review Program in Section 26);

6. For **artificial limbs or eyes** for the initial replacement of natural limbs or eyes, along with replacement after the useful life expectancy of the prosthesis. Prosthetic appliances provided also include the first pair of aphakic lenses (no implant) following cataract surgery, breast prostheses, and surgical brassieres after surgery and cranial prostheses (wigs) for hair loss that is the result of injury or disease (e.g., burns, lupus, Alopecia Totalis, fungus, chemotherapy or radiation) but does not include hair loss that is due to male or female pattern baldness (male or female pattern baldness is not considered a disease or injury). Wigs shall be a covered charge as determined appropriate;

7. For initial trusses, **braces** or supports, **casts**, medically necessary prescribed stockings or elastic bandages or splints used in the reduction of fractures and dislocations and crutches and replacement when medically necessary due to normal wear, change in medical conditions, individual outgrows the device, etc.;

8. For charges made by a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.) for **private duty nursing**, other than a nurse who normally lives in your home or is a blood relative. The Plan requires pre-certification by your physician for the necessity of such care. Services do not include non-medical care, such as bathing, grooming, exercising, feeding, and the administration of medication which can usually be self-administered (for private duty nursing care, please refer to Section 26 on Utilization Review Program);

9. For **rental of an artificial kidney machine** and any medically necessary supplies for dialysis home testing related to the dialysis treatments. Benefits for home hemodialysis do not include furniture, installation charges, or any charges for maintenance purposes;

10. For **diagnostic x-rays and laboratory tests**;

11. For radium, radioactive isotopes, x-ray therapy, and **chemotherapy**;

12. For **anesthesia and its administration**, and inhalation therapy for treatment of a respiratory condition by inhalation of water vapors, oxygen, or other substances;

13. For **local ambulance service** when used to transport you or your eligible dependents from the place where the injury occurred or where the individual was stricken by an illness to the nearest hospital where treatment is rendered; and for local ambulance service from a hospital to another hospital, when the discharging hospital has inadequate facilities for treatment and the receiving hospital has appropriate treatment facilities. Covered charges for the use of an air emergency ambulance will not exceed $5,000 per occurrence;

14. For **blood**, including the cost of blood plasma and blood plasma expanders;

15. For prescription drugs, physical therapy, x-rays, and laboratory services **rendered in a skilled nursing facility**, provided that confinement begins within 14 days following a hospital confinement of at least 3 consecutive days and both the hospital and skilled nursing facility confinement are for the same injury or illness. **No other services or supplies, except those presented in the preceding sentence will be covered when administered in a skilled nursing facility**;

16. For **drugs and medicines** while hospital-confined;

17. For expenses incurred for care in a **neonatal, critical care or intensive care unit**;

18. For **medical and surgical supplies**, such as oxygen, surgical dressing, and colostomy bags. Items ordinarily found in the home for general use like adhesive bandages, petroleum jelly, and thermometers are not covered;

19. For charges made by a legally qualified physician for treatment of **well-baby care** based on the following schedule:
    (a) First year of life - six (6) visits;
    (b) Second year of life - two (2) visits;
    (c) Age two (2) and older - annually.
    These periodic reviews include a medical history, complete physical examination, developmental assessment, anticipatory guidance, immunizations, and laboratory tests;

20. For charges made by a **convalescent facility** for expenses incurred during the first 120 days of confinement per calendar year, provided that confinement begins within 14 days following a hospital stay of at least 3 consecutive days (unless treatment or surgery occurred on an outpatient basis), and provided that the hospital and convalescent facility confinement are both for the same illness or injury (convalescent confinements, please refer to Section 26 on the Utilization Review Program);

21. For therapeutic treatment such as **chiropractic services** for the correction by normal or mechanical means of structural imbalance or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is a result of or related to distortion, misalignment or subluxation, or in the vertebral column and not related to an injury or disability arising out of or in connection with employment. **Such benefits will be payable to a maximum of 30 visits per calendar year. No benefits will be payable for any treatment or services rendered strictly for palliative or maintenance purposes or for conditions not resulting from a muscular or skeletal injury or imbalance**;

22. For charges for services of a **certified nurse-midwife**, up to the reasonable and customary charges which would have been payable if treatment had been rendered at a hospital;

23. For **more than one operation performed through the same incision**, covered expenses recognized by the Plan will be the reasonable and customary charges for the major (largest charge) surgical procedure and 50% of the reasonable and customary charges for each subsidiary surgical procedure. If more than one operation is performed in remote operative fields and through separate incisions, payment for surgical fees will consider the reasonable and customary charges for each totally unrelated, independent surgical procedure (this provision does not apply to surgeries of the foot);

24. For charges for services directly related to and arising from an **organ transplant**, provided such organ transplant coverage is recognized by Aetna. Covered charges shall include any organ or tissue procurement or acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a nonliving donor, or on behalf of a living donor who is not a person covered by this Health Fund and who is not covered

by any other group or individual health care plan up to a maximum of $25,000 related to a donor's expenses. If a living donor is covered by another group or individual health care plan for the expenses related to the donation of an organ or tissue, the Health Fund will reimburse that donor for any deductibles, coinsurance, co-payments, or reasonable and customary expenses related to the procurement or acquisition of the donated organ or tissue that are excluded by the donor's health care plan up to a maximum of $25,000 for a donor's related expenses. You should contact the Fund Office and/or Aetna to determine if a particular organ transplant will be covered under the Health Fund;

25. For charges for **voluntary sterilization** (i.e., tubal ligation or vasectomy [not payable for a dependent child]);

26. For **maternity charges** for a female member or eligible dependent spouse, including charges for complications of pregnancy and circumcision of male newborns. The length-of-stay for a normal vaginal birth is 48 hours from the time of delivery and 96 hours for a cesarean birth unless both the mother and physician agree to a shorter stay. **Maternity charges are not covered for a non-spouse dependent child**;

27. For charges incurred for **diabetic supplies** (i.e., test strips, lancets and autoclix), as well as osteomy/colostomy supplies and insulin infusion pump, when medically necessary and accompanied by a physician's letter of medical necessity;

28. For **autologous blood donations** in anticipation of major surgery for a specific, foreseeable immediate need. Covered expenses include the drawing, storing, and subsequent transfusion of the blood;

29. For **physical therapy** by a licensed physician or physiotherapist, up to **a maximum of 60 treatments in any calendar year**;

30. For one **mammographic examination** annually, or at anytime at the recommendation of a physician;

31. For charges for services or treatment received in an **emergency room** for serious and sudden conditions, which are considered an emergency under the Health Fund, provided care is rendered within 72 hours of the onset of the illness or injury;

32. For charges for, or in connection with, **oral surgery** excluded as a Dental Expense for the prompt repair of natural teeth or other body tissues, as a result of non-occupational accidental bodily injury, including the following:
    (a) Excision of partially or completely unerupted, impacted teeth;
    (b) Excision of a tooth root without extraction of the entire tooth;
    (c) The closed or open reduction of fractures or dislocation of the jaw; or
    (d) Incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

33. For hospital and other medical expenses incurred in connection with **cosmetic surgery** which is necessary as a result of a non-occupational bodily injury or congenital birth defect;

34. For charges recognized by the **Women's Health and Cancer Rights Act of 1998** including: **reconstruction of the breast** on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prosthesis; surgical brassieres; and treatment of physical complications of all stages of mastectomy, including lymphedemas;

35. For expenses incurred for outpatient emergency medical treatment arising from the **ingestion or consumption of a controlled drug.** Benefits for confinement as an inpatient in a lawfully operated hospital, for expenses arising from the ingestion or consumption of a controlled drug, are payable for 30 days per person in a calendar year subject to the requirements of the Connecticut Laborers' Family Services Program, (see Section 20);

36. For charges incurred for the use of a facility for **ambulatory (one-day) surgery** performed in hospital operating rooms, outpatient surgical facilities in hospitals, or freestanding surgical centers;

37. For one **cervical cytology screening** per calendar year. "Cervical cytology screening" is defined as an annual pelvic examination, collection, and preparation of a Pap smear, and associated diagnostic and laboratory services in connection with examining and evaluating the Pap smear;

38. For charges for diagnosis and treatment of **infertility**, provided such procedures are not experimental. Benefits will be payable for the following:
    (a) Artificial insemination;
    (b) In-vitro fertilization and embryo placement;
    (c) Any cost associated with the attendant sperm, egg and/or inseminated egg procurement, processing and banking, to the extent such costs are not covered by the donor's insurer, if any, regardless of whether the donor is the insured's spouse;

    The following maximums apply to the diagnosis and treatment of infertility for husband and wife combined:
    (a) Diagnostic services to determine the cause for the inability to conceive. These services are subject to general medical benefit limitations and maximums;
    (b) Prescription drugs to treat infertility are limited to a maximum lifetime benefit of $5,000;
    (c) The treatment of infertility as described above is limited to a maximum lifetime benefit of $10,000 per couple;

    These benefits are not available to a dependent child.

39. For medical examination required by the University of Connecticut Speech and Hearing Clinic to dispense a hearing aid;

40. For charges of an approved **cardiac rehabilitation program** subject to an annual maximum of $500 in a calendar year (only for Phase 3 when patient is asymptomatic, otherwise cardiac rehabilitation is a covered medical expense);

41. For **inoculations** including but not limited to Hepatitis, Pneumonia, Lyme Disease, or any other medically necessary and preventative vaccines;

42. For **allergy shots** when administered in a physician's office and submitted with a diagnosis;

43. For **interferon shots** when administered in a physician's office and submitted with a diagnosis;

44. For treatment, services or supplies in connection with any instability of the feet, including shoes, inserts, **orthotics**, subject to a lifetime maximum of $500;

45. For **stress tests** when submitted with a physician's diagnosis;

46. For **sleep apnea** tests when submitted with a physician's diagnosis stating medical necessity;

47. For annual **flu shots**;

48. For **vaccines**;

49. For **home health care** expenses as a result of a non-occupational illness or injury, up to a maximum of 120 visits per calendar year. In order for benefits to be payable for the reasonable and customary charges made by a home health care agency, the following requirements must be satisfied:
    (a) You or your eligible dependent must be discharged from a hospital from which the participating Home Health Care Agency has contracted to accept referrals, and you must receive approval from Aetna prior to obtaining any Home Health Care Services;
    (b) You or your eligible dependent must receive prior approval from Aetna if Home Health Care Services are to be provided instead of a hospital admission;
    (c) If hospitalized, the use of Home Health Services must enable you or your eligible dependents to be discharged from the hospital earlier than would otherwise be possible, and such discharge must be recommended by the attending physician; and
    (d) You or your eligible dependent must be essentially confined to home and physically or mentally incapable of obtaining medically necessary services and treatment on an outpatient basis ("homebound");

    Benefits are payable for the reasonable and customary charges made by a Home Health Care Agency for the following necessary services or supplies furnished to you or your eligible dependent in your home, in accordance with the Home Health Care Plan, for care which commences within seven days following termination of a hospital confinement as a resident inpatient and which is provided for the same or related condition for which you or your eligible dependent was hospitalized:

    (a) Part-time or intermittent nursing care by a registered graduate nurse or by a licensed practical nurse under the supervision of a registered graduate nurse, if the services of a registered graduate nurse are not available;

(b) Part-time or intermittent Home Health Aide Services, consisting primarily of patient care of a medical or therapeutic nature, by other than a registered graduate or licensed practical nurse. (The Home Health Aide cannot be a family member and must be an employee of the Home Health Care Agency or working under supervision of a Home Health Care Professional). The Plan will pay the reasonable and customary charges of a Home Health Aide, up to a maximum of 120 visits per calendar year;

(c) Physical therapy, occupational therapy, and speech therapy (subject to the guidelines established by Aetna) provided by the Home Health Care Agency;

(d) Medical supplies prescribed by a physician and laboratory services by or on behalf of a hospital, to the extent such items would have been covered as medically necessary if the individual had remained in the hospital. Such supplies will be limited to a 30 day supply. (The supplies must be necessary for proper at-home treatment and provided by a pharmacy or the hospital from which you or your eligible dependent was discharged);

(e) Medical social services provided to or for the benefit of a Participant covered by the Plan diagnosed by a legally qualified physician to be terminally ill, not to exceed a maximum amount of $200;

(f) Laboratory tests and x-rays provided by a medical laboratory or by the hospital in which you or your eligible dependent was hospitalized;

In no event will Home Health Care Expenses include charges for:

(a) Services or supplies of a Home Health Care Agency furnished to an individual eligible for Medicare;

(b) Services and supplies not included in the Home Health Care Plan, such as elastic stockings, sheepskin, lotions, mouthwash, or body powder;

(c) Housekeeping services, unless they are necessary in conjunction with services to provide medical treatment for you or your eligible dependent;

(d) Custodial care;

(e) Services of a person who ordinarily resides in the individual's home or is a member of the family of either the employee or the employee's spouse;

(f) Any period during which you or your eligible dependent is not under the care of a physician;

(g) Services or supplies furnished on account of sickness resulting from occupational disease; or for accidental bodily injuries arising out of and in the course of such member's or dependent's employment; or

(h) For services for which benefits are not payable according to the "General Limitations and Exclusions" Section of this Plan. If a Participant or dependent is eligible for Home Health Care coverage under more than one policy or contract, the Home Health Care benefits will only be provided by that policy or contract which would have provided the greatest benefits for hospitalization, if such individual had remained hospitalized;

50. For **hospice care** if such person submits a statement to the Fund Office and/or Aetna from a hospice physician attesting to the fact that he is terminally ill with six (6) months or less to live. Such statement must be submitted to the Fund Office within two (2) weeks prior to receiving any hospice care. Coverage includes both medical and non-medical treatment, when received in a licensed hospice program. Covered Charges for hospice care are subject to limitations and restrictions set forth in the Plan. Included in these limitations is coverage for bereavement counseling services by a licensed social worker or licensed minister for the patient's covered family members up to a maximum of $200 and furnished within six (6) months after the patient's death;

51. For **pre-admission testing** on an outpatient basis, prior to a hospital admission and ordered by a physician, payable at 100% of the reasonable and customary charges. However, in order for benefits to be paid for such charges, **all** of the following provisions must be satisfied: (a) a claim is submitted in accordance with the Plan's claims procedures; (b) tests are related to the scheduled surgery or hospital admission ("scheduled" means that the surgery or hospital room has been reserved before testing was performed); (c) the tests were ordered by the same physician who ordered the surgery or hospital confinement; (d) the tests are performed in the hospital where the confinement or surgery will occur and accepted by the hospital, in lieu of the same tests made during confinement; (e) the person would have been eligible for benefits if such tests were performed while such person was confined in a hospital as an inpatient; (f) the tests are not for a routine physical examination; (g) charges for the scheduled surgery and/or hospital

confinement are covered medical charges under this plan; (h) the test results appear in the person's medical file kept by the hospital wherein such person is confined or the scheduled surgery is performed; and (i) the person does not cancel the scheduled surgery or hospital confinement, unless for reasons beyond the control of the physician, hospital, or such person;

52. Charges for a **routine annual physical examination** by a legally qualified physician for one (1) medical examination per calendar year, including related charges incurred for immunizations. No payment will be made for charges in connection with any dental work or eyeglasses or their fittings;

53. Charges in connection with a **second surgical opinion** from a legally qualified physician who is not affiliated or associated with the surgeon issuing the initial diagnosis. If a second surgical opinion does not confirm the need for surgery the Health Fund will pay for a third surgical opinion. All laboratory and x-ray charges required by a physician issuing a second or third opinion will be covered. There are a number of qualifications and restrictions to recognize the charges for second surgical opinion set forth in the Plan which include: (a) the surgery consultation must be made by a physician who is Board Certified in the field of medical specialization concerned with the proposed surgery; (b) the individual must be examined in person by the physician rendering the second or third surgical opinion, and a written report must be submitted to the Fund Office of the second opinion and/ or third opinion if applicable; and (c) any physician who renders the second or third surgical opinion cannot perform the surgery and cannot have a financial interest in the outcome;

54. For **surgical assistance expenses** up to a maximum of 20% of the surgical allowance for charges made by a physician for surgical assistance services in connection with a covered surgical procedure. Surgical assistance services are the services of a physician for necessary technical surgical assistance given to the operating physician, while the Participant or eligible family member is confined in a hospital as an inpatient and at the time when surgical assistance is not routinely available as a hospital service;

55. **Charges for the treatment of morbid obesity** including surgical procedures and hospital x-rays and laboratory charges shall be determined based on a physician's determination that the percentage of excess body weight exceeds 100% of the national recommended insurance guidelines for body weight. Coverage will **exclude** any prescription drugs or dietary treatment associated with weight control or reduction. There are a number of criteria that need to be satisfied under Aetna's Utilization Review Program to qualify for Bariatric Surgery (Gastric Bypass Surgery). You should contact Aetna for the medical guidelines;

56. Charges for the treatment of **sexual dysfunction** due to a spinal cord injury, prostate surgery, diabetes, vascular disease or medication-induced dysfunction where a change in medication is not possible. The lifetime maximum benefit for the treatment of sexual dysfunction is $5,000;

57. Charges for an **educational outpatient disease management program** for diabetes or asthma, designed to improve patient knowledge of the disease and techniques for self-management and compliance with proper health procedures. Covered expenses shall not exceed a lifetime maximum benefit of $500, and shall be subject to the following conditions:
    (a) The program is recommended by a physician; and
    (b) The Participant submits a receipt showing the following information:
        - The cost of the program;
        - The name, address, and telephone number of the program sponsor;
        - The dates and times classes were held;
        - The dates attended by the Participant; and
    (c) The training is provided by a certified, registered or licensed health care professional trained in the care and management of the disease and who is authorized to provide such care within the scope of the professional's practice;

58. Medically appropriate services of a **naturopath** which otherwise would be provided by a physician excluding the dispensing of herbal teas or other compounds and vitamins.

18 MEDICAL EXPENSES NOT COVERED

No payment will be made for the following medical expenses:

1. Charges in excess of the limitations applicable to the treatment of inpatient and outpatient mental and nervous disorders and alcohol and substance abuse benefits;
2. Charges incurred for services, treatment, or supplies allowable under the Dental Expense Benefit;
3. Charges for **elective** or **cosmetic surgery**, except as described in Section 17;
4. Charges for eye refractions, eyeglasses, contact lenses, or their fittings not covered by the Vision Benefit through Davis Vision;
5. Hearing aids or their fittings not provided through the University of Connecticut Speech and Hearing Clinic;
6. Charges for **transportation**, except local ambulance services;
7. Charges related to accidental bodily injury or illness arising out of and in the course of your employment;
8. Services and supplies for the diagnosis and/or treatment of obesity, including **diet control, nutritional counseling and weight reduction, and surgery** except as set forth in #55 in Section 17;
9. Non-medical services such as employment counseling, **speech therapy and/or educational therapy for learning or related disabilities**;
10. **Vitamins**, except as deemed **medically** necessary, whether or not prescribed by a physician, and any prescriptions or medications used for weight control, unless otherwise specifically included;
11. Routine physical examinations and immunizations, except as specifically included;
12. Prescriptions for animals;
13. Prescription drugs, except as payable through Aetna;
14. Any maternity charges incurred for the **pregnancy of a dependent child** or surrogate mother;
15. Any charges related to the **adoption of a child**;

16. Charges for, or in connection with **transsexual** surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, such surgery;

17. Any charges for **telephone** consultations with a physician;

18. Charges directly or indirectly related to homemaker services or care primarily for rest, custodial, domiciliary, or **convalescent care**, including convenience and comfort items;

19. Charges incurred for **personal** or comfort **items** such as:
    (a) personal care kits provided on admission to a hospital;
    (b) television;
    (c) telephone;
    (d) infant photographs;
    (e) complimentary meals;
    (f) birth announcements; and
    (g) any other item not strictly provided for the treatment of an illness or injury;

20. Therapeutic devices or appliances, including hypodermic needles, support garments, and other non-medical substances, regardless of the intended use;

21. Any services, treatment, or supplies for or in connection with **temporomandibular** joint dysfunction (covered under the TMJ Benefit);

22. **Massage** and/or rolfing therapy, unless approved in advance as an alternative to physical therapy with an effective therapeutic value;

23. For the reversal of voluntary sterilization and any infertility services or treatment resulting from voluntary sterilization; and

24. Services for which benefits are not payable according to the **"General Plan Limitations and Exclusions"** in Section 27.

19 PRESCRIPTION DRUG BENEFITS

A. In General

The Prescription Drug Benefit is administered through Aetna. This is an in-network only, self-funded benefit, with the funding for claims payments being the responsibility of the Health Fund.

The co-payment for generic drugs at a retail pharmacy is 10% of the cost of the drug with a $5.00 minimum co-payment and a $10.00 maximum co-payment.

For example:

At a retail pharmacy if the cost of your generic prescription is $35.00, 10% of the cost would equal $3.50. Since the minimum co-payment for generic drugs is $5.00, your cost would be $5.00.

The co-payment for brand name drugs at a retail pharmacy is 20% of the cost of the drug with a $10.00 minimum co-payment and a $20.00 maximum co-payment.

For example:

At a retail pharmacy, if the cost of your brand name prescription is $85.00, 20% of the cost would equal $17.00, which falls between the $10.00 minimum and $20.00 maximum co-payment.

The following illustrates your co-payments:

Type of Medication	Network/ Retail Pharmacy	Mail Service Pharmacy
Generic Medications	10% of the cost $5.00 minimum copayment; $10.00 maximum copayment	$15.00
Brand Name Medications	20% of the cost $10.00 minimum copayment; $20.00 maximum copayment	$30.00
Maximum Dispensed	30 day supply	90 day supply

WE ENCOURAGE YOU TO REQUEST YOUR PHYSICIAN AND/OR YOUR PHARMACIST TO PRESCRIBE AND/OR DISPENSE GENERIC DRUGS WHEN AVAILABLE AND APPROPRIATE.

Each eligible Participant will be issued a Health Fund/Aetna identification card. This identification card is required to access this benefit at a local pharmacy. New Participants will receive cards when they become eligible.

In order to use your Health Fund/Aetna identification card, simply go to any participating pharmacy and present your identification card to the pharmacist, sign the claim form or signature log, and pay the lesser of the price of the prescription or the applicable co-payment. The remainder of the charge will be billed directly to and paid by the Health Fund. The co-payments are not reimbursable by the Health Fund. These co-payments are not applied to your out-of-pocket maximum or deductible.

Your identification card, if eligible, enables you to receive up to the lesser of a 30 day supply or 100 pills of a covered medication filled at any one of Aetna's participating pharmacies. You can call Aetna Pharmacy Management directly, toll free at 1-800-238-6279 to verify which pharmacies are in the network.

If you obtain prescriptions through a nonparticipating pharmacy after being mailed an identification card, you **will not** be reimbursed by the Fund for the cost of the prescription drug purchase.

In the event when you first become eligible for coverage and have not yet received an identification card, if the prescription was purchased after the effective date of your coverage, please submit a claim form with your prescription to Aetna or the Fund Office for reimbursement.

This Prescription Drug Benefit is not intended to, nor will it reimburse you or your eligible dependents for the prescription co-payments of another plan that you may be covered under.

B. Covered Prescription Drugs

Payment will be made for the following drugs obtained for yourself or an enrolled eligible dependent through a participating pharmacy upon presentation of a valid Health Fund/Aetna identification card. Covered prescription drugs are subject to the Plan's Limitations and Exclusions provisions. Covered prescriptions include:

1. All drugs bearing the legend "Caution: Federal law prohibits dispensing without a prescription" and drugs requiring a prescription under applicable state law;

2. Prescribed injectable insulin, including syringes for diabetics, diabetic supplies (blood/urine tests); and

3. When dispensed, in any one order, prescriptions up to the lesser of a 30 day supply or 100 pills, with the exception that Maintenance/Mail Order prescription drugs are dispensed for a 90 day supply.

C. Maintenance/Mail Order Prescription Drugs

For maintenance prescription drugs (medications required for an extended period of time) on an ongoing or continuing basis, you and your dependents should utilize Aetna Rx Home Delivery. Simply complete the Mail Order application form. Mail order forms can be obtained from the Fund Office or you can contact Aetna Rx Home Delivery directly. Include your co-payment in the form of a check, credit card payment, or money order, and mail to Aetna Rx Home Delivery. You will receive a 90 day supply through the mail order program.

If your medication must be taken without delay, fill your prescription immediately at a participating pharmacy and submit a second prescription to the mail order program to obtain future refills. Your prescription will be sent to you First Class Mail or UPS for up to a 90 day supply. Note that instructions for refilling your prescription will be included with your first order.

If you have any questions or concerns, you or your eligible dependents may contact the Health Fund at 1-800-922-3240 or at (203) 934-7991 or Aetna Rx Home Delivery directly at 1-866-612-3862. You can also contact Aetna Rx Home Delivery at Aetna.com or aetnarxhomedelivery.com to obtain information about your prescription order through the mail order program. In addition, your physician may contact Aetna Rx Home Delivery directly to arrange for your maintenance prescription.

D. Limitations and Exclusions

No payment will be made for:

1. Any non-legend drugs other than insulin;

2. Any vitamins except as deemed medically necessary as approved by Aetna;

3. Any weight loss or diet medication or supplements unless prescribed in connection with a treatment not associated with prescribed weight loss and subject to prior authorization by Aetna;

4. Fertility medications in excess of a combined lifetime maximum of $5,000 per couple;

5. Growth hormones, except where there is prior authorization by Aetna;

6. Investigational or experimental drugs (compounded medications for non-FDA approved use);

7. Drugs intended for use in a physician's office or another setting other than home use;

8. Therapeutic devices, appliances or support garments;

9. Prescriptions for animals;

10. Drugs payable under any Workers' Compensation Law;

11. Drugs which an eligible person is entitled to receive without charge under local, state, or federal programs;

12. Drugs dispensed during confinement in hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution which operates on its premises a facility for dispensing pharmaceuticals;

13. Immunological agents;

14. Over-the-counter medications;

15. Medication to treat sexual dysfunction, including erectile dysfunction in excess of six (6) pills per month;

16. Any medication used strictly for cosmetic purposes;

17. Charges for injection or administration of drugs;

18. Drugs not received from a licensed pharmacy;

19. Certain medications including but not limited to Imitrex and Ritalin unless prior authorization is received;

20. Methadone treatments; and

21. Services for which benefits are not payable according to the "General Plan Limitation and Exclusions" Section 27 of this booklet.

E. What Can You Do To Maximize Your Pharmacy Benefit When Getting Medications?

- Use generic medications whenever possible.
- Use the mail-order program for maintenance prescriptions.
- If you or your physician has any questions regarding the most cost effective drug therapy, they can contact Aetna Pharmacy Management at 1-800-238-6279.

20 CONNECTICUT LABORERS' FAMILY SERVICES PROGRAM

The Connecticut Laborers' Family Services Program (FSP) is designed to provide prompt, professional assistance for Participants and eligible dependents needing treatment for mental health related problems, and other personal and family difficulties. **We encourage you to access help for problems, including alcoholism and drug abuse, family difficulties, marital problems, child and adolescent concerns, illness of a family member, financial pressure, and job stress, that can disrupt your life and the lives of your loved ones.**

The Trustees have contracted with Health Management Center, Inc. (HMC) to provide you and your eligible dependents with **confidential**, professional assistance. Health Management Center is an organization of social workers, counselors, and psychologists. HMC cross-references their network with Aetna's mental health network of providers. HMC will coordinate and refer you and/or your family member to a qualified professional in Aetna's network in the area where you live and work to receive the appropriate assistance and care. HMC represents that it has selected these health care providers based on their demonstrated commitment to providing and maintaining the highest quality of care. HMC is an independent and separate entity, not affiliated with or under the control of the Trustees of the Fund. The Trustees do not take responsibility for the results of the counseling received through FSP nor will the Trustees interfere in the professional relationship.

Important: In order to receive benefit payments from the Health Fund for any treatment of mental or nervous conditions, alcoholism, or substance abuse, you and your eligible dependents must contact the FSP before receiving treatment, regardless of whether the Fund may be primarily or secondarily responsible for the services. When you call the FSP, one of the trained FSP professionals at Health Management Center, Inc. will help you identify and evaluate your problems, and if necessary, refer you to an appropriate resource. If inpatient treatment is required, you will be referred to an Aetna participating facility. Benefits will be paid on all emergency hospital admissions, provided the confinement is determined by Aetna to be an appropriate admission.

If you do not use the Connecticut Laborers' Family Services Program, no benefits will be paid by the Plan for any services or treatment for mental or nervous conditions, alcoholism or substance abuse. If you neglect to follow the recommended treatment plan established in conjunction with Aetna's Utilization Review Program, no benefits will be paid under this benefit or any other benefit otherwise available under the Plan.

There are two ways to take advantage of the Connecticut Laborers' Family Services Program:

1. You may contact Health Management Center directly;
2. A company personnel director, a Local Union representative, or Fund Office personnel may recommend that you contact Health Management Center.

We encourage you to take advantage of the Connecticut Laborers' Family Services Program for any personal problems by contacting Health Management Center.

HMC can be contacted at the following toll free telephone numbers:

In Connecticut: (800) 752-6864
Outside Connecticut: (800) 624-6864

21 TREATMENT OF MENTAL AND NERVOUS DISORDERS

To receive benefit payments for treatment of mental and nervous disorders (inpatient or outpatient), you and your eligible dependents must contact the Connecticut Laborers' Family Services Program before receiving any treatment for mental and nervous disorders. **It is important to note that the inpatient and outpatient calendar year and lifetime maximums for treatment of mental and nervois disorders are combined with any treatment you may receive for alcohol and/or substance abuse.**

A. Inpatient Treatment Benefit

If you or your eligible dependents incur covered medical charges for a mental/ nervous disorder as an inpatient in an Aetna PPO hospital or an approved facility solely for the treatment of mental and nervous disorders, benefits will be payable at 100% after a $250 co-payment per admission, subject to a maximum of **60 days in a calendar year**, provided your hospitalization was approved by HMC and concurrent review by Aetna. The maximum inpatient benefit for treatment of mental and nervous disorders is **90 days per lifetime per person**.

For benefits to be payable, the confinement must be recommended by a physician as being medically necessary for treatment of the diagnosed condition and approved by Health Management Center (see Section 20). Covered charges will include the charges for treatment recognized by the medical profession as appropriate methods for the treatment of mental and nervous disorders, alcohol, and/or substance abuse, in accordance with broadly accepted standards of medical practice, taking into account the current condition of the individual. If private accommodations in a facility are used, covered medical expenses will not exceed the facility's average daily rate for semi-private accommodations.

Benefits for partial hospitalization and/or intensive outpatient treatment are limited to 120 sessions in a calendar year. "Partial hospitalization" means continuous treatment of not less than 4 hours and not more than 12 hours per day. The 120 sessions available under partial hospitalization will be reduced by 2 sessions for every one day of inpatient confinement. If the cost of one session of partial hospitalization exceeds 50% of the cost of care provided as an inpatient for one day at the same hospital, such care will be considered inpatient care. "Intensive outpatient treatment" means treatment of not more than 3 hours per day and 3 days per week.

B. Outpatient Treatment Benefit

If you or your eligible dependents incur covered medical charges as an outpatient by an Aetna network provider solely for the treatment of mental and nervous disorders, benefits will be paid in full subject to a $15 office visit or session co-payment to a combined maximum of 25 visits per person in a calendar year. For benefits to be payable, the treatment must be recommended by an appropriately licensed clinician and approved by Health Management Center (see Section 20). **No benefits are payable for services of a nonparticipating provider.**

Outpatient treatment of mental and nervous disorders will cover expenses of a certified psychiatric-mental health clinical nurse specialist or social worker providing psychiatric or psychological services in a child guidance setting, while under the supervision of a psychiatrist or psychologist.

22 TREATMENT OF ALCOHOL AND SUBSTANCE ABUSE

Before receiving treatment for alcohol and/or substance abuse (inpatient or outpatient), you and your eligible dependents must contact the Connecticut Laborers' Family Services Program. **It is important to note that the inpatient and outpatient calendar year and lifetime maximums for treatment of alcohol and substance abuse are combined with any treatment you may receive for mental/nervous disorders.**

A. Combined Inpatient and Outpatient Benefit Payable

If you or your eligible dependents incur covered medical charges as an inpatient in an HMC network referred, licensed hospital or approved facility solely for the treatment of alcohol and/or substance abuse, benefits will be payable at 100% after a $250 co-payment per admission, subject to a maximum of **60 days in a calendar year and 90 days per lifetime per person**.

For benefits to be payable, the treatment must be recommended by a physician as being medically necessary for treatment of the diagnosed condition and approved by Health Management Center (see Section 20). Treatment must initially be approved by HMC but ongoing care is subject to Aetna's Utilization Review Program. Covered charges will include the reasonable and customary charges for treatment recognized by the medical profession as appropriate methods for the treatment of alcohol and/or substance abuse, in accordance with broadly accepted standards of medical practice, taking into account the current condition of the individual. If private accommodations in a facility are used, covered medical expenses will not exceed the facility's average daily rate for semi-private accommodations.

Benefits for partial hospitalization and/or intensive outpatient treatment are limited to 120 sessions in a calendar year. "Partial hospitalization" means continuous treatment of not less than 4 hours and not more than 12 hours per day. The 120 sessions available under partial hospitalization will be reduced by 2 sessions for each one-inpatient day. If the cost of one session of partial hospitalization exceeds 50% of the cost of care provided as an inpatient for one day at the same hospital, such care will be considered inpatient care and count towards the annual and lifetime inpatient maximum benefit. "Intensive outpatient treatment" means treatment of not more than 3 hours per day and 3 days per week.

B. Effective Treatment of Alcoholism

Effective treatment of alcoholism is a program of alcoholism therapy that meets both the following tests:

1. It is prescribed and supervised by a physician, who certifies that a follow-up plan has been established which includes therapy by a licensed provider with expertise in substance abuse or group therapy under a physician's direction, at least once a month; and
2. It includes attendance at least twice a month at meetings of organizations devoted to the therapeutic treatment of alcoholism.

Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment and will not be covered under this Plan. However, benefits will be payable for detoxification and/or maintenance, if appropriate treatment is received within 7 days immediately following detoxification. Detoxification is care aimed primarily at overcoming the after effects of a specific drinking episode. Maintenance care consists of providing a sheltered environment without access to alcohol.

C. Effective Treatment of Substance Abuse or Drug Addiction

Effective treatment of substance abuse or drug addiction includes diagnostic evaluation, medical, psychiatric and psychological care, counseling, and rehabilitation when prescribed and supervised by a physician for incapacitation by, or physiological or psychological dependence on drugs.

D. Definition of an Alcoholism or Drug/Substance Abuse Treatment Facility

When applied to the treatment of alcoholism and substance abuse, a treatment facility is an institution (or distinct part thereof) which meets fully all of the following tests:

1. It is primarily engaged in providing, for compensation from its patients and on a full-time basis, a program for diagnosis, evaluation and treatment of alcoholism;

2. It provides, or has a formal agreement with a hospital in the area to provide emergency care services, including, but not limited to, detoxification and medical treatment services continuously on a 24 hour basis;

3. It is under the continuous supervision of a staff of physicians on a 24 hour basis, and it continuously provides skilled nursing services on a 24 hour basis under the direction of a full-time registered graduate nurse, with licensed nursing personnel on duty at all times;

4. It provides, or has a formal agreement with a hospital in the area to provide diagnostic x-ray, laboratory and pharmaceutical services;

5. It prepares and maintains a written plan for admission, care, treatment and discharge for each patient. The plan must be based on the diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the direction of a physician; and

6. It meets any applicable licensing standards established by the jurisdiction in which it is located.

For benefits to be payable, the treatment must be recommended by a physician as being medically necessary for treatment of the diagnosed condition and approved by Health Management Center or Aetna (see Section 20). No benefits are payable for services of an Aetna nonparticipating provider.

23 DENTAL, ORTHODONTIC, AND TMJ BENEFITS

A. Dental Benefits

Covered dental expenses for non-occupational accidental bodily injury or disease included under the Plan are the reasonable and customary charges for services rendered or supplies furnished or recommended by a dentist while you are eligible for coverage.

If two (2) or more dental services are rendered, payment will be made for each dental service, subject to the reasonable and customary amount for a particular combination of dental services.

For many dental conditions, there is more than one method of satisfactory treatment. If this is the case, the covered dental expenses will not exceed the reasonable and customary charges for the services and supplies which are usually employed in the treatment of the disease or injury and which are recognized by the profession to be appropriate methods of treatment, in accordance with broadly accepted national standards of dental practice, taking into account the overall current oral condition of the patient.

Aetna maintains a preferred provider organization (PPO) network of dentists. Although the plan of benefits is the same if you use a network or non-network dentist, by utilizing a network dentist, the dentist has agreed to accept Aetna's reimbursement level and therefore there is no balance billing for charges in excess of reasonable and customary allowance. Your benefit dollars will go further by utilizing a network dentist.

You can find a network dentist in your area by reviewing your provider list or contacting the Fund Office, Aetna or accessing Aetna's website at Aetna.com. You can obtain a provider list free of charge by contacting the Fund Office. The first step in locating a dentist on the website is to click on "members and consumers." The next step is to click on "services and tools." The menu will then reflect a selection "find a doctor." The next screen will allow you to determine the area and type of dentist you wish to locate in Aetna's network.

B. Calendar Year Maximum

The annual benefit maximum per individual is $2,000. A separate lifetime limit applies to Orthodontic Benefits, described later in this Section of the booklet.

C. Preventive Care Dental Services

The Dental Benefit pays 100% of the reasonable and customary dental fees for the following Preventive Care Dental Services:

1. Oral examinations once every six (6) consecutive months;
2. Prophylaxis (cleaning of teeth) once every six (6) consecutive months;
3. X-rays determined necessary and within guidelines maintained by Aetna;
4. Space maintainers including all adjustments within six (6) months after installation – limited to initial appliance only for children under age sixteen (16);
5. Fluoride treatments for dependent children only under age nineteen (19) once every six (6) consecutive months; and
6. Sealants for dependent children up to age nineteen (19), subject to a maximum allowance of $100 per person per calendar year.

D. Basic Dental Services

The Dental Benefit pays 80% of the reasonable and customary dental fees for the following Basic Dental Services:

1. Non-routine Visits – Emergency palliative treatment per visit; consultation by other than the attending dentist;
2. Extractions – Uncomplicated (single); each additional tooth; surgical removal of erupted tooth (including tissue flap and bone removal);
3. Periodontics – Sub gingival curettage, root planing, per quadrant (not prophylaxis); occlusal adjustment, related to periodontal surgery, per quadrant;
4. Endodontics – Pulp capping direct, excluding final restoration; vital pulpotomy, excluding final restoration;
5. Amalgam Restorations Primary or Permanent Teeth – Cavities involving one surface, two surfaces, three or more surfaces;
6. Synthetic Restorations – Silicate cement filling; acrylic or plastic filling; composite resin, one surface;
7. Crowns – Stainless steel (when tooth cannot be restored with a filling material);

8. Recementation – Inlay; crown; bridge;

9. Denture Re-linings and Re-basings – Upper or lower denture duplication (jump case) per denture (limited to one in any 36 consecutive months); denture reline (includes full and partial); office, cold cure (limited to one in any 12 consecutive months); denture reline (includes full and partial); laboratory (limited to one in any 12 consecutive months); and

10. Denture Adjustments – Adjustments to denture more than six months after installation or if by dentist other than the original provider.

E. Major Dental Services

The Dental Benefit pays 70% of the reasonable and customary dental fees for the following Major Dental Services:

1. Restoration Inlays – One, two, three, or more surfaces; only, in addition to inlay allowance;

2. Restorative Crowns – Acrylic; acrylic with gold; porcelain; porcelain with gold; gold (full cast); gold (3/4 cast); cast post and core (in addition to crown);

3. Pontics – Cast gold (sanitary); case with semiprecious metal (sanitary); slotted facing; slotted pontic; porcelain fused to gold; porcelain fused to semiprecious metal;

4. Removable Bridge (Unilateral) – One piece chrome casting clasp attachment (all types), per unit including pontics;

5. Denture and Partial Dentures – Complete Maxillary denture; Complete Mandibular denture; Upper or lower partial, with two chrome clasps with rests, acrylic base; with chrome lingual bar and clasps, acrylic base;

6. Adding Teeth to Partial Denture – First tooth; First tooth with clasp; Each additional tooth and clasp; and

7. Implants or occlusions for the replacement of missing teeth.

A complete list of dental procedures covered by this benefit under Preventive, Basic, and Major services may be obtained from Aetna.

Note: Oral surgery is considered a medical expense, refer to Section 17 item #32.

F. Pre-Determination of Dental Benefits

This Plan contains a pre-determination of benefits provision. The intent of this provision is to inform you, in advance, the amount that is likely to be paid by the Plan for a proposed dental procedure or course of treatment.

Before beginning a course of treatment for which dental charges are expected to exceed $300, a description of the proposed services and supplies, and the estimated charges should be submitted to Aetna. You and your dentist will then be notified by Aetna of the amount of the benefit payable for the proposed course of treatment. Emergency treatment, oral examinations, including prophylaxis and dental x-rays, are considered part of a course of treatment for the purpose of pre-determination, but these services may be rendered before a pre-determination of benefits is made. Failure to submit a request for pre-determination may result in benefit payments of less than what you might otherwise expect.

Whether or not you have submitted a course of treatment for pre-determination of benefits, you are responsible for furnishing all diagnostic and evaluative material, as may be required by Aetna to evaluate coverage under the Plan. This material may include, but is not limited to, dental x-rays, models, charts, and other reports. A pre-determination does not guarantee payment of the claim, unless you are eligible when services are provided and all other Plan requirements are fulfilled.

G. Orthodontic Services

FOR ELIGIBLE DEPENDENT CHILDREN UP TO AGE 19

The Orthodontic Benefit pays 50% of the reasonable and customary dental fees for Orthodontia Services required by one or more of the following conditions:

1. Overbite or overjet of at least four millimeters;
2. Maxillary (upper) or mandibular (lower) arches in either protrusive or retrusive relation of at least one cusp;
3. Cross bite; or
4. An arch length discrepancy of more than four millimeters in either the upper or lower arch.

The Orthodontic Benefit will be paid for your eligible dependents up to age 19. Covered charges will be payable in equal quarterly installments of 50% of the reasonable and customary charges incurred throughout the estimated duration of the treatment plan, up to a lifetime maximum benefit of $3,000. However, the initial payment for charges related to the installation of an appliance will be limited to 25% of the total reasonable and customary charges for the course of treatment incurred.

H. Orthodontic Treatment Plan

An orthodontic treatment plan must be submitted to Aetna before any expenses will be considered for payment. After Aetna has reviewed the treatment plan, you and your orthodontist will be advised of an estimate of benefits payable under the Plan. A treatment plan consists of:

1. A description of the malocclusion classification;
2. Recommended and prescribed treatment;
3. An estimate of the duration of treatment (completion date);
4. An estimate of total charges for appliances and active treatment; and
5. Supportive evidence such as cephalomistric x-rays, study models, or other material Aetna deems necessary.

I. Extended Benefits Upon Termination

No payment will be made for dental services or supplies furnished on or after the date of termination of an individual's coverage hereunder, whether such termination is on an individual basis or upon termination of this benefit, except under the following specified circumstances:

1. In the case of appliances or modification of appliances not related to orthodontic treatment, if the master impression was taken by a dentist while coverage was in force under the Dental Benefits, covered charges will be payable if the appliance is delivered or installed within sixty (60) days after the termination of coverage;
2. In the case of a crown, bridge or inlay or onlay restoration, if the tooth or teeth were prepared while coverage was in force under the Dental Benefits, covered charges will be payable if the crown, bridge, or cast restoration is installed within sixty (60) days after the termination of coverage;

3. In the case of a crown, bridge or inlay or onlay restoration, if the tooth or teeth were prepared while coverage was in force under the Dental Benefits, covered charges will be payable if such root canal therapy is completed within sixty (60) days after the termination of coverage; and

4. In the case of orthodontic treatment commencing while coverage was in force under the Orthodontic Benefit, benefits will be payable through the end of the month in which coverage terminated, based on prorating the applicable quarterly installment.

The above benefits are subject to all other conditions, limitations and exclusions of the Health Fund.

J. Dental Limitations and Exclusions

In addition to excluding any services not set forth in the Schedule of Benefits, no benefits are payable under this Section for the following dental care or services:

1. Charges for any dental procedures, which are included as covered medical expenses under the Comprehensive Medical Expense Benefits;

2. Charges for treatment by other than a dentist, except that cleaning or scaling of teeth may be performed by a licensed dental hygienist, if such treatment is rendered under the supervision and direction of the dentist;

3. Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures;

4. Charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while you or your dependents were not eligible under the Plan, or which were ordered while you or your dependents were insured under the Plan, but which are finally installed or delivered more than sixty (60) days after termination of coverage;

5. Charges for the replacement of a lost or stolen prosthetic device;

6. Charges in connection with an occupational accidental bodily injury or disease;

7. Consultations, if the dentist is or will be performing additional treatment;

8. The replacement of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within five (5) years of the date of the last placement of such appliance, crown, inlay or onlay restoration or fixed bridge, unless such replacement is required as a result of bodily injury;

9. Charges in connection with temporomandibular joint dysfunction (TMJ), except as described in Section "K";

10. Any orthodontic services received before your dependents were eligible for such coverage under this Health Fund; and

11. Services for which benefits are not payable according to the "General Plan Limitations and Exclusions" as set forth in Section 27.

K. Temporomandibular Joint Dysfunction Benefit (TMJ)

The Health Fund will provide payment for diagnosis, x-rays, consultation, appliances, and treatment for TMJ at 80% of the reasonable and customary charges, subject to an all-inclusive lifetime maximum of $500 per individual.

This benefit is subject to limitations and exclusions and no payment will be made for the following:

1. An office visit charge on the same day an appliance is inserted;

2. Any other dental services performed on the day an appliance is inserted;

3. Services or treatment rendered by a medical doctor, unless x-rays are submitted to the Fund Office and the condition is found to be medical in nature; and

4. Services for which benefits are not payable according to the "General Plan Limitations and Exclusions," see Section 27.

The TMJ Benefit is the only payment for TMJ provided by the Fund. TMJ coverage is not provided under any other benefit available under the Plan, including Medical Expense Benefits or Dental Expense Benefits.

24 VISION CARE BENEFIT

This benefit is provided **exclusively through Davis Vision, Inc.** for eligible members and dependents under the eligibility rules established by the Trustees.

Covered Vision Services include one basic eye examination, eyeglasses, and/or contact lenses once every 12 months for active eligible members and dependent child(ren) up to age 19; and one basic eye examination and eyeglasses once every 24 months for eligible spouses and dependent child(ren) 19 years of age and older and retirees unless a participating provider or ophthalmologist recommends that more frequent examinations be rendered. At the physician's request, and subject to review and recommendation by Davis Vision, Inc., the Fund Office may authorize subsequent examinations, but in no case will reexamination be authorized for a patient no longer eligible under the Plan.

A. Participating Providers

Participating providers are licensed optometrists located throughout Connecticut, as well as nationally. They have agreed to provide high quality, comprehensive vision care services and are carefully monitored by Davis Vision's optometric experts. Stringent standards have been established for eye examinations, testing examinations, testing equipment and all other professional services rendered.

Davis Vision is an independent and separate entity, not affiliated with or under the control of the Trustees of the Fund. The Trustees cannot take responsibility for the results of the examinations received through Davis Vision nor will the Trustees interfere in the professional relationship.

B. Covered Expenses

A comprehensive basic eye examination and eyeglasses from the Plan's selection may be obtained at participating providers at no cost to you or your eligible dependents. **This vision program provides coverage for routine services only.** If further testing or treatment of an eye condition is required, it may be covered under the Hospital and Medical Expense Benefits of the Plan.

- **Eyeglasses (Lenses and Frames).** The Plan selection includes a wide assortment of high-quality current designer frames that are available at every Davis Vision participating provider's office. Both laborers and eligible dependents may elect to receive contact lenses (subject to the

applicable co-payment) in lieu of receiving eyeglasses through a participating optometrist. Laborers who require bifocals may select two pairs of eyeglasses (distance and near) instead of bifocals. Laborers may elect to receive safety glasses in lieu of standard eyeglasses.

- **Contact Lenses.** One pair of standard, soft daily wear contact lenses, or an initial supply (two multi-packs) of disposable contact lenses is available for most prescriptions requiring a co-payment of $25 for soft contact lenses, and a $45 co-payment for disposable contact lenses.

In lieu of eyeglasses, you can receive a $45 credit towards other special contact lenses supplied through a Davis Vision network optometrist's office. In addition, there is a substantial discount for contact lenses available through a mail order facility, called Lens 123. This is available only for replacement contact lenses. Information regarding mail order contact lenses is available from Davis Vision.

The Vision Benefit through Davis Vision provides a one-year guarantee on damaged eyeglasses dispensed by a network optometrist. Eyeglasses from the collection will be repaired or replaced if they are damaged beyond repair at no cost to you provided the damaged eyeglasses are returned to a panel optometrist's office. **There is no warranty for lost or stolen eyeglasses.**

C. How to Use the Plan

When vision care services are needed, you should contact the Fund Office or you can contact Davis Vision directly at 1-800-999-5431 or their website at davisvision.com. Davis Vision's toll free number provides access to an interactive voice response system to locate providers nearest you. You also have the option of using Davis Vision's website to locate a participating network provider or optometrist by clicking "find a doctor." When the next page asks you for your member ID or login name, enter your Social Security number. Your password is the first five letters of your last name. Once your eligibility is verified, you can contact a participating Davis Vision Optometrist to schedule an appointment.

A separate verification of eligibility is required for each family member requesting services under this Plan. Upon contacting a participating optometrist, advise the office that your coverage is through Davis Vision and the Connecticut Laborers' Health Fund.

In order to use this benefit, you must be eligible under the Plan at the time services are provided.

You may make an appointment with a Davis Vision participating provider of your choice directly. In doing so, the optometrist will verify your eligibility with Davis Vision and the Fund Office.

If you or your eligible dependents receive any care, treatment, services, or supplies from a non-participating provider for an eye examination, lenses, and/or frames, no payment will be provided to you under this Plan.

D. Laser Eye Surgery

The Health Fund through Aetna will recognize as a covered expense laser or Lasik eye surgery reimbursed at 50% coinsurance, subject to a lifetime maximum of $1,250. There is also a preferred provider network available through Davis Vision that performs these services.

E. Limitations and Exclusions

No payments will be made for expenses incurred for:

1. Covered eye examinations in excess of one every 12 months for eligible members and dependent children up to age 19, except at the recommendation of a Davis Vision participating optometrist for a more frequent examination;
2. Covered examinations in excess of one per every 24 months for retirees, eligible spouses and dependent children 19 years of age and older, except at the recommendation of a Davis Vision optometrist for a more frequent examination;
3. Eyeglasses (frames in conjunction with lenses) newly prescribed more than one (1) every 12 months for eligible members and dependent children up to age 19, and per every 24 months for eligible spouses and dependent children 19 years of age and older. An exception is made if in lieu of bifocal lenses a member or dependent wishes to receive eyeglasses for distant vision and separate eyeglasses for close-up/reading;
4. Special procedures, such as orthoptics or vision training and special supplies, such as nonprescription sunglasses or subnormal vision aids;
5. Anti-reflective coatings or charges for tinting and charges for sunglasses or light-sensitive glasses in excess of the amount that would be a covered charge for non-tinted glasses;

6. Eye examinations required by an employer as a condition of employment, or which the employer is required to provide by virtue of a labor agreement or those required by a government body;

7. Charges for services or supplies received while the individual is not eligible, or charges for lenses and frames which are furnished or ordered prior to the date the individual became eligible under the Plan;

8. Ancillary services whether performed by an optometrist or ophthalmologist; or

9. Services for which benefits are not payable according to the "General Plan Limitations and Exclusions". Please refer to Section 27.

25 HEARING CARE BENEFIT

This is an exclusive benefit only provided through the Speech and Hearing Clinic at the University of Connecticut, in Storrs. The Health Fund provides a Hearing Care Benefit that will reimburse eligible Participants and dependents 100% of covered charges up to $2,000 for each aid/hearing appliance. The cost of hearing aids or appliances in excess of $2,000 will be reimbursed at 80% coinsurance of the charge in excess of $2,000 and the individual receiving the hearing aid is responsible for 20% of the cost of the hearing aid in excess of $2,000. This benefit includes the evaluation of hearing loss, the prescribing and fitting of a hearing appliance, if appropriate, and rehabilitative services for eligible Participants and dependents. Hearing appliances include hearing aids, "in-the-canal" hearing appliances or programmable hearing appliances, if deemed appropriate by the audiologist.

The University of Connecticut Speech and Hearing Clinic is an independent and separate entity not affiliated with or under the control of the Trustees of the Fund. The Trustees cannot take responsibility for the examinations and treatments received through the University of Connecticut, nor will the Trustees interfere in the professional relationship.

A. Hearing Evaluation

If you or your Eligible Dependent would like a hearing evaluation, contact the Fund Office to verify your eligibility. After eligibility has been established, the Fund Office will assist you in scheduling an appointment with the University of Connecticut Speech and Hearing Clinic in Storrs, Connecticut.

At the University of Connecticut Speech and Hearing Clinic, you will be given a series of tests by an audiologist who is licensed by the State of Connecticut Department of Public Health and certified by the American Speech – Language – Hearing Association. Results and recommendations will be explained to you at the time of your appointment, and a written report will be mailed to you at a later date.

Eligible Participants and dependents may receive a hearing evaluation once every three (3) years, or as recommended by an audiologist from the University of Connecticut or a physician.

B. Hearing Aids

An extensive selection of hearing aids and appliances is available through the University of Connecticut Speech and Hearing Clinic. The hearing aid(s), if prescribed, will be supplied by the Speech and Hearing Clinic and will include any necessary accessories, such as earmolds and an initial supply of batteries. Hearing aids or appliances will be paid in full up to $2,000 per appliance and at 80% of reasonable and customary charges in excess of $2,000. Eligible Participants and dependents may receive a hearing aid or appliance only as recommended by an audiologist from the University of Connecticut or a physician. The Fund will not replace lost, stolen or damaged hearing instruments that are beyond their warranty period.

C. Medical Evaluation

A medical evaluation by a physician is required, prior to the actual fitting of a hearing aid/appliance. This evaluation is necessary to assure that you do not have a medical condition that would prevent the use of a hearing aid or that would be aggravated by the use of a hearing aid. The medical evaluation can be provided by the physician of your choice, or you can request the University of Connecticut Clinic to provide a list of Board Certified physicians in your area. You will be responsible for arranging this appointment. Covered charges for a medical evaluation are subject to the same in-network co-payments and out-of-network deductibles and coinsurance described in the Hospital and Medical Benefits Section of this booklet.

D. Return Policy

If you are dissatisfied with the hearing aids dispensed, you can return the hearing aid or aids within 30 days to the University of Connecticut Clinic. You will be responsible to pay $50 per hearing aid. The Clinic will then reimburse any cost you paid for the hearing aid(s).

E. Other Information

1. To assist eligible Participants and dependents in effectively managing their hearing handicaps, group and individual aural rehabilitation is available at University of Connecticut.

2. Minor repairs to hearing aids and earmolds will be available at the University of Connecticut. Major repairs are arranged by the audiologist with the manufacturer or an independent laboratory.

3. The number of earmolds and hearing aids, and frequency of their repair or replacement will be determined by the Speech and Hearing Clinic's audiologist, according to the individual's needs and generally accepted guidelines of normal wear and maintenance.

4. In the case of children, a parent or other responsible adult must accompany the child to all appointments.

5. Hearing aids will be provided only through the Speech and Hearing Clinic at the University of Connecticut in Storrs.

26 UTILIZATION REVIEW PROGRAM

All scheduled non-emergency hospitalizations must be reviewed before you or your eligible dependents are admitted to a hospital or receive treatment. Review may be obtained by calling Aetna from 8:00 a.m. to 5:00 p.m., Monday through Friday at 1-800-225-1263.

For any treatment of a mental health condition, alcoholism and/or substance abuse you must contact the Connecticut Laborers' Family Services Program (FSP) administered by Health Management Center (HMC) to obtain approval for a treatment program in order for these charges to be considered by the Plan.

The Utilization Review Program managed by Aetna is designed to work with you and your physician to keep medical care costs as low as possible, consistent with good medical care. In many instances, review of the need for hospitalization and exploration of available alternatives will indicate that admission to the hospital may be avoided and quality treatment may be better provided in a less restrictive environment. This program is added to your benefit Plan to help you use alternatives effectively so you can avoid the inconvenience of a hospital stay entirely, or spend some of your time recovering in a less restrictive setting, perhaps even in your own home. To achieve the best results, follow the steps described in this Section of the booklet for non-emergency and emergency medical care. These procedures are in your best interest, whether or not this Health Fund is primarily or secondarily liable for such care.

Failure to contact and follow the medical treatment plan approved by Aetna will result in an increase in your coinsurance amount by 20%, subject to a maximum of $500 per occurrence.

The Utilization Review Program does not apply to retirees or covered dependents covered by Medicare as the primary insurer.

All treatment decisions rest with you and your physician (or other health care provider). You should follow whatever course of treatment you and your physician (or other health care provider) believe to be the most appropriate, even if a proposed surgery or treatment is not certified as medically necessary or services are not recognized as a covered expense. Aetna is an independent and separate entity, not affiliated with or under the control of the Trustees of the Fund. The Trustees cannot take responsibility for the decisions made by Aetna.

If you feel that a decision is wrong, you have the right to appeal a decision. See Section 6 for information.

With respect to the administration of this Plan, your employer, the Board of Trustees and the Plan are not engaged in the practice of medicine, and none of them takes responsibility for the quality of health care services. With regard to Utilization Review, you should keep in mind the following:

1. Not all services proposed or provided by a treating physician will be considered medically necessary;
2. Certification of medical necessity does not necessarily mean that you or your dependents are eligible for Plan benefits or that Plan benefits will be payable; and
3. Patients should follow whatever treatment is most appropriate, but Plan benefits may be affected by the determination of the Utilization Review Program.

A. Non-Emergency Cases

If your physician recommends that you or your eligible dependent be admitted to a hospital on a non-emergency basis for day treatment, show the physician your health benefits identification card. You or your dependent must contact Aetna to obtain **pre-admission authorization**. Your physician may also provide the information necessary for the pre-admission approval by calling Aetna directly.

For maternity cases, you or your eligible dependent spouse are encouraged to notify Aetna of the pregnancy during the first trimester, and call 1-800-225-1263 within 24 hours after the delivery.

Under federal law, this Health Fund may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that the provider obtain authorization from the Health Fund or Aetna 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 physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (96 hours if applicable).

Aetna's professional staff and nurses will review the clinical information submitted by your physician and, if medically necessary, approve the hospital admission for the recommended length of stay. Its staff will work with your physician throughout your confinement to assure that your continuing care needs are effectively met.

B. Emergency Cases

In the event you or your eligible dependent is confined to a hospital on an emergency admission basis, you, a responsible family member, or the attending physician must call Aetna no later than 48 hours after admission or the next business day at the toll-free number (1-800-225-1263), notifying an Aetna representative of the confinement and providing the information required to establish an initial number of approved hospital days.

Emergency hospitalization means a confinement required as the result of an unforeseen medical situation that requires immediate medical treatment to prevent loss of life or permanent damage to the organs or systems of the body.

C. Extension of Time

If the initially approved hospital days have been used and you or your eligible dependent remain confined, you or your physician must call Aetna to obtain authorization for additional time required in the hospital. If Aetna agrees that continued confinement is medically necessary, additional days will be approved.

D. Large Case Management

Aetna will also provide a special service designed to assist patients with serious illnesses or injuries. Many people who have used this kind of service have found that it provides valuable assistance and peace of mind during difficult periods of illness. Serious medical cases include:

1. Chronic illnesses requiring Home Health Care;
2. Acute catastrophic injury;
3. Infectious diseases (severe/serious);
4. Burns (severe);
5. Terminal illness; and
6. Neonatal complications.

A case management coordinator from Aetna will contact you and your family to discuss medical care needs. Your personal case management coordinator will help you by:

1. Facilitating communication among the professionals involved in your treatment plan;
2. Providing information about your treatment and coverage options; and
3. Identifying any additional medical resources that may be available to you.

You are encouraged to take advantage of this valuable case management service.

27 GENERAL PLAN LIMITATIONS AND EXCLUSIONS

In addition to any limitations or specific exclusions described elsewhere in this Summary Plan Description (booklet), there are general limitations and exclusions that apply to all benefits. No payment will be made for expenses incurred for you or any one of your eligible dependents for any of the following:

1. For services, supplies or treatments which are not prescribed, recommended, or **approved as medically necessary** by an attending physician or exceeding the reasonable and customary limits. This exclusion also applies to any hospital confinement or any part of a confinement;

2. For fees which are in **excess of the reasonable and customary charges** for services, supplies, or treatment;

3. For **cosmetic surgery**, including, but not limited to, liposuction, unless required because of:

   (a) An accidental bodily injury, provided treatment occurs within one year from the date of the injury;

   (b) Reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved part; or

   (c) Reconstructive surgery, when required because of a congenital disease or anomaly which has resulted in a functional defect;

4. For expenses incurred as a result of past or present **services in the armed forces** of any government;

5. For services or supplies **not listed as covered charges**;

6. For expenses incurred as a result of participation in a **felony**, riot, or insurrection, or for expenses incurred as a result of an incident in which it is reasonably concluded that you were the aggressor;

7. For charges incurred for the completion of claim forms, and mailing fees;

8. For charges incurred for **handling fees**, unless directly related to test results;

9. For expenses incurred for functional **visual training**;

10. For **genetically engineered biological products**;

11. For meals, meal preparation, **personal comfort**, other equipment such as, but not limited to, air conditioners, air purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercise equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, nonprescription drugs and medicines, first aid supplies and non hospital adjustable beds, **convenience items**, housekeeping services, custodial care, and protective or companion services;

12. For any expenses related to **surrogate parenting**;

13. For any services rendered by a physician or any other provider of medical services to himself or his immediate family, including parents, spouse, brothers, sisters, children, and grandchildren;

14. For an injury or an illness that is **employment-related** or that is covered under the Workers' Compensation Law, occupational disease law, or similar laws or for which a third-party has liability;

15. For expenses incurred during confinement in a hospital owned or operated by the Federal Government, unless required by law;

16. For any charges which you or your dependent are **not legally required** to pay, including charges that would not have been made if no insurance coverage existed;

17. For charges for **custodial care**, which are institutional services and supplies, including room and board, that are designed primarily to assist the individual in the activities of daily living, rather than connected to a medical program which can be expected to improve the individual's medical condition;

18. For charges which are not received by Aetna or the Fund Office, along with all required supporting information necessary to process the claim, **within 15 months** from the incurred date; provided that the 15 month filing requirement does not apply with respect to life insurance claims;

19. For loss caused by **war** or any act of war;

20. To the extent that you or your dependent is in any fashion paid or entitled to payment for those expenses by or through a **public program**;

21. For **experimental drugs** or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution – limited by federal law to investigational use";

22. For **experimental procedures** or treatment methods not approved by the American Medical Association, the American Dental Association, or the appropriate medical or dental specialty society;

23. For medical treatment or procedures unless proven to be safe, efficacious, scientifically established therapies, or unless found to have a demonstrable benefit for a particular illness or disease. Ineffective or experimental surgical or medical treatments or procedures, research studies or other experimental health care procedures under continued scientific testing and research with questions to safety and efficacy are not covered unless approved by Aetna;

24. For services, treatments, or supplies furnished by or at the direction of the United States Government, any state or other political subdivision thereof, or any of its agents or agencies;

25. For expenses incurred for **elective abortion**, except those charges directly resulting from complications of such abortion, or for an abortion where the life of the mother would be endangered, if the fetus was carried to term;

26. For services of a **faith-healer**;

27. For any expenses related to **routine foot care**, including, but not limited to treatment, services, or supplies in connection with:

    (a) corns;

    (b) weak, strained, or flat feet;

    (c) calluses;

    (d) any instability or imbalance of the feet;

    (e) nails; or

    (f) shoes, orthotics in excess of $500 per lifetime, or any other inserts;

28. For **travel**, except as specifically included in this Plan;

29. For any expenses related to services or treatment received for an accident or injury resulting from operating a motor vehicle or motorcycle, while you or your dependent is **intoxicated with alcohol or illegal drugs** and for which a legal arrest and conviction for "DWI" is imposed;

30. For services of interns, residents, and physicians in training;

31. For charges incurred for **speech therapy** unless required for rehabilitation due to an injury or illness;

32. For diagnosis and treatment of **learning disabilities**, including but not limited to educational training programs and visual training and speech therapy;

33. For medical treatment of **obesity**, including but not limited to, specialized medical weight reduction programs and medications; except for individuals determined as "morbidly obese" which is at least 100% more than the ideal weight of an individual's normal body weight for the individual's age, sex, height, and body frame, whereas medical, dietary and drug therapy shall be recognized as a covered expense subject to Aetna's guidelines and pre-approval;

34. For any services or supplies for or in connection with **acupuncture** unless pre-approved by Aetna in lieu of anesthesia, as medically appropriate;

35. For **vitamins**, except as deemed medically necessary;

36. Any expenses related to **transsexual** surgery, gender dysphoria or sexual reassignment, including medications, implants, hormone therapy or psychiatric treatment;

37. For **biofeedback**;

38. Treatment or therapy for the purpose of eliminating or **modifying snoring**, unless associated with sleep apnea and determined medically necessary subject to Aetna's approval;

39. For care and **treatment of hair loss**, unless as otherwise indicated;

40. For antibacterial soaps/detergents, shampoos, toothpastes and mouthwash/rinse;

41. For **hypnosis/hypnotherapy**;

42. For **magnetic therapy**;

43. For **scleral therapy** as the initial treatment for the diagnosis of varicose veins;

44. For **court-ordered treatment**, unless otherwise recognized by the Plan;

45. For **auto-transfusion** and storage of blood, except autologous blood preparation and transfusion; and

46. For any charges or expenses for which a third party may be liable in accordance with Section 11.

28 DEFINITIONS

These are some of the terms used in your booklet. Some other terms are described when they are used. PLEASE READ THESE TERMS CAREFULLY. They may help you to better understand your benefits.

Allowable Expense means any necessary, reasonable, and customary item of expense, at least a part of which is provided by any one of the plans that covers the person for whom a claim is made. When the benefits from a plan are in the form of services, not cash payments, the reasonable cash value of each service is both an allowable expense and a benefit paid.

Ambulatory Surgical Facility means any public or private establishment that:

1. Is licensed as such by the state;
2. Is supervised by a group of physicians;
3. Has permanent facilities;
4. Is equipped and operated primarily for the purpose of performing surgical procedures; and
5. Provides continuous physician and registered graduate nursing services, whenever a patient is in the facility.

An ambulatory surgical facility does not include physicians' or dentists' offices, or any facilities whose primary purpose is the termination of pregnancy, or a facility which provides services or other accommodations for patients to stay overnight.

Birthing Center means an institution that, for a fee, provides room and board, skilled nursing, and midwife services to expectant mothers. One or more licensed nurses must be on duty at all times under the supervision of a registered graduate nurse (R.N.). The facility must have available at all times, under an established agreement, the services of physicians, licensed to prescribe and administer drugs and perform surgery. Physicians must comply with the legal requirements involved in the operation of such an institution, including the maintenance of medical records on all patients.

Complications of Pregnancy means:

1. Conditions requiring hospital stays, when the pregnancy is not terminated, and the diagnosis is distinct from pregnancy, but is adversely affected by pregnancy or caused by pregnancy; and

2. Non-elective cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Consultation means a review of the medical history of the patient, review of laboratory and x-ray examinations, an examination of the patient, and a report written by the consulting physician, if requested by the primary care physician.

Convalescent Facility means an institution (or distinct part thereof) that is licensed to provide, and is engaged in providing services on an inpatient basis, for persons convalescing from an injury or illness, which meets fully every one of the following tests:

1. It utilizes professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.), under the direction of a registered graduate nurse (R.N.);
2. It utilizes physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;
3. Its services are provided for compensation from its patients and under the full-time supervision of a physician or registered graduate nurse (R.N.);
4. It provides 24-hour per day nursing services by licensed nurses under the direction of a full-time registered graduate nurse (R.N.);
5. It maintains a complete medical record on each patient;
6. It has an effective utilization review plan; and
7. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental disabilities, custodial or educational care, or care of mental disorders.

Covered Charges means the reasonable and customary charges which are incurred for the medically necessary treatment of conditions that are covered under this Plan.

Custodial Care means all supplies, including room and board, which are provided, whether you are disabled or not, primarily to assist in the activities of daily living. Such services and supplies are custodial care without regard to the practitioner or provider by whom or by which they are prescribed, recommended, or performed. Some examples of such services are: help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine.

Dentist means a person authorized by law and duly licensed to practice dentistry.

Durable Medical Equipment means equipment prescribed by a physician that is medically necessary and:

1. Can withstand repeated use;
2. Is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness;
3. Is not disposable or nondurable;
4. Is appropriate for use in the home; and
5. Is not primarily and customarily for your convenience.

The Fund will not pay for the rental or purchase of any such equipment that is not approved by Aetna regardless of medical necessity. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails), electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. **Durable Medical Equipment does not include air conditioners, exercise equipment, saunas, air purifiers, arch supports, articles of special clothing, bed pans, corrective shoes, dehumidifiers, elevators, wheel chair ramps, heating pads, hot water bottles, etc., and this list is not exhaustive of items not considered Durable Medical Equipment.**

Experimental Procedure means:

1. Any medical procedure, equipment, treatment, or course of treatment, or drug or medicine that is meant to investigate and is limited to research;
2. Techniques that are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies;
3. Procedures which are not proven in an objective way to have therapeutic value or benefit;
4. Any procedure or treatment whose effectiveness is medically questionable;
5. Is found by the Fund or its designee not to be in accordance with generally accepted medical and dental practice; and
6. Does not have governmental approval.

Home Health Care Agency means an agency or organization which meets each of the following requirements:

1. It is primarily engaged in and is federally certified as a Home Health Care Agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services;
2. Its policies are established by a professional group associated with such agency or organization, including at least one physician and at least one registered graduate nurse, to govern the services provided;
3. It provides for full-time supervision of such services by a physician or by a registered graduate nurse;
4. It maintains a complete medical record on each patient; and
5. It has an administrator.

Home Health Care Plan means a program for continued care and treatment of the Participant or eligible dependent established and approved in writing by such Participant's or eligible dependent's attending physician within 7 days following termination of a hospital confinement as a resident inpatient for the same or related condition for which the individual was hospitalized, together with such physician's certification that the proper treatment of the injury or illness would require continued confinement as a resident inpatient in a hospital, in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospital means an institution that:

1. Is primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services for the diagnosis, treatment, and rehabilitation of injured, disabled, or sick persons;
2. Maintains clinical records on all patients;
3. Has bylaws in effect with respect to its staff of physicians;
4. Has a requirement that every patient be under the care of a physician;
5. Provides a 24-hour nursing service rendered or supervised by a registered graduate nurse;
6. Has a hospital utilization review plan in effect;
7. Is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and

8. Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

Unless specifically provided, the term "hospital" does not include any institution, or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility, or facility for the aged or for the care and treatment of drug addicts or alcoholics, except as mandated by state law, nor does it mean any institution that makes a charge that you or your dependents are not required to pay.

Illness means any sickness, disorder, or disease that is not employment-related. Pregnancy is treated in the same manner as an illness under this Plan for you or an eligible dependent spouse.

Injury means physical damage to you or your dependent's body. Only injuries that are not employment-related are considered for benefits under this Plan, except under the Life Insurance and Accidental Death and Dismemberment Benefits.

Medical Social Services means services rendered under the direction of a legally qualified physician, by a qualified social worker holding a Master's degree from an accredited school of social work, including, but not limited to:

1. Assessment of the social, psychological, and family problems related to or arising out of such covered person's illness and treatment;
2. Appropriate action and utilization of community resources to assist in resolving such problems; and
3. Participation in the development of the overall plan of treatment for such covered person.

Medically Necessary means any service, supply, treatment, or hospital confinement which:

1. Is essential for the diagnosis or treatment of the injury or illness for which it is prescribed or performed;
2. Meets generally accepted standards of medical practice; and
3. Is ordered by a physician. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it medically necessary or make the expense a covered charge.

Medicare means the health insurance program set forth in Parts A and B, Title XVIII of the Social Security Act of 1965, as amended.

Midwife or Nurse-Midwife means a person who is certified to practice as a nurse-midwife and fulfills both of these requirements:

(1) a person licensed by a board of nursing as a registered graduate nurse; and

(2) a person who has completed a program approved by the state for the preparation of nurse midwives.

Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse, or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N." or "L.P.N."

Obstetrical Procedure means one of the following obstetrical procedures:

1. An abdominal operation for extrauterine or ectopic pregnancy;
2. The delivery of a child(ren) by means of a cesarean section;
3. The delivery of a child(ren) by means of other than a cesarean section; or
4. Services in connection with miscarriage, with or without dilation and curettage.

Organ Transplant means the medically necessary removal of a human organ (e.g., heart, lung, or liver) from the recipient, and the insertion of the replacement human organ through surgical means, provided such procedure is not considered experimental.

Pharmacy means a licensed establishment where prescription drugs are dispensed by a pharmacist.

Physician means, with respect to any particular medical care and service, any holder of a certificate or license authorizing such holder or licensee to perform the particular medical or surgical services. This definition of physician will include a licensed psychologist for the treatment of mental and/or nervous disorders and alcohol and substance abuse.

Post-Operative Care means care rendered by the operating physician, in connection with a surgical procedure, during the period of continuous hospital confinement in which the surgical procedure is performed, subject to the reasonable and customary charges.

Pre-Existing Condition (Only Applies to Non-jobsite Participants) means an injury or illness for which a person receives treatment, incurs expenses, or receives a diagnosis from a physician, during the 6 calendar months prior to the date that person becomes covered for benefits. The term pre-existing condition will also include any condition related to such injuries or illnesses.

Reasonable and Customary means the usual charge made by a person, a group, or an entity which renders or furnishes the services, treatments, or supplies that are covered under this Plan. In no event does it mean a charge in excess of the general level of charges made by others who render or furnish such services, treatments, or supplies to persons:

1. Who reside in the same area; and
2. Whose illness or injury is comparable in nature and severity. The term "area" means a county or such greater area that is necessary to obtain a representative cross section of the usual charges made.

Skilled Nursing Services means one or more of the professional services that may be rendered by a registered graduate nurse or by a licensed practical nurse under the direction of a registered graduate nurse.

Surgical Procedure means any procedure in the following categories:

1. The incision, excision, or electrocauterization of any organ or part of the body;
2. The manipulative reduction of a fracture or dislocation;
3. The suturing of a wound; or
4. The removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder, or ureter.

Totally Disabled means that:

1. Because of injury or illness, you are prevented from engaging in or performing any kind of work for pay or profit; or
2. Because of injury or illness, your dependent is prevented from engaging in substantially all the normal activities of a person of like age in good health.

29 RETIREE BENEFITS

A. Eligibility Provisions

You are eligible for retiree coverage if you satisfy all of the following eligibility requirements:

1. You must be eligible for and receiving a monthly pension from the Connecticut Laborers' Pension Fund or another related Pension Fund recognized by the Health Fund; and

2. You have maintained active eligibility for benefits (including COBRA self-pay coverage) immediately prior to your retirement (eligibility as of the first of the month your monthly pension benefits begin); and

3. You must have worked at least 10,000 hours in Covered Employment for which contributions were received by the Connecticut Health Laborers' Fund during the fifteen (15) consecutive calendar years, prior to your retirement. There is a special rule if you were a union member working for a Connecticut employer who was obligated to provide health insurance benefits, but not through the Health Fund. This special rule requires you to have worked at least 5,000 hours in Covered Employment (for which contributions are received by the Health Fund) in the fifteen (15) years immediately preceding your retirement; and, the Trustees must also determine that the Health Fund would have received contributions for at least 10,000 hours of work activity in the fifteen (15) years immediately preceding your retirement, if the Collective Bargaining Agreement had required contributions to this Fund; and

4. You have elected to make and have made the required monthly self-payments for this retiree coverage for yourself and, if applicable, for your spouse and/or other eligible dependents. We recommend that you have the required monthly self-payment authorized as an automatic deduction from your monthly pension check from the Connecticut Laborers' Pension Fund.

If you are married at the time of application for retiree coverage, election of coverage for your spouse may be made at that time only.

B. Eligibility Provisions for Non-Bargained Employees

If you are a non-collectively bargained employee who has maintained coverage under this Plan for at least 10 consecutive years and you have maintained active eligibility immediately prior to your retirement (including COBRA coverage), then you will be eligible to continue benefits as a retiree provided you make the required self-payments.

C. Effective Date of Coverage

Coverage for retirees will become effective the first of the month after your coverage as an active employee with the Connecticut Laborers' Health Fund terminates provided you have satisfied all conditions of eligibility including the filing of an application and arranging for the payment of the required monthly self-payment.

D. Termination of Insurance

All coverage under the Retiree Benefits Program will cease upon nonpayment of the required monthly retiree contribution. If coverage terminates for nonpayment of the retiree contribution, it may not be reinstated.

All coverage under the Retiree Benefits Program will cease upon the member's death except that if the spouse and/or dependent was enrolled in the Plan, he or she may elect to remain in the Plan subject to payment of the required monthly contribution and the provisions pertaining to Continuation of Coverage.

E. Change of Coverage

Retiree medical benefits for a retiree or spouse who is not covered by Medicare will automatically convert to the Medicare Supplement Benefit effective the first of the month in which the retiree (or spouse) becomes eligible for Medicare. The retiree (or spouse) must submit a copy of his/her Medicare card to the Fund Office.

F. Payment of Required Premium

The required premium for coverage must be paid by the tenth day of each month. Payment may be provided by a deduction from your monthly pension benefit from the Connecticut Laborers' Pension Fund as authorized by you, or

by direct payment. We encourage pensioners to have these payments made automatically each month to avoid a potential loss of coverage. If your monthly pension benefit from the Connecticut Laborers' Pension Fund is sufficient to cover the cost of these benefits, you are encouraged to have the required premium deducted from your monthly pension check. Under federal law, any such authorization must be revocable. However, if such authorization is not in place and you fail to remit the required payment by the tenth of the month, **your coverage under this Plan will terminate effective the last day of the month for which payment was timely made, and there is no provision for reinstatement.**

The Fund and the Fund Office assume no responsibility or liability if you allow coverage to terminate.

G. Coverage for Dependent Children

A retired laborer with a dependent child(ren) will be permitted to carry the child(ren) under the Retiree Medical Benefits Plan. If both the retired laborer and spouse are receiving benefits under the Medicare Supplement Benefit, any dependent child will continue to receive benefits under the Retiree Medical Benefits Plan, subject to payment of the required premium.

H. Continuation of Coverage-In General

No benefits or rules described in this Booklet or the Plan are guaranteed (vested) for any retiree, Participant, spouse, or dependent. All benefits and rules may be changed, reduced, or eliminated prospectively at any time by the Board of Trustees, at their discretion.

If you do not elect Retiree Benefits for you and your dependent spouse at retirement, you will not have the option to elect these benefits in the future. If your spouse is covered under another insurance program and you are a dependent under that program, you may request a suspension of your Retiree Benefits while you and your spouse remain covered under your spouse's plan. Likewise if you retire as a laborer and secure other employment with active insurance coverage, you may elect to suspend your retiree coverage. To be eligible for a suspension of Retiree Benefits, you must have participated in the Retiree Program for at least one month and you must provide written evidence to the Fund Office that you and your spouse are covered under another plan. When you or your spouse's coverage ceases, you both can be added back on the Retiree Program by contacting the Fund Office in writing. If only your spouse is

covered under another plan, the same rules apply and your spouse can be added to the Retiree Program when your spouse ceases to be covered under that Plan.

IMPORTANT:

When your active eligibility runs out you will be given an option to either maintain your active benefits by making COBRA self-payments or, if eligible, you may continue coverage under the retiree plan. If you are retired and elect COBRA coverage, you and your spouse will not be eligible for the retiree program when COBRA runs out (typically 24 months). Retiree benefits are a onetime election and must be a continuation of your active eligibility. If you elect not to participate in this program when first available, you will not be given another opportunity.

I. Benefits for Retirees Prior to Age 65 (or Not Medicare Eligible)

Prior to Medicare eligibility, Plan benefits extended to retirees shall be the same benefits provided to active Participants with the following exceptions:

1. The life insurance benefit shall be reduced to $5,000; and
2. Vision benefits shall be limited to one examination every 24 months; and
3. No benefits or payment will be made for Accidental Death and Dismemberment, or Weekly Disability Income Benefits.

J. Medicare Supplement Benefit for Retirees Eligible for Medicare

If you are a retiree entitled to Medicare, medical coverage under the Plan is provided in conjunction with Medicare and is referred to as a Medicare Supplement Program. Medicare is the primary carrier for retirees and/or spouses age 65 and over or otherwise eligible for Medicare. With the exception of prescription drug claims, vision and hearing claims, retirees and/or their spouses who are covered by the Medicare Supplement Program must first submit their hospital and medical claims to Medicare. Upon payment of the expenses, along with an explanation of benefits statement, the expenses not paid by Medicare should then be submitted to Aetna.

Unlike the coordination of benefits with active coverage, Medicare is considered "Primary" (pays first) for covered medical and hospital expenses, and your retiree benefits through the Fund are "Secondary" (pays second). The benefits

provided under the Retiree Medicare Supplement Program will be coordinated with the benefits payable under Medicare for the same expenses. For example, if a retiree or spouse of a retiree is age 65 or over, or otherwise eligible for Medicare, reimbursement will first be made under Medicare, and if there are any expenses remaining unpaid, the expenses, including Medicare deductibles, will be paid at 80%, subject to the limitations and exclusions of this Plan.

It is important to note that the benefit levels, limitations, and exclusions for Medicare Parts A and B coverage are subject to change by the Federal Government. The Fund shall only reimburse under the Medicare rules in effect on the date the claim was incurred. With the exception of prescription drugs, the only covered medical expenses reimbursable by the Fund are those in which Medicare is the primary payor. If Medicare does not consider such charges as a covered expense, this Medicare Supplement Program will not recognize those charges for payment. This Program is designed to increase the reimbursement of expenses not paid in full by Medicare, plus extend to you Prescription Drug, Vision, and Hearing Benefits.

Medical expenses covered by this program include hospital charges recognized by Medicare Part A, but not paid in full, for semiprivate hospital accommodations, and outpatient charges. Covered charges also include the reasonable and customary physician charges in excess of the amount paid by Medicare Part B. The deductible required by Medicare is also considered a covered expense. If a specific medical expense is not recognized by Medicare as a covered service, the Fund will not consider those charges as a covered expense. This Plan will recognize all the covered expenses first considered and covered by Medicare except:

1. Accidental Death and Dismemberment Benefit
2. Weekly Disability Income Benefit
3. Dental Expense Benefit
4. Orthodontic Expense Benefit
5. Temporomandibular Joint Dysfunction Expense Benefit
6. Vision benefits shall be limited to one examination every 24 months

In addition to recognizing the balance of expenses not paid in full by Medicare, you also receive the same Prescription Drug Benefit received by active laborers.

The life insurance benefit is reduced to $1,000.

K. Continuation of Coverage – For Surviving Spouses and Dependents

Upon the death of a retired laborer, benefits under this Plan will be extended to the member's spouse and/or dependent children, if they were covered under this Plan at the time of the retiree's death. A deceased laborer's spouse receiving Retiree Medical Benefits and/or Medicare Supplement Benefits will be permitted to continue these benefits indefinitely as long as he or she continues making the required monthly payments.

A child no longer satisfying the requirements as a dependent child under the provisions of the Plan, and a divorced or legally separated spouse are not eligible to continue coverage under this coverage. However, if a child of a retiree no longer satisfies the requirements as a dependent under the Plan, the dependent child is entitled to elect COBRA coverage; and if a divorced or legally separated spouse of a retiree is no longer eligible under the Plan, the divorced or legally separated spouse is entitled to elect COBRA coverage.

For a widow/widower to continue insurance coverage, they must notify the Fund Office of their election to continue this retiree insurance coverage. Without such notification, this continuation option will not be available. Coverage must be continuous and under no circumstances will the option to make self-payment to the Fund be permitted on a retroactive basis. The Fund assumes no responsibility or liability should you allow your insurance coverage to terminate. **If you believe that an event has occurred where your retiree insurance coverage has lapsed, it is your responsibility to contact the Fund Office to arrange for continuation of insurance coverage.**

30 PLAN INFORMATION

Type of Administration of the Plan: The Plan is administered and maintained by a joint Board of Trustees consisting currently of four (4) union representatives and four (4) employer representatives.

Name and Address of the Fund:

Connecticut Laborers' Health Fund
435 Captain Thomas Boulevard
West Haven, Connecticut 06516-5896

Contributing Employers: You may make a written request to the Fund Office for information as to whether a particular employer is a contributing employer with respect to this Plan and, if so, you may request the address of that contributing employer.

Reference to Collective Bargaining Agreement: The Fund is maintained pursuant to Collective Bargaining Agreements with the Connecticut Laborers' District Council and with Local Unions of the Connecticut Laborers which provide for the rate of employer contributions to the Fund and areas of work for which contributions are payable and certain other terms governing contributions. Copies of Collective Bargaining Agreements may be obtained, upon written request to the Board of Trustees, and is available for examination at the Fund Office or your Local Union office.

The Type of Plan: This Plan provides Life Insurance, Accidental Death and Dismemberment, Weekly Disability Income, Hospital Medical Expense, Prescription Drug, Dental, Orthodontic, Temporomandibular Joint Dysfunction, Vision and Hearing Care Benefits to eligible Participants and their dependents.

TRUSTEES FOR THE CONNECTICUT LABORERS' HEALTH FUND

Management	Union
C. D'Arcy Didier, *CoChairman* Connecticut Construction Industries Association, Inc. 912 Silas Deane Highway Wethersfield, CT 06109	Charles T. LeConche, *CoChairman* Connecticut Laborers District Council 475 Ledyard Street Hartford, CT 06114
Frank P. Gillon, Jr. 330 Six Rod Highway Hamden, CT 06518	Richard Beckenbach Local Union #675 7 Harmony Street Danbury, CT 06810
Marvin B. Morganbesser Connecticut Construction Industries Association, Inc. 912 Silas Deane Highway Wethersfield, CT 06109	Victor Perugini Local Union #390 P.O. Box 4085 Waterbury, CT 06704
Louis Stone Chapel Construction of New Haven, Inc. 100 Ashmun Street New Haven, CT 06511	Anthony Scarnati P.O. Box 1111 Greenwich, CT 06836

Administration: The Fund is administered by the Board of Trustees. The Board of Trustees employs Mr. Richard F. Weiss as the Fund's Executive Director to supervise the day-to-day administration of the Health Fund:

Mr. Richard F. Weiss
Connecticut Laborers' Health Fund
435 Captain Thomas Boulevard
West Haven, Connecticut 06516-5896
Telephone (203) 934-7991
Toll-Free Number (800) 922-3240

The **Employer Identification Number (EIN)** assigned by the Internal Revenue Service to the Board of Trustees as Plan Sponsor is 06-0960814. The **Plan number** assigned by the Board of Trustees is 501.

Name and Address of Designee as Agent for Service of Legal Process:

Mr. Richard F. Weiss, Executive Director
Connecticut Laborers' Health Fund
435 Captain Thomas Boulevard
West Haven, Connecticut 06516-5896

In addition, legal process may be served upon any Board of Trustees member at the addresses shown on the preceding page.

Plan Year: The Plan fiscal year end is July 31, and records of the Fund are kept on a fiscal year basis, ending on such date.

Source of Contributions to the Fund: The Plan's benefits are financed through employer contributions made at a fixed rate per hour worked under the provisions of the Collective Bargaining Agreements and the Trust Agreement.

Identity of any Organization Used for the Accumulation of Assets Through Which Benefits are Provided: Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement and held in a Trust Fund, for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. The Fund's assets and reserves are held in the custody of Citizens Bank and invested by professional investment managers hired by the Board of Trustees with their performance results monitored by an independent investment advisor.

Eligibility: The Fund's requirements with respect to eligibility, as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits are described in the previous sections of this document.

Appeal Procedure: The Plan's appeals procedures are described elsewhere in this document.

Administrative Services: Some administrative services are provided by Aetna and Davis Vision. Aetna also acts as a claims fiduciary with respect to health and dental claims. However, no insurer guarantees benefits under the Plan. Aetna's address is: 151 Farmington Avenue, Hartford, Connecticut 06156.

STATEMENT OF FEDERAL LAW RELATING TO MATERNITY AND NEWBORN INFANT COVERAGE:

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

STATEMENT OF FEDERAL LAW RELATING TO WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan and described previously.

If you would like more information on WHCRA benefits, call the Fund Office at (800) 922-3240.

31 PLAN AMENDMENT OR TERMINATION

The Board of Trustees has the authority to terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time. This includes the authority to terminate, suspend, withdraw, amend, or modify Plan coverage for current and/or future retirees, and to change the cost sharing aspects of the Plan as applicable to all Participants including current and/or future retirees.

Plan benefits and eligibility rules for active, retired, or disabled Participants and their dependents:

1. Are not guaranteed;
2. May be changed or discontinued by the Board of Trustees;
3. Are subject to the Trust Agreement, which establishes and governs the Fund's operations;
4. Are subject to the provisions of any group insurance policies purchased by the Board of Trustees; and
5. Are subject to changing legislation.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan, as it exists at the time the claim occurs.

32 STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a Participant in the Connecticut Laborers' Health Fund, 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 Your Plan and Benefits

Examine, without charge, at the Fund Office, 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 Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Fund Office may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Board of Trustees is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description for the rules governing your COBRA Continuation Coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under the Plan, if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan; when you become entitled to elect COBRA Continuation Coverage; when your COBRA Continuation

Coverage ceases; if you request it before losing coverage; or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a 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 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT!

All claims should be reported immediately.

NOTIFY:

Connecticut Laborers' Health Fund
435 Captain Thomas Boulevard
West Haven, Connecticut 06516-5896
Phone: (203) 934-7991 or 1-800-922-3240

UPON THE OCCURRENCE OF THE FOLLOWING EVENTS:

1. You get married;
2. A child is born;
3. A child reaches age 19;
4. When and where a child attends a college or university;
5. You are divorced or separated;
6. You change your address;
7. You want to change your beneficiary;
8. You or your spouse reach age 65; or
9. You or your spouse become covered by Medicare.

IT IS YOUR RESPONSIBILITY TO ENSURE THAT THE FUND ADMINISTRATIVE OFFICE HAS AN UP-TO-DATE RECORD ON FILE FOR YOU.