LaborersôDistrict Council
Health & Welfare Trust Fund
No. 2

A Guide to Receiving Health Care Benefits

For Eligible Members

and Dependents

Summary Plan Description
and Plan Document
July 2017

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July 2017

Dear Participant of the Laborersô District Council Health & Welfare Trust Fund No. 2:

This booklet explains your benefits under the Laborersô District Council Health & Welfare Trust Fund No. 2 (referred to in this document as the ñFundò or the ñPlanò). In it, youôll find information on obtaining health care benefits, special benefits you may qualify for, how to file a claim and eligibility.

We want you to receive all the benefits you are entitled to, so please review this booklet thoroughly and share it with your family. Please keep the booklet handy for future reference.

Nota: Este documento está disponible en español a petición del Fondo.

Sincerely,

BOARD OF TRUSTEES

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If you have any questions about the health care coverage offered by this Fund, please call the Fund Office at 410-872-9500 or toll-free 1-866-553-6559 Monday through Friday (except holidays) between 8:30 a.m. and 5:00 p.m.

Certain capitalized words have specific meanings. These are defined either in the Definitions section below, or specific sections in the document.

DEFINITIONS

Board of Trustees
The Board of Trustees of the Laborersô District Council Health & Welfare Trust Fund No. 2.

Collective Bargaining Agreement
The labor agreement(s) between the Union(s) and participating Employers, which provides for contributions to this Fund.

Covered Person
The Participant or the Participantôs Dependent who has enrolled in the Fund.

Delinquent Employer
An Employer who has not made timely required contributions to the Fund.

Effective Date
The Effective Date of this Summary Plan Description and Plan Document is July 1, 2017.

Employee
A person who: (1) is currently or was recently employed by an Employer; and (2) has satisfied the Fundôs eligibility rules, as set forth in this document.

Employer or Contributing Employer
An Employer who has agreed to make contributions to this Fund in accordance with the terms and conditions of the applicable Collective Bargaining Agreement or other written agreement, including a Participation Agreement, accepted by the Board of Trustees.

ERISA
The Employee Retirement Income Security Act of 1974, as amended.

Fund (also referred to as the Plan)
Laborersô District Council Health & Welfare Trust Fund No. 2.

Participant
An Employee or a Retiree who has satisfied the Fundôs eligibility rules and is covered for benefits provided by the Fund.

Participation Agreement
An agreement between the Board of Trustees and an Employer that requires the Employer to report and pay contributions to the Fund on your behalf.

Plan Administrator or Fund Administrator
The Board of Trustees of the Laborersô District Council Health & Welfare Trust Fund No. 2.

Plan Year
The Plan Year is October 1st through September 30th each year.

Physician
A duly licensed doctor of medicine (M.D.); a duly licensed doctor of Osteopathy (D.O.); a duly licensed dentist (D.D.S. or D.M.D.) for damages to natural teeth and cancers of the mouth; and, a duly licensed podiatrist (D.P.M.) for purposes of treating covered conditions of the feet. A physician may also include a health care provider who is recognized by the Plan Administrator (or its delegate) and is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices, which might include clinical nurse specialists, nurse practitioners, and physician assistants.

Retiree
A former Employee who has satisfied the Fundôs eligibility rules for Retiree coverage, as set forth in this document.

Third-Party Administrator
The person or firm retained by the Board of Trustees to administer the Fund on a day-to-day basis. Carday Associates, Inc. is the Third-Party Administrator.

Union or Local Union
Mid-Atlantic Regional Laborers; Baltimore Washington Laborers; and/or Laborers Local 11.

ELIGIBILITY

ELIGIBILITY

- You are eligible for the Fund if you work the required number of hours for a participating Employer. This coverage is provided at no cost to you.
- Your Spouse and Children (as defined in this document) may also be covered at no cost.
- You can buy coverage after you retire if you have the required service credits.
- If you and/or your Dependents lose eligibility, you can buy continuation coverage for up to 18, 29, or 36 months under COBRA, depending upon your individual circumstances.

Active Employees

This section discusses how and when you can be covered under medical, dental, and loss of time benefits. Keep in mind that life insurance and asbestosis screening benefits have different eligibility rules ï please see those sections for more information.

When you can first join

To join the Fund, you must meet two qualifications:

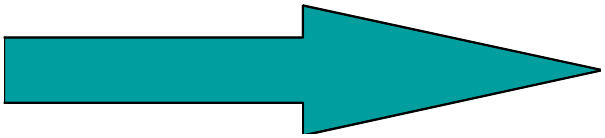
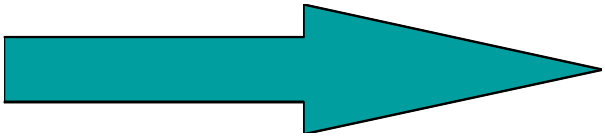
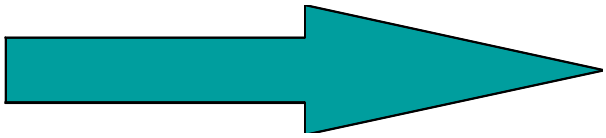
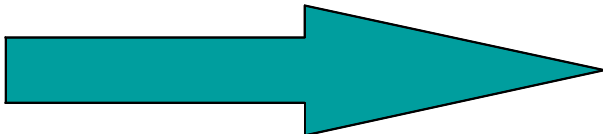
1. You must work for an Employer who makes contributions to the Fund on your behalf (because of a Collective Bargaining or Participation Agreement), and

2. You must have worked at least 300 hours in a Work Quarter for which contributions were actually made in your behalf.

Once you have worked the required 300 hours in a Work Quarter, your participation in the Fund will start at the beginning of the Eligibility Quarter.

In order to maintain your eligibility, at the end of each calendar quarter the Third-party Administrator will examine your work history. If you have worked 600 hours in the preceding two Work Quarters, or 300 hours in the current Work Quarter, the Fund will maintain your eligibility to the end of the applicable Eligibility Quarter.

The following table shows when your initial eligibility period begins and ends, based on when you reach 300 hours of work (or fall below the required hours threshold):

The Work Quarters...	Determine Your Eligibility for...	The Eligibility Quarters
January February March		June July August
April May June		September October November
July August September		December January February
October November December		March April May

Shortly after you become eligible, you will receive an identification card that shows you are participating in the Fund. (If you are eligible but do not receive a card, contact the Fund Office at 410-872-9500 or 1-866-553-6559.)

When coverage ends

When the Third-party Administrator examines your prior work history at the end of each calendar quarter, if you did not work at least 600 hours in the preceding two Work Quarters or 300 hours in the current Work Quarter, your last day of coverage will be the last day of the previous Eligibility Quarter as shown on the chart (above).

Employer Delinquency

You also will lose coverage if your Employer does not make its required contributions. However, in their sole and absolute discretion, the Trustees may continue your coverage for up to three months while the Fund pursues the Employerôs delinquent contributions.

Loss of eligibility

If you stop working for an Employer under this Fund and begin working for an employer within the geographical jurisdiction of the Laborersô District Council of Washington, D.C. and Vicinity, that is not an Employer under this Fund, the eligibility of you and all your Dependents ends on the date you stopped working for the Employer. You will not become eligible for the Fund again until you again meet the initial eligibility requirements described above.

If you lose eligibility for the Fund because you terminate employment or your hours are reduced, you can elect COBRA continuation coverage (described later in this document). You might also eligible for government subsidized coverage, such as coverage from the Health Insurance Marketplace (the ñExchangeò).

Exceptions for those who are hospitalized or disabled

If you are in the hospital on the date your coverage is due to end, you will receive an extension for up to three months, or until your hospital stay ends, whichever happens first.

If you become totally and permanently disabled, your coverage will be extended for up to nine months after the end of the quarter in which you were last eligible. For example, if the last day you worked before you became disabled was in January, the end of that quarter is March 31, and your coverage will continue until December 31. You can elect COBRA when your coverage ends.

Newly Organized Group

If you are an Employee in a New Organized Group, you will become eligible for benefits immediately, but if you fail to work 300 hours in the first three consecutive months, coverage will terminate until such time as you become eligible under the normal eligibility rules of the Fund as described on page 4 of this summary. For additional information regarding benefits offered to Newly Organized Group Employees, contact the Fund Office.

Retirees Employees

Required Service

You can participate in the Fund after retiring if you meet all of these requirements:

- you were eligible for coverage under this Fund at any time within 12 months of the date you retired;
- you have earned at least 10 years of Future Service Credit under the Laborersô District Council Pension and Disability Trust Fund No. 2; and
- you are *not* eligible for Medicare. (Most people become eligible for Medicare at age 65.)

If you are eligible at the time you retire, you and your Spouse will have the chance to accept or reject this coverage within 45 days of retiring. If you reject it, you cannot join later unless you and/or your Spouse are covered by other health coverage at your retirement. If you and/or your Spouse have other health coverage when you retire, you will have a one-time option to waive Retiree coverage through the Fund to participate in the other coverage. If you (or your Spouse) accept this one time option to waive Retiree coverage through the Fund, you (or your Spouse) can have your Retiree coverage in the Fund reinstated in the future once your other health coverage terminates.

To qualify for future reinstatement of Retiree coverage through the Fund, you must file a Retiree Coverage Waiver Election form (available from the Fund Office) with the Third-party Administrator within 45 days after your retirement date. In addition, you must provide evidence that you and/or your Spouse were continuously covered under another plan to be reinstated in Retiree coverage.

If you are not eligible for Retiree coverage, you may be able to buy COBRA continuation coverage. However, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace (the ñExchangeò), Medicaid, or other group health plan coverage options (such as a Spouseôs plan) during a ñspecial enrollment period.ò For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov or call 1-800-318-2596. You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you.

See the COBRA continuation coverage discussion below for more information.

Monthly contributions

Once you join the Fund as a Retiree, you must pay monthly contributions for yourself and any participating Spouse. Contact the Fund Office for current rates. These rates are subject to change.

Your contributions will be deducted directly from your pension check each month if you provide the Fund with the proper authorization. If thereôs not enough money in your pension check to cover the contribution amount, you must send a check for any additional amount to the Third-party Administrator at the following address:

Laborersô Trust Funds
c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Your payments must be received by the beginning of the month of coverage, or your coverage will end. **The Fund will not send you any invoices and you are responsible for determining how much you must pay each month. You cannot reinstate your coverage if it ends because you do not pay your full monthly contribution.** Please contact the Third-party Administrator if you have any questions about how much you must pay each month.

When coverage ends

Your Retiree coverage ends when one of the following events occur:

- you become eligible for Medicare (usually when you reach age 65),
- you become eligible as an active Employee,
- you stop making contributions,
- you die,
- the Fund stops offering Retiree coverage, or
- the Fund is terminated.

The Third-party Administrator will notify you in writing when your coverage ends.

Widowed Spouse Coverage

If you and your Spouse are both receiving Retiree coverage under the Fund when you die, your widowed Spouse can continue to participate for up to 12 months at the rate established by the Trustees from time-to-time.

Once your widowed Spouse coverage ends, COBRA continuation coverage is available to the widowed Spouse for another 36 months. This coverage is explained below. The COBRA rate is different from (currently higher than) the rate established by the Trustees for the initial 12 months of widowed Spouse coverage.

A widowed Spouse who continues to participate must submit checks for the monthly contribution on a timely basis (within 45 days of the start of the first month of widowed spouse coverage, and then within 30 days of the due date in later months ï the due date is usually the first day of the month).

When widowed Spouse coverage ends

In addition to terminating after twelve months, your widowed Spouseôs Retiree may end earlier if one of the following events occur:

- your Spouse become eligible for Medicare (usually when he or she reaches age 65),
- your Spouse stops making contributions or does not make the full contribution on time,
- your Spouse dies,
- the Fund stops offering Retiree coverage,
- the Fund stops offering widowed Spouse coverage, or
- the Fund is terminated.

If your widowed Spouse coverage ends for any reason, it cannot be reinstated.

Eligible Dependents

Dependents of active Employees

If you participate in the Fund, your Dependents are also covered. ñDependentsò are your:

- Spouse,
- Child(ren) up to age 26

The term ñSpouseò means that the person is recognized as your spouse for federal tax purposes. The Board of Trustees may require documentation proving a legal marital relationship.

The term ñChild(ren)ò means stepchildren, foster children, and adopted children. ñChildrenò also include children for whom you have been appointed legal guardian by a court, as well as children for whom you are determined to be the legal guardian in the sole and absolute discretion of the Trustees.

Dependents of Retirees

Only your Spouse who is not eligible for Medicare can be a Dependent under the Fund after you retire. As a Retiree, your Medicare-eligible Spouse and your Children are *not* eligible for coverage.

When Dependent coverage begins and ends

Your Dependentôs coverage begins when yours does, or when that person first becomes your Dependent. You must give the Third-party Administrator the names, birth dates, and relationships of all Dependents you wish to cover and evidence that they are your Dependents, such as marriage certificates, birth certificates, etc. In addition, the Fund must obtain Social Security numbers for all enrolled Dependents to comply with new IRS reporting required by the Affordable Care Act. Your failure to provide this information may result in your Dependentôs termination of coverage.

Your Dependentôs coverage ends when yours does or when that person is no longer a Dependent. However, if you remain eligible, your Child who is no longer a Dependent due to age will not lose coverage until the end of the month that he or she turns age 26.

Dependent status shall also continue for a Child beyond his or her 26th birthday if the Child is disabled due to physical or mental incapacity that prevents self-support, the disability began while the Child was eligible for benefits as a Dependent, and the Child is permanently and totally disabled, lives with the Participant for more than one-half of the year, and does not provide more than one-half of his/her own support (including federal disability benefits).

You must notify the Third-party Administrator immediately when a Dependent is no longer a Dependent (for example, when you and your Spouse divorce). If you do not notify the Third-party Administrator, and the Fund makes payments to or on behalf of an ineligible person, your future benefits may be retained by the Fund and used to offset the amount of the payments. The Fund may also pursue other legal remedies against you, your former Dependent, or other parties to recover amounts paid to an ineligible person. As described below, your Dependent might also lose eligibility for COBRA.

Non-collectively bargained employees of Contributing Employers

If you are an employee of a Contributing Employer who is not subject to a Collective Bargaining Agreement, you can participate in the Fund if your Employer has a Participation Agreement with the Board of Trustees. The following conditions apply:

- your participation must be approved in advance by the Board of Trustees;
- your Employer must contribute for every non-collectively bargained employee at the highest hourly rate for its Employees subject to the Collective Bargaining Agreement, based on 40 hours a week (regardless of the actual hours worked);
- you must follow the same schedule of benefits as your Employerôs Employees who are subject to the Collective Bargaining Agreement;
- all of your Employerôs non-collectively bargained employees must participate in the Fund (however, partners, sole proprietors and independent contractors *may not* participate);
- all Fund rules and regulations apply, including those that this SPD describes; and
- your employer or the Board of Trustees can terminate your participation at any time.

HIPAA Special Enrollment Rights

If you decline enrollment for yourself or your Dependents because of other health insurance coverage there are three categories of "special enrollment" events under the Health Insurance Portability and Accountability Act ("HIPAA") that may allow you to change your election and enroll in medical coverage under the Fund.

First, when you marry, give birth to a Child, adopt a Child or a Child is placed with you for adoption, the Fund allows you to enroll yourself, your Spouse, and your newly born/adopted Child within 30 days of the date of the event.

Second, if you refused coverage for yourself, your Spouse, or your Child because of other coverage and your Dependent(s) experience a ñloss of eligibilityò for that other coverage, then you can enroll yourself, your Spouse, and/or your Children who lose eligibility within 30 days of the event.

A "loss of eligibility" results if any of the following occurs:

- Loss of eligibility for reasons other than failure to pay premiums or fraud;
- Cessation of all contributions by their employer;
- Ceasing to be a "dependent," as defined in the other plan; or
- Loss of coverage to a class of similarly situated individuals under the other plan (for example, part-time employees).

Third, if you request enrollment within 60 days, you may enroll yourself, your Spouse, and a Child if either of the following conditions is satisfied:

- You, your Spouse, or your Child loses eligibility for Medicaid or a state child health plan;

  or

- You, your Spouse, or your Child is determined to be eligible for group health plan premium assistance under a Medicaid plan or a state child health plan.

Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 requires Plan Administrators to recognize qualified medical child support orders (ñQMCSOsò). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled to enrollment in a parentôs group health plan as ñalternate recipients.ò Both you and your Dependents can obtain, without a charge, a copy of the Fundôs QMCSO procedures from the Board of Trustees.

Upon receipt of a medical child support order, the Board of Trustees will notify the Participant and each child will be notified within a reasonable period of time whether the order is qualified. A representative may be designated to receive copies of any notices that are sent to the child. If it has been determined that the order is a QMCSO, the child will then be considered a Dependent under the Fund effective on the date the Trustees determine the order to be qualified.

Eligibility under the Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act ("FMLA") of 1993 entitles employees eligible under the Act to take up to 12 weeks of unpaid job-protected leave each year for:

- the employee's own illness;
- to care for a seriously ill child, spouse or parent;
- the birth or placement of a child with the employee in the case of adoption or foster care; or
- a ñqualifyingò exigencyò as defined in applicable regulations arising out of the fact that a covered family member is on active duty or called to active duty status in the National Guard or Reserves in support of a federal contingency operation.

In addition, the FMLA provides that an eligible employee who is a qualifying family member or next of kin of a covered military service member is able to take up to 26 work weeks of leave in a single 12 month period to care for the covered service member with a serious illness or injury incurred in the line of duty.

Generally, employees eligible for leave under the FMLA are those who have been employed at least 12 months by the employer and who have provided at least 1,250 hours of service to the employer. An employee at a work site at which there are fewer than 50 employees might not be eligible for FMLA leave unless the total number of employees of that employer within a 75 mile radius of that employee equals or is greater than 50.

Contributing Employers must notify the Fund Office when their Employees take FMLA leave. However, please contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your Employer's responsibility to report your period of absence. In addition, if you have any questions about the FMLA, you should contact your employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under U. S. Government, Department of Labor, Employment Standards Administration.

Employees on Military Leave

If you are called into or are returning from active military service, you may have special rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). These special rights under USERRA are extended to you only if you are in active employment at the time you are called into military service. USERRA does not extend special rights to Retirees or Dependents who are called into military service.

If you are called into active military service, you may elect to continue Fund coverage as mandated by USERRA. The maximum period of coverage under a USERRA election is the lesser of:

(i) the 24-month period beginning on the date on which military leave begins; or

(ii) the day after the date on which you, after returning from military leave, are required to apply for or return to a position or employment and fail to do so.

If you continue your coverage under the Fund while on military leave, the Fund may require you to pay up to 102% of the full cost of coverage under the Fund. However, if you are on active duty for 30 days or less, the Fund will not require you to pay more than your share, if any, for the coverage.

USERRA continuation coverage runs concurrent to COBRA continuation coverage. Exhaustion of your USERRA continuation coverage does not constitute a ñqualifying eventò for COBRA purposes.

Reinstatement of Eligibility after Military Leave

If you enter the uniformed services as defined in USERRA for active military duty or training, inactive duty or training, full-time National Guard or public health service duty, or fitness-for-duty examination, and you otherwise meet the requirements of USERRA (see below), coverage for you and your eligible Dependents will terminate under the rules for active employees.

If you are discharged other than dishonorably from Uniformed Service and you otherwise meet the requirements of USERRA (see below), Plan coverage for you and your eligible dependents will be reinstated on the day you return to work for an Employer as an Employee. To be reinstated, USERRA generally requires that:

- You (or an appropriate military officer) give advance written or oral notice to your Employer that you are entering uniformed service (unless such advance notice is impossible, unreasonable or precluded by military necessity);

- You not be dishonorably discharged from uniformed service;

- The cumulative length of all of your absences with the Employer due to uniformed service must generally be no longer than five years; and

- Upon leaving the uniformed service, you must you must report back to your pre-service Employer for re-employment and/or report to your local union for a referral to covered employment within the following specified periods of time:

    - Uniformed service of less than 31 days, or for any length for a fitness for duty examination ï you must generally report for work on the first regularly scheduled workday at least 8 hours after you arrive home from service, or

    - Uniformed service of more than 30 days, but less than 181 days ï you must generally report for work within 14 days after completion of service.

If you meet USERRAôs requirements, you and your eligible Dependents will be eligible for a period after your return that would be the same as the period of eligibility after the date that you left your Employer. If you have not yet worked sufficient hours in covered employment to again meet the requirements for continuing eligibility at the end of that period, you may be able to elect COBRA continuation coverage. You must elect COBRA within 60 days of the date your coverage terminates. You may continue at the COBRA rate until you meet the eligibility requirements again or your maximum COBRA period expires, whichever first occurs.

MEDICAL BENEFITS

Kaiser Permanente Flexible Choice and HMO Select

The following is a general description of the benefits, services, exclusions and limitations provided under the Kaiser Permanente Flexible Choice (ñFlex Choiceò) and the Kaiser Permanente HMO Select Plans. This is only a summary and does not fully describe your benefit coverage. For details on your benefit coverage, please refer to the Group Evidence of Coverage and applicable Riders that Kaiser Permanente issues. The Evidence of Coverage is the legally binding document between Kaiser Permanente and its members. In the event of ambiguity, or a conflict between this summary and the Evidence of Coverage, the Evidence of Coverage shall control. Additionally, Kaiser Permanente provides materials that describe its Flex Choice and HMO Select Plans, which are incorporated by reference. If you do not believe that you have received those materials or the Group Evidence of Coverage and applicable Riders, please contact the Fund Office and/or Kaiser.

- If you are an active Employee or a Retiree not yet eligible for Medicare, or a Dependent not yet eligible for Medicare, your benefits will be provided through the HMO Select Plan.

- If you or a Dependent live or work more than 50 miles from a Kaiser Permanente center, your benefits will be provided through the Flex Choice Plan.

In general, the benefits provided by the HMO Select and Flex Choice Plans are similar, as long as you use network providers. The main difference between the two plans is the choice of providers.

HMO Select Plan

With the HMO Select Plan you have your choice of using the Kaiser Permanente Health Centers or any of the thousands of participating providers located throughout the region. You can find participating providers by consulting the directory provided in your enrollment materials or, for more up-to-date information, by calling Kaiser Permanente at (301) 468-6000, toll-free at 800-777-7902, or via the Kaiser website at www.kp.org.

Under the HMO Select Plan, with the exception of Emergency Services and out-of-area Urgent Care Services, all covered in-plan services must be provided by or authorized and arranged by your Plan Primary Care Physician. Gynecology, behavioral health, substance abuse, dental and optometry services may be obtained without a referral from your Primary Care Physician; however, they must be provided by a Plan Physician or Plan Provider.

Flexible Choice Plan

Under the Flex Choice Plan, you have your choice of an even larger, nation-wide network of providers. The Flex Choice Plan uses the Private Healthcare Systems (ñPHCSò) Multiplan

Network. Participating providers in the PHCS network can be found at www.multiplan.com/kaiser.

With the exception of Emergency Services and out-of-area Urgent Care Services, all covered in-plan services must be provided by or authorized and arranged by your Plan Primary Care Physician. Gynecology, behavioral health, substance abuse, dental and optometry services may be obtained without a referral from your Primary Care Physician; however, they must be provided by a Plan Physician or Plan Provider.

Because the Flex Choice Plan uses providers who are not part of Kaiserôs own network, you must pre-certify all hospital admissions by calling SHPS at 1-800-448-9776 before your admission. In case of emergency, you must notify SHPS within 48 hours of admission or by the end of the first business day following treatment (whichever is later). SHPS is open 24 hours a day, 7 days a week. Failure to pre-certify may result in penalties, which are described in the Kaiser materials you should have received.

The Schedules of Benefits for the Flex Choice and HMO Select Plans, along with a listing of the terms and conditions of coverage for each (sometimes known as the ñCertificate of Insuranceò or ñEvidence of Coverageò), has been provided to you and is incorporated by reference. If you need an additional copy of any of these documents, please contact the Fund Office or Kaiser Permanente.

Designation of Primary Care Providers and/or OB/GYN

The Flex Choice and HMO Select Plans require you to designate a primary care provider. You have the right to select any primary care provider who participates in Kaiser Permanenteôs network and who is available to accept you or your family members. For children, you may select a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at Kaiser Permanente at (301) 468-6000, toll-free at 800-777-7902. You may also contact the Third-party Administrator at 410-872-9500 or 1-866-553-6559.

You do not need prior authorization from Kaiser Permanente, the Third-party Administrator, the Fund or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente at (301) 468-6000, toll-free at 800-777-7902. You may also contact the Third-Party Administrator at 410-872-9500.

Annual and Life Limits

The Fund does not impose annual or lifetime limits on essential health benefits (as defined in guidance and regulations issued by the Department of Health and Human Services).

DENTAL BENEFITS

Dental benefits are provided to all Participants, Dependents, and Retirees and their Covered Spouses through **Group Dental Service (GDS).**

The Fund has contracted with **Group Dental Service of Maryland, Inc. (GDS-MD)** to provide managed Dental Benefits through a closed panel of Participating Dentists. This means that dental services are covered only when performed by a Participating Dentist, except for emergency care or when otherwise approved by GDS-MD.

How to Choose a Participating Dentist

To choose a Participating Dentist, call **GDS-MD's Administrative Office at 1-800-242-0450.** A Member Services Representative will provide you with a list of Participating Dentists that are close to where you live or work. You can also visit www.gdsmd.com to search for a provider online. Click onto the labor unions link and then select ñall other unionsò. You and each of your covered Dependents are free to choose the same or a different Participating Dentist as their primary dentist. You or your Dependent may change your selection at any time by calling GDS-MD.

Covered Dental Services

This is a basic outline of covered dental services under the Dental Plan. This is only a summary of the covered dental services. For a complete list of covered dental services, please **contact GDS-MD at 1-800-242-0450.**

Diagnostic & Preventive	***Member Co-Payment***
Periodic Oral Exam	$20
Bitewings - Two Films	$10
Panoramic Film (once per 3 years)	$25
Prophylaxis - Adult (once per 6 months)	$35
Basic Restorative	
Amalgam - One Surface, Primary/Permanent	$30
Amalgam - Two Surfaces, Primary/Permanent	$40
Resin - One Surface, Anterior	$30

	Member Co-Payment
Crowns (Single Restorations)	
Crown - Porcelain/Ceramic Substrate	$550
Crown - Porcelain fused to High Noble Metal	$550 + gold
Crown - Porcelain Fused to Predominately Base Metal	$550
Endodontics	
Anterior Root Canal Therapy	$250
Bicuspid Root Canal Therapy	$350
Molar Root Canal Therapy	$450
Periodontics	
Periodontal Scaling & Root Planning	$90
Removable Prosthetics	
Complete Upper and/or Lower Denture	$500
Upper and/or Lower Partial - Cast Metal Frame w/Resin Base	$500
Oral Surgery	
Extraction, Erupted Tooth or Exposed Root	$30
Surgical Removal of Erupted Tooth	$75

This is only a summary of the covered dental services. For a complete list of covered dental services as well as Exclusions and Limitations of coverage, please call **GDS-MD at 1-800-242-0450.**

LOSS OF TIME BENEFITS

Workerôs compensation only pays benefits when you miss work due to a *job-related* accident or illness. However, the Fund has a ñloss of timeò benefit that pays you $200 a week for up to 13 weeks if you are disabled by an accident or illness that is *not* job-related or otherwise covered by another source (see ñSubrogationò page 20).

Benefits can begin after a Physician examines you and confirms your disability. Benefits will not begin for an illness until you have been sick for eight days. However, if you are in an accident or are hospitalized, you are eligible for benefits right away.

You do not have to be bedridden to be eligible for the loss of time benefits. However, you must be unable to work in your normal job, and you must be receiving treatment from a Physician.

Once you are eligible for benefits, you will receive weekly checks if:

a) you and your Physician fill out a loss of time claim form and return it to the Third-party Administrator;

b) your Physician certifies that you are unable to work based on his or her examination of you;

c) your Physician sees you once a week during the time you are disabled; and

d) if requested, you **must** have another examination by a Physician that the Fund selects.

You can receive loss of time benefits for up to 13 weeks, as long as you are still unable to work due to the disability. If your disability ends during a work week, loss of time benefits shall be paid at the rate of $40 per day of disability during that work week with a maximum payment of $200.

If you have a subsequent disability for the same or a related cause within two weeks of returning to work, your second period of disability will be considered a continuation of the first period. You will receive benefits without any waiting period (unless you have already received the maximum 13 weeks of benefits).

Generally, you must have recovered completely and completed at least two weeks of full time active employment with an Employer for loss of time benefits to be payable during a second period of disability. However, if you returned to full-time active employment with an Employer for less than two weeks, you will be eligible for loss of time benefits for an injury or illness entirely unrelated to the cause(s) of the previous disability.

ASBESTOSIS SCREENING (ALSO AVAILABLE TO RETIREES)

If you have been working at the trade for at least 20 years, you are eligible for one asbestosis screening -- paid for in full by the Fund. The screening is an evaluation of asbestosis, cholesterol and lead levels in the body.

You must obtain the screening through the George Washington University Hospital Clinic (or another Board of Trustees approved facility). To schedule an appointment, please contact your local union.

You will not have to pay anything for the screening or file a claim. Once you have been screened, the provider of the screening services will bill the Fund directly.

LIFE INSURANCE BENEFIT

The Laborersô District Council Health & Welfare Trust Fund No. 2 provides a Supplemental Life Insurance Benefit to Active Participants and Pensioners receiving a monthly benefit from the Laborersô District Council Pension & Disability Trust Fund No. 2. Active Participants will receive a $10,000 Life Insurance and Accidental Death & Dismemberment Benefit. Pensioners will receive a $2,500 Life Insurance Benefit. This Benefit is insured through:

UNUM
1699 King Street, Suite 100
Enfield, CT 06082
Policy No.: 408240

Eligibility for the Supplemental Life Insurance Benefit will be based upon:

Active Participants - You must be an Employee and Participant under the Laborersô District Council Health & Welfare Trust Fund No. 2 and ***a member in good standing of Local 11.***

Pensioners - You must be receiving a pension from the Laborersô District Council Pension & Disability Trust Fund No. 2 and ***a member in good standing of Local 11.*** *Note that this Benefit is only provided on behalf of the Pensioner.*

If you are unsure whether you qualify as a member in good standing of Local 11, please contact the Local directly:

LOCAL 11: (202) 723-3366

PLEASE MAKE SURE THAT YOU HAVE A CURRENT BENEFIT ENROLLMENT FORM ON FILE WITH THE FUND OFFICE, TO ASSURE THAT YOU HAVE NAMED A BENEFICIARY FOR THE SUPPLEMENTAL LIFE INSURANCE BENEFIT. If the Fund Office does not have a current Benefit Enrollment Form on file for you, or if your designated beneficiary dies before you, the Supplemental Life Insurance Benefit will be paid to the first who survives you, in the following order except to the extent the insurerôs certificate of coverage specifies otherwise:

1. Surviving Spouse,
2. Surviving children equally,
3. Surviving parents equally,
4. Surviving brothers and sisters equally, and
5. Your estate.

SUBROGATION, REIMBURSEMENT, AND COORDINATION OF BENEFITS

Benefits provided by Kaiser Permanente are governed by Kaiserôs own Subrogation and Reimbursement and Coordination of Benefits rules. Those rules are explained in materials that Kaiser provides separately to you, and are incorporated by reference. Please contact the Fund Office if you did not receive or need a new copy of those materials.

The following rules apply if you receive benefits from the Fund *other than* through Kaiser Permanente, unless otherwise specified in the documents for the benefit, such as the applicable insurerôs certificate of coverage.

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury, or otherwise responsible for your medical bills. The Board of Trustees, in its discretion, may determine to not provide benefits under the Fund for you if a third party may be responsible for the payment of benefits, until a determination is made by the proper and final decision-maker regarding the third partyôs responsibility to you. The rules in this Section govern how the Fund pays benefits, if at all, in such situations.

These rules have two purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit the Fund to pay your covered expenses until your dispute with a third party is resolved.

Second, the rules protect the Fund from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, then to the extent determined appropriate by the Trustees in their sole and absolute discretion, this Fund must be reimbursed for the benefits it has advanced to you. That reimbursement must come out of any recovery whatsoever that you receive that is in any way related to the event, which caused you to incur the medical expenses.

Rights to Subrogation and Reimbursement

If you incur covered expenses for which a third party may be liable, you must notify the Fund. Even if you do not notify the Fund, the Fund automatically acquires any and all rights that you might have against the third party.

The Board of Trustees may, in its sole discretion, require the execution of a Subrogation Agreement by you (or your authorized representative, if you are a minor or you cannot consent) before this Fund pays you any benefits related to such expenses. If the Board of Trustees requires execution of the Fundôs Subrogation Agreement, no benefits will be provided unless you, your spouse (if any) and your attorney (if any) sign the form. You must also notify the Fund before you retain another attorney or an additional attorney, since that attorney must also execute the Subrogation Agreement. The Fundôs Subrogation Agreement must be signed by you and your attorneys and received at the Fund Office on the earlier of either (1) one year

from the date of your accident; or (2) thirty (30) days after the date of the letter from the Fund Office forwarding the Subrogation Agreement to be signed. No Benefits will be paid by the Fund for the expenses related to that accident if the Agreement is not signed.

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE SUBROGATION AGREEMENT DIMINISH OR BE CONSIDERED A WAIVER OF THE FUNDôS RIGHT OF SUBROGATION AND REIMBURSEMENT.

At the Fundôs request, you must complete a form(s) which includes, but is not limited to, the following information:

- The details of your accident or injury;
- The name and the address of the person or entity you claim caused the accident or injury, as well as the name and address of that personôs or entityôs insurance company and attorney; and
- The name and address of your attorney.

You must also:

- Sign the Fundôs Subrogation Agreement;
- Have your attorney sign the Subrogation Agreement and return it to the Fund Office before any benefits are paid;
- Provide the Fund Office with quarterly reports regarding the status of your third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and
- Promptly respond to any inquiries from the Fund regarding the status of the third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.

Your duty to provide this information to the Fund is a continuing one.

In addition to its subrogation rights, the Fund has the right to be reimbursed for payment made on your behalf under these circumstances. The Fund must be reimbursed from any settlement, judgment, or other payment that you obtain from the liable third party before any other expenses, including attorneysô fees and costs, are taken out of the payment regardless of how you, the third party, or the court characterize the nature of the recovery. In enforcing the Fundôs rights to subrogation and reimbursement, the Trustees are not limited by any determination of the trier of fact as to the causal relationship between the injuries giving rise to these expenses and the liability of the third party if evidence exists which, in the opinion of the Trustees, supports causation.

The Fundôs right to recover benefits is first priority over all other claims and it shall apply to the entire proceeds of any recovery. This includes any recovery by judgment, settlement, arbitration award or otherwise. The Fundôs right to recover shall not be limited by application of any statutory or common law ñmake wholeò doctrine (i.e., the Fund has a right of first reimbursement out of any recovery, even if you are not fully compensated) or the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. The Fund is entitled to recovery from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Fund is not required to participate in or pay costs or attorney fees to any you attorney hire to pursue a damage claim.

Right of Future Subrogation and Reimbursement

In addition to satisfaction of the existing lien from any recovery by you, the Fund is also entitled to a future credit for future related expenses equal to the net proceeds received by you.

ñNet proceedsò shall be defined as the amount of your total recovery and/or judgment less payment in full of the amount of the Fundôs lien, less payment of your attorneysô fees and costs related to the third party action. You must spend the net proceeds on medical or related expenses arising out of or related to the injuries which were the subject of the third party action and which would have otherwise been covered by the Fund until the amount of said proceeds is exhausted.

It is only at that point that your further related Fund benefits will again be the responsibility of the Fund pursuant to the terms of the Fund. The Fund will not resume payment of medical and related benefits until such time as you have provided the Fund with proof that you have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Administrator will determine the net proceeds available for a future credit.

Assignment of Claim

You may not assign any rights or causes of action that you may have against any third-party without the express written consent of the Fund.

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to the Fund. If this Fund recovers from the third party any amount in excess of the benefits paid to you, plus the attorneysô fees, costs and expenses incurred in making the recovery, then the excess will be paid to you.

CLAIMS AND APPEALS PROCEDURES

Insured Benefits – Claim and Appeal Process

All claims and appeals relating to your insured benefits are subject to the claims and appeals procedures (including any preservice procedures) of the applicable insurer. Information and procedures about how to make and file claims and appeals are detailed in the materials provided from the insurer. You may obtain those materials directly from the insurer or from the Fund Office. Claims and appeals relating to insured benefits should be sent directly to the applicable insurer. You should be aware that it is important that you follow the procedures in making your claims and appeals. Otherwise, your claims will not be paid.

Your insured benefits include the following:

Medical Coverage	Kaiser Permanente
Dental Coverage	Group Dental Services
Life Insurance Benefit	Unum

Loss of Time – Claim and Appeal Process

Claims and appeals relating to Loss of Time benefits should be sent to the Fund Office.

The Claim Form

Claims must be submitted on forms acceptable to the Fund. You can get a claim form from your Fund Office. Instructions for filling it out will be found on the front or back of each form.

A new claim cannot be processed without a FULLY COMPLETED claim form, so make sure you answer all the questions. Unanswered questions may delay benefit consideration until the missing information is obtained. In addition, you must submit with your claim form any other materials necessary for the processing of your claim.

Notice of Claim

All claims must be filed within one year of the first day you are off from work. In addition, any additional information needed by the Fund in order to complete the processing of the Claim must be submitted within one year of the initial claim. Claims submitted after expiration of the one-year period will be denied.

Submit your claim to the Fund Office and Trustees at this address:

Laborersô District Council Health & Welfare Trust Fund No. 2
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500 or 1-866-553-6559

The Fund reserves the right and opportunity to examine the individual whose injury or disease is the basis of claim when and as often as it may be reasonably required.

Assignment

Benefits are not assignable and are only payable to the disabled Employee.

Notice of Claim Determination

The Plan Administrator will notify you of its decision regarding your claim within a reasonable period of time, but no later than 45 days from receipt of your claim. The Plan Administrator may extend the period to notify you of its decision for up to an additional 30 days if the extension is necessary due to matters beyond the Plan Administratorôs control. If the Plan Administrator decides to extend the notification period, it will notify you of that decision before the expiration of the initial expiration period, including the reason for the extension and the date it expects to make its determination. The Plan Administrator may extend the date for responding to your claim for a second 30-day period because of matters beyond the control of the Plan Administrator. If this occurs, the Plan Administrator will notify you before the first extension expires.

If an extension is required because you have failed to submit all necessary information, you will be allowed 45 days to provide any necessary information. The Fund Office will decide your claim within 30 days after you submit the required information.

Claim Review Procedure

If a claim is denied or partly denied, you will be notified in writing within the applicable time period and given the opportunity for a full and fair review.

The written denial will give: (a) specific reason(s) for denial, (b) a reference to the specific Fund provision(s) on which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and the reason why such material or information is needed, (d) an explanation of the Fundôs claim review procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review, (e) if any internal rule, guideline, protocol or other similar criterion was relied on in making the denial, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request, and (f) if the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit, the denial must provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to your medical circumstances or a statement that such explanation will be provided free of charge upon request.

If your claim is not acted on within 45 days after you submit your claim form and all relevant documentation, you may proceed to the review procedure, described below, as if the claim had been denied.

Appeal Procedure

Where a claim has been denied or partly denied, you may appeal the denial and have it reviewed by the Board of Trustees.

You (or your representative) must file your appeal within 180 days after you receive written notice your claim has been denied to:

Board of Trustees of the
LaborersÔ District Council Health & Welfare Trust Fund No. 2
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

You may submit written comments, documents, records, and other information related to your claim. You will also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The TrusteesÔ review will take into account all comments, documents, records, and other information submitted relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

A decision by the Board of Trustees will be made promptly and no later than the next scheduled meeting of the Board of Trustees that immediately follows receipt of your request for a review, unless the request for review is filed within 30 days before the date of such meeting. In such case, a decision by the Board of Trustees will be made no later than the date of the second meeting of the Board of Trustees following receipt of the claim. If special circumstances require a further extension of time for processing, the Board of Trustees will decide your appeal no later than the third meeting of the Board of Trustees following receipt of the request for review. If such an extension of time for review is required because of special circumstances, you will be provided with written notice of the extension, a description of the special circumstances, and the date the benefit determination will be made before the extension.

The Board of Trustees will not give any weight or deference to the original decision. If the Board of Trustees makes any determination on review based in whole or in part on medical judgment, the Board of Trustees will consult with a health care professional, who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in the initial denial.

Once the decision is made by the Board of Trustees, you will be notified as soon as possible and within five days. The decision on review will be in writing and will include the specific reasons for the decision and the specific plan provisions upon which the determination was made. The decision on review will include a statement that you are entitled to receive, upon request and without charge, all documents, records and other information relevant to the claim. If any internal rule, guideline, protocol or other similar criterion was relied on in making the

determination on review, the notice of the decision will include a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the determination on review and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request. If the determination on review is based on a determination of medical necessity, experimental treatment, or a similar exclusion or limit, the denial will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to your medical circumstances or a statement that such explanation will be provided free of charge upon request. If the Fund consulted with any medical or vocational experts on your case, the identity of such experts will be disclosed to you upon request.

The decision by the Board of Trustees will be final and binding on all parties.

Asbestosis Screening – Claim and Appeal Process

Claims and appeals relating to Asbestosis Screening benefits should be sent to the Fund Office.

The Claim Form

You will not have to pay anything for the Asbestosis Screening or file a claim. Once you have been screened, the provider of the screening services will bill the Fund directly.

However, if coverage of all or any part of the Planôs Asbestosis Screening has been denied, you can file a claim with the Fund in writing to the Fund Office.

Notice of Claim

All claims must be filed within one year from the date of your asbestosis screening. In addition, any additional information needed by the Fund in order to complete the processing of the Claim must be submitted within one year of the initial claim. Claim submitted after the expiration of the one-year period will be denied.

Submit your claim to the Fund Office and Trustees at this address:

LaborersôDistrict Council Health & Welfare Trust Fund No. 2
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500

Assignment

Benefits are not assignable and are only payable to the Employee or Retiree.

Notice of Claim Determination

The Fund Office will notify you of its decision regarding your claim within a reasonable period of time, but no later than 30 days from receipt of your claim. The Fund Office may extend the period to notify you of its decision for up to an additional 15 days if the extension is necessary due to matters beyond the control of the Fund Office. If the Fund Office decides to extend the notification period, it will notify you of that decision before the expiration of the initial expiration period, including the reason for the extension and the date it expects to make its determination.

If an extension is required because you have failed to submit all necessary information, you will be allowed 45 days to provide any necessary information. The Fund Office will decide your claim within 15 days after you submit the required information.

Claim Review Procedure

If a claim is denied or partly denied, you will be notified in writing within the applicable time period and given the opportunity for a full and fair review.

The written denial will give: (a) specific reason(s) for denial, (b) a reference to the specific Fund provision(s) on which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and the reason why such material or information is needed, (d) an explanation of the Fundôs claim review procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review, (e) if any internal rule, guideline, protocol or other similar criterion was relied on in making the denial, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request, and (f) if the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit, the denial must provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to your medical circumstances or a statement that such explanation will be provided free of charge upon request.

If your claim is not acted on within 30 days after you submit your claim form and all relevant documentation, you may proceed to the review procedure, described below, as if the claim had been denied.

Appeal Procedure

Where a claim has been denied or partly denied, you may appeal the denial and have it reviewed by the Board of Trustees.

You (or your representative) must file your appeal within 180 days after you receive written notice your claim has been denied to:

Board of Trustees of the
LaborersÔ District Council Health & Welfare Trust Fund No. 2
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

You may submit written comments, documents, records, and other information related to your claim. You will also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The TrusteesÔ review will take into account all comments, documents, records, and other information submitted relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

A decision by the Board of Trustees will be made promptly and no later than the next scheduled meeting of the Board of Trustees that immediately follows receipt of your request for a review, unless the request for review is filed within 30 days before the date of such meeting. In such case, a decision by the Board of Trustees will be made no later than the date of the second meeting of the Board of Trustees following receipt of the claim. If special circumstances require a further extension of time for processing, the Board of Trustees will decide your appeal no later than the third meeting of the Board of Trustees following receipt of the request for review. If such an extension of time for review is required because of special circumstances, you will be provided with written notice of the extension, a description of the special circumstances, and the date the benefit determination will be made before the extension.

The Board of Trustees will not give any weight or deference to the original decision. If the Board of Trustees makes any determination on review based in whole or in part on medical judgment, the Board of Trustees will consult with a health care professional, who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in the initial denial.

Once the decision is made by the Board of Trustees, you will be notified as soon as possible and within five days. The decision on review will be in writing and will include the specific reasons for the decision and the specific plan provisions upon which the determination was made. The decision on review will include a statement that you are entitled to receive, upon request and without charge, all documents, records and other information relevant to the claim. If any internal rule, guideline, protocol or other similar criterion was relied on in making the determination on review, the notice of the decision will include a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the determination on review and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request. If the determination on review is based on a determination of medical necessity, experimental treatment, or a similar exclusion or limit, the denial will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to your medical circumstances or a statement that such explanation will be provided free of charge upon request. If the Fund consulted with any medical or vocational experts on your case, the identity of such experts will be disclosed to you upon request.

The decision by the Board of Trustees will be final and binding on all parties.

ADDITIONAL RULES AND REQUIREMENTS

Statute of Limitations

A claimant, including but not limited to an Employee, Spouse, Dependent, or an estate, may not commence a judicial proceeding against any person, including the Plan, the Board of Trustees, a Plan fiduciary, the Plan Administrator, the Third-party Administrator, a claims administrator, insurer, or any other person, with respect to a claim for any benefits under the Plan, without first exhausting the applicable claims and appeals procedures. A claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in an appropriate court to review the decision on appeal, but only if the action is commenced no later than the earlier of: (1) three years after the date the service or treatment was provided, or the event giving rise the benefit occurred, or (2) the first anniversary of the final decision on appeal.

Selection of Service Providers

Use of any health care provider is the voluntary act of the Participant or Dependent. Nothing in this document or elsewhere is meant to be a recommendation or instruction to use any provider. You should select a provider or course of treatment based on the factors you deem appropriate. All providers are independent contractors, not employees of the Fund. The Fund makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission by any provider in connection with Fund coverage. The provider is solely responsible for services and treatments rendered.

IRS Information Reporting and Medicare Secondary Payer Reporting

You may get a letter from the Employer or third-party administrator asking you to confirm or provide Social Security number information for your enrolled Dependents. Generally, Medicare requires the Plan's third-party administrator to provide this information electronically. For information on the authority for requesting the Social Security number, visit www.cms.hhs.gov/MandatoryInsRep. Go to the Downloads section and select the June 23, 2008 ALERT.

The Fund must obtain Social Security numbers for all enrolled Dependents to comply with IRS reporting required by the ACA. Your failure to provide this information may result in your Dependent's termination of coverage.

No Guarantee of Employment

Nothing contained in this SPD/Plan Document shall be construed as a contract of employment between an Employer and any employee, or as a right of any employee to be continued in the employment of an Employer, or as a limitation of the right of an Employer to discharge any of its employees, with or without cause.

Assignment of Benefits Prohibited

Except for assignments to health care providers required under insurance policies, your right to receive benefits under the Plan may not be assigned, voluntarily or involuntarily, to any other person. You cannot at any time assign to any other person or entity, including but not limited to a health care provider from whom you receive services, your right to make a claim or sue to recover benefits under the Plan, to enforce rights due under the Plan, or to any other causes of action which you might have against the Plan, its delegates, its fiduciaries, its Trustees, or any other person.

Misrepresentation or Fraud

To the extent permitted by law, the Plan Administrator, Third-party Administrators, insurer, and Claims Administrators reserve the right to terminate an Employeeôs or Dependentôs benefits, deny future benefits, take legal action against an Employee, Dependent, or any other party, and/or set off from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan, in the case of any person who obtains benefits wrongfully due to intentional misrepresentation or fraud.

CONTINUATION COVERAGE

COBRA Coverage

If coverage (eligibility) under the Fund terminates at the result of a ñqualifying event,ò Covered Persons may purchase a temporary extension of Fund coverage (called ñcontinuation coverageò) at a group rate that amounts to 102% of Plan costs. An Employee, Spouse, or Child who is a Covered Person could become ñqualified beneficiariesò if coverage under the Plan is lost because of the qualifying event. This continuation coverage is sometimes referred to as ñCOBRAò coverage.

You May Have Other Options When You Lose Group Health Coverage

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouseôs plan) during a ñspecial enrollment period.ò **Some of these options may cost less than COBRA.**

You should compare your other coverage options with COBRA and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, itôs important that you choose carefully between COBRA and other coverage options, because once youôve made your choice, it can be difficult or impossible to switch to another coverage option. **For more information about coverage available through the Health Insurance Marketplace, and to locate an assister in your area**

who you can talk to about the different options, visit www.HealthCare.gov or call 1-800-318-2596. If you enroll in COBRA, you can only enroll in the Marketplace at specific times.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another special enrollment event such as marriage or birth of a Child. But be careful - if you terminate your COBRA continuation coverage early without another special enrollment event, you must wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage until then.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstance.

ñQualifying Eventsò for Continuation Coverage

If you are an Employee, Spouse or Child covered by the Fund, you have a right to purchase this continuation coverage for a period up to 18 months, if you lose your coverage because of a reduction in the Employee's hours of employment or the termination of the Employee's employment (for reasons other than gross misconduct).

If you are the Spouse of an Employee covered by the Fund, you have the right to purchase continuation coverage for a period up to 36 months if you lose coverage under the Fund for any of the following reasons:

(1) the death of the Employee;

(2) divorce or legal separation from the Employee; or

(3) your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

If you are a Child of an Employee covered by this Fund, you have the right to purchase continuation coverage for a period up to 36 months if you lose coverage under the Fund for any of the following reasons:

(1) the death of the Employee parent;

(2) parents'divorce or legal separation;

(3) the Employee parent becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(4) you cease to satisfy the definition of Dependent under the rules of the Plan (for example, when a Dependent Child turns age 26).

If you are the Spouse of a Retired Employee covered by this Fund, you have the right to purchase continuation coverage for a period up to 36 months, if you lose coverage under the Fund for any of the following reasons:

(1) the death of the Retired Employee;

(2) divorce or legal separation from the Retired Employee; or

(3) the Retiree becomes entitled to Medicare benefits (under Part A, Part B, or both).

Disability Extension to Twenty-Nine (29) Months

This extension will apply when any qualified beneficiary is determined by the Social Security Administration (ñSSAò) to have been disabled at any time prior to the end of the first sixty (60) days of COBRA coverage (resulting from a termination of employment or reduction of work hours), and continues to be disabled at the end of the initial 18 month period of coverage. For the disability extension to apply, you must notify and provide a copy of the SSA Determination of Disability letter to the Fund Office within the 18 month COBRA period *and* no later than 60 days after the latest of: (1) the date of the SSA Determination of disability; (2) the date on which the qualifying event occurs; or (3) the date on which the Qualified Beneficiary loses coverage due to the qualifying event.

Your Reporting Responsibilities

The Employee or Retired Employee or his or her family members have the initial responsibility to inform the Fund Office of a divorce, legal separation, a child losing Dependent status under the Fund, the Employee or Retiree becoming entitled to Medicare benefits (under Part A, Part B, or both), or the death of a Dependent or the Retired Employee. Written notice must be provided no later than 60 days after the event or the date coverage terminates, whichever is later. Covered Persons may be required to provide additional information to support the qualifying event (e.g. a divorce decree).

The Employeeôs contributing Employer has the initial responsibility to notify the Fund Office of the Employeeôs death, termination of employment, or reduction in hours.

Electing Coverage

When the Fund Office is notified that one of these events has happened, the Fund Office will in turn notify the qualified beneficiaries that they have the right to elect continuation coverage. Qualified beneficiaries must inform the Fund Office that they want to purchase continuation coverage within 60 days from the date they would lose coverage because of one of the events described above. Qualified beneficiaries who elect coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium during a disability extension. The first premium is due 45 days after the date of the election for coverage. All subsequent premiums are due on the first day of each month (with a 30 day grace period).

Duration of Coverage

If you lose coverage due to a qualifying event, you may elect to continue the same coverage that you had immediately preceding the qualifying event; however, that continuation coverage is subject to changes made by the Board of Trustees to the same coverage maintained by similarly situated Employees or Retirees (as applicable). You have the same right to change your coverage that similarly situated Employees or Retirees have, if any (including any open enrollment rights to change coverage).

The Board of Trustees may modify the premiums for continuation coverage from time to time. Contact the Fund Office for information about continuation coverage premiums. If a Covered Person does not elect and/or pay for continuation coverage, then their coverage under the Fund will end.

Ways In Which Continuation Coverage May Be Cut Short

Continuation coverage may be cut short for *any* of the following reasons:

(1) the Employeeôs or a re-hired Retireeôs Employer no longer contributes to the Fund for purposes of providing group health coverage to its Employees;

(2) the qualified beneficiary does not pay the premium for continuation coverage on time;

(3) the qualified beneficiary becomes covered under another group health plan, whether as an Employee or otherwise;

(4) the qualified beneficiary becomes entitled to benefits under Medicare;

(5) in the case of eleven (11) month extensions due to certain disabilities, a final determination that the qualified beneficiary is no longer disabled.

Qualified beneficiaries must pay the full premium for continuation coverage, plus a 2% administrative fee.

Please note that if you or a Dependent have a change in marital status or address, you or your Dependent must notify the Fund Office immediately.

PRIVACY AND SECURITY INFORMATION

The Fund will comply with the Standards for Privacy and Security of Individually Identifiable Health Information promulgated by the Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (ñHIPAAò). Under these standards, the Fund will protect the privacy of HIPAA protected health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected health information will be disclosed only: (1) to the extent authorized by the Covered Person; (2) as required to administer the Fund, including the review and payment of claims and appeals; or (3) as otherwise allowed or required by law. You may authorize the disclosure of your protected health information to third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Fund by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

The Fund has provided participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Fund's use and disclosure of protected health information, or your rights with regards to this information, you may contact the Fund Office.

ADMINISTRATIVE INFORMATION

The Laborersô District Council Health & Welfare Trust Fund No. 2 has established a benefit Fund to provide health and disability benefits to Participants and their Dependents. The Fund is a **group health plan**.

The Fund is administered by a joint Board of Trustees made up of Employer and Union trustees. The Board hired a Third-party Administrator to keep the records of the Fund, make benefit payments, and handle the Fundôs day-to-day administration.

Some benefits under the Fund are paid for directly by the Trust, and others are provided through insurance contracts. Medical, dental, and life insurance benefits are provided through insurance contracts, which means that the applicable insurance company is responsible for paying those benefits and the Fund is responsible only for paying premiums to the insurance company. However, loss of time and asbestos screening benefits are provided on a self-insured basis, which means that the Fund pays for those benefits directly from the Trust.

The name, address and telephone number of the **Third-party Administrator** are as follows:

Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
Telephone: 410-872-9500

The **Plan Administrator** and its **Named Fiduciary** is the Board of Trustees. You can reach the **Board of Trustees** at the following address:

Board of Trustees
Laborersô District Council Health & Welfare Trust Fund No. 2
c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500 or 1-866-553-6559

The names and addresses of its members (the Trustees) are as follows:

Union Trustees	*Employer Trustees*
David Allison, Chairman Baltimore Washington Laborersô 11951 Freedom Drive, Suite 310 Reston, VA 20190	George Maloney, Co-Chairman 7130 Columbia Gateway Drive, Suite A Columbia, MD 21046
Orlando Bonilla, Co-Secretary Mid-Atlantic Regional Laborersô 11951 Freedom Drive, Suite 310 Reston, VA 20190	Ronnie Kennedy DPR Construction 11109 Sunset Hills Rd., Suite 200 Reston, VA 20190
Hugo Carballo Mid-Atlantic Regional Laborers 3680 Wheeler Avenue, Suite 100 Alexandria, VA 22304	Michael Buch Buch Construction 11292 Buch Way Laurel, MD 20723
Dennis Desmond Laborersô Local 11 5201 First Place, NE Washington, DC 20011	Pat Hurley 7130 Columbia Gateway Drive, Suite A Columbia, MD 21046
Julio Palomo Laborersô Local 11 5201 First Place, NE Washington, DC 20011	Cherie Pleasant Construction Contractors Council 3033 Wilson Blvd., #700 Arlington, VA 22201

The Board of Trustees specifically reserves the right and sole discretionary authority to interpret and construe the rules and regulations of the Fund, including all terms and provisions set forth in this document. Any such interpretation or construction will be final and binding on all concerned parties. No Employer or Union representative acting in such capacity nor any employee of the Fund Office is authorized to interpret or construe the rules and regulations of the Fund. For example, no oral statements by Fund (or Union) personnel or their delegates may modify in any respect the written terms of the Fund.

In addition, the Board of Trustees may delegate certain duties to other persons and may seek such advice as the Board deems necessary with respect to the Fund. The Board of Trustees shall be entitled to rely on the information and advice furnished by such delegates and advisors, unless it knows such information or advice to be inaccurate or unlawful.

The **Employer Identification Number** (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 52-0228954.

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

The **Plan year** is October 1st to September 30th each year.

The **Third-party Administrator**, Carday Associates, Inc., has been designated as the **agent for service of legal process**. Its address is:

Board of Trustees
Laborersô District Council Health & Welfare Trust Fund No. 2
c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Service of legal process may also be made on a Trustee or the Plan Administrator.

Sources of Contributions

Self-insured benefits, as well as premiums for insured benefits, are paid from the Fundôs assets, which include:

- contributions made by your Employer on your behalf pursuant to a Collective Bargaining Agreement or a Participation Agreement;
- premiums paid by Retirees and their Spouses;
- earnings from investments;
- COBRA continuation coverage premiums; and
- USERRA continuation coverage premiums.

The assets are held in trust to provide benefits for Participants and their covered Dependents, and to pay the Fundôs reasonable administrative expenses. The Board of Trustees maintains the Trust that holds the Fundôs assets.

You can find out if your employer contributes to the Fund (and, if so, its address) by writing to the Third-party Administrator at the address shown on page 37. In addition, the Third-party Administrator maintains a list of contributing Employers and participating Unions, and copies of the applicable Collective Bargaining Agreements, which you may obtain by writing to the Board of Trustees. That list and the applicable Collective Bargaining Agreements may also be examined at the Fund Office; copies are available by paying reasonable copying costs.

Fund Amendment and Termination

The Fundôs ability to provide benefits depends on certain factors that may vary from year to year -- or even month to month. It is anticipated that the Fund will remain in effect indefinitely. However, federal law, or other considerations, may also require changes to the Fund. The Board of Trustees reserves the right to amend, modify, discontinue, suspend or terminate any part or all of this Fund at any time, for any reason, in its sole discretion. This includes, but is not limited to, changing the schedules of benefits and the eligibility rules for the Fund. In addition, the continuance of the Fund is subject to the maintenance of collective bargaining agreements, which provide for employer contributions to the trust fund that provides the Fund benefits. Therefore, the benefits described in this booklet are subject to change at any time, at the Board of Trusteesô discretion.

If the Fund is terminated and there are assets remaining in the Fund, that money will be used to pay claims incurred before the termination date and any reasonable administrative expenses. The Fund's assets will be used exclusively for the benefit of Participants in the Fund and to pay the Fundôs reasonable expenses. In no event will any of the assets revert to any Employer or to the Union(s). Upon liquidation of the Fundôs assets, Participants and beneficiaries will have no further rights or interest in the Fund.

In summary, keep in mind that benefits provided by the Fund:

- are not guaranteed;
- are not intended or considered to be deferred income;
- are not vested;
- are contingent upon the right of the Board of Trustees to make modifications or terminate such benefits;
- are subject to the rules and regulations adopted by the Board of Trustees; and
- may be modified or discontinued, and such modification or termination right is not contingent on financial necessity.

Disqualification or Loss of Benefits

Certain circumstances may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits. The following are some examples of when coverage might be lost:

- Loss of Participant eligibility (e.g., hours of work for which Employer contributions are made to the Fund, or termination of employment);
- Failure to file necessary forms required to support a claim;
- Failure to file claims within the specified time limit;
- Filing false claims or false information in support of a claim;
- Failure of your Employer to make contributions to this Fund on your behalf;
- Failure of your Employer to comply with its responsibilities under the Fundôs Agreement and Declaration of Trust;
- Ceasing to be a Dependent;
- Failure to repay amounts you owe to the Fund;

- Failure to submit requested documentation of Dependent status in connection with a dependent status verification (as discussed more fully below);
- Coordination of benefits;
- Amendment or termination of the Fund;
- Expiration of the applicable Collective Bargaining Agreement; or
- Fraud or intentional misrepresentation.

However, please be aware that the Trustees can terminate coverage for other reasons, as well.

From time to time, you will be required to provide documentation as proof of your Dependentôs eligibility status, including such items as a marriage certificate, birth certificate, or adoption papers. Failure to provide adequate documentation, upon request, will result in termination of coverage for the affected individual(s) without any coverage extension under COBRA. In addition, coverage of ineligible dependents is in violation of the Fundôs policy. Employees identified as covering ineligible dependents may be subject to legal action and discontinued from Fund coverage.

YOUR RIGHTS UNDER ERISA

The Employee Retirement Income Security Act of 1974 (called ñERISAò) gives those who participate in plans, such as the Fund, certain rights. These include the right to:

- Receive information about the Fund and benefits.
- Examine, without charge, all Fund documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Fund with the U.S. Department of Labor, such as detailed annual reports and Fund descriptions. These Fund documents are to be available at the Fund Office and other specified locations, such as work sites and union halls.
- Obtain copies of all Fund documents and other Fund information upon written request to the Fund administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Fundôs annual financial report. The law requires the Fund to give each Participant a copy of its summary annual report.
- Continue health care coverage for yourself, Spouse or Children if there is a loss of coverage under the Fund as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description/Plan document and the documents governing the Fund and the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Fund Participants, ERISA imposes duties upon the people who are responsible for the operation of a Fund.

The people who operate your Fund, called ñfiduciariesò of the Fund, have a duty to do so prudently and in the interest of you and other Fund 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 benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you have a right to an explanation of the reason for the denial, 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 these rights. For instance, if you request materials from the Fund 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 Fund to provide the materials and pay you up to $110 a day until you receive them (unless the materials were not sent because of reasons beyond the Fundôs control).

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Fundôs decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If you believe that the Fund fiduciaries have misused the Fundôs money or that you have been 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 lost, the court may order you to pay them, for example, if it finds your claim is frivolous.

If you have questions about this Fund, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund, 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 Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

REQUIREMENTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall at a minimum provide for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. As part of the Fundôs Schedule of Benefits, such benefits are subject to the Fundôs appropriate cost control provisions such as deductibles and coinsurance.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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 motherôs or newbornôs attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).